



HIV AUSTRALIA

The criminalisation of HIV: *Criminal Law v Public Health*

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AFAO's aims are to:

- Advocate on behalf of its members at the federal level, thereby providing the HIV community with a national voice;
- Stop the transmission of HIV by educating the community about HIV/AIDS, especially those whose behaviour may place them at high risk;
- Assist its members to provide material, emotional and social support to people living with HIV;
- Develop and formulate policy on HIV issues;
- Collect and disseminate information for its members;
- Represent its members at national and international forums; and
- Promote medical, scientific and social research into HIV and its effects.

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AFAO is the peak non-government organisation representing Australia's community-based response to the HIV epidemic. AFAO's members are the state and territory AIDS councils, the National Association of People Living with HIV/AIDS, the Australian Injecting and Illicit Drug Users League, Scarlet Alliance and the Anwernekenhe National Alliance.

This issue of *HIV Australia* focuses on the criminalisation of HIV transmission and exposure in Australia and internationally. Contributors analyse recent prosecution trends and discuss the stigmatising effects of criminalisation – the most significant impact being the potential undermining of public health policies and HIV prevention and treatment programs. On page 22 of this issue we feature a list of information and policy resources related to these issues.

The next issue of *HIV Australia* will look at HIV-related issues in prisons.

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HIV AUSTRALIA

Volume 8, No. 4

Australian news	4	HIV and criminal law: global advocacy for justice	26
News from the Asia Pacific	5	EDWIN J BERNARD proposes an advocacy approach to combat the overreaching application of criminal law in cases involving HIV non-disclosure and transmission	
International news	6		
Australian criminal law and the sexual transmission of HIV: a contemporary policy response	7	Sex work: equal justice under law	34
SALLY CAMERON examines options for policy and law reform to address arbitrary application of criminal laws in relation to HIV transmission and exposure		THE HON MICHAEL KIRBY <small>AC CMG</small> addresses delegates at the inaugural Asia-Pacific Consultation on HIV and Sex Work, held recently in Pattaya, Thailand	
HIV transmission and the criminal law: a discordant relationship	11	The Vienna Declaration: full-on global drug prohibition versus HIV control	36
SEAN SLAVIN advocates for the repeal of laws pertaining to HIV transmission and exposure, calling for greater reliance on public health mechanisms		DR ALEX WODAK comments on the international declaration signed at the recent International AIDS Conference, calling for a harm minimisation approach to 'the war on drugs'	
Don't ask: don't tell – Act right: play safe!	14	Support for prison NSP trial – but where?	38
IAIN BRADY outlines the operation of HIV disclosure law in NSW and its impact, both in theory and in practice, on HIV-positive people		SEAN COSTELLO reports from the ACT on the ongoing struggle to introduce the first trial of a needle and syringe program in an Australian prison	
Closed courts for open justice	17	Regional Feature: HIV and prison in Thailand – a double sentence	41
MELISSA WOODROFFE explains how suppression orders are used protect the confidentiality of a person's HIV status in court		KARYN KAPLAN profiles an innovative program model for injecting drug users in a Thailand prison	
HIV and consent: when yes means no	20	Book review: Sally Cameron reviews a new internationally produced resource published by NAM, HIV & the criminal law	44
INDRAVEER CHATTERJEE highlights problems arising from the use of archaic laws to inform contemporary cases, such as how legal definitions of 'consent' affect criminal cases involving HIV transmission		Web Watch: Guide to Australian HIV Laws and Policies for Healthcare Professionals	45
Resource profile	22	Treatment briefs	49
A list of current Australian and international resources relevant to HIV and criminal law			
Whose safety? Regulation of the sex industry in Western Australia	24		
SCARLET ALLIANCE outlines the development of the Western Australian government's stance on regulation of the sex industry			
Punitive laws that harm HIV responses: a CHOGM priority?	27		
JOHN GODWIN discusses the use of HIV specific laws in Commonwealth countries and considerations for the upcoming Commonwealth Heads of Government meeting in Perth			

HIV Australia welcomes submissions from interested authors.
To submit an article or report for consideration, email editor@afao.org.au

Review of national testing policies

The Australasian Society of HIV Medicine (ASHM) has been contracted by the Department of Health and Ageing (DoHA) to coordinate the revision of the National HIV Testing Policy as well as hepatitis B and C testing policies. An Expert Reference Committee (ERC) will be overseeing the review. The next round of the consultation process will commence in March. For further information see www.ashm.org.au

PrEP success

On 25 November 2010, *The New England Journal of Medicine* published the results of the first human study to show that pre-exposure prophylaxis (PrEP) is effective in reducing sexual transmission of HIV. The study, called iPrEx, conducted among men who have sex with men in six countries, compared daily oral dosing of Truvada (a fixed-dose combination of two antiretroviral drugs, tenofovir and emtricitabine) with a placebo control.

HIV infections were 44% lower among participants in the Truvada group. In total, 100 people became infected during the trial—36 in the Truvada group and 64 in the placebo group. An increase in protection from HIV infection was associated with high adherence. Among those in the Truvada group who took more than 50% of doses (as measured by self-report and returned pills), efficacy was 50%, while among those who took more than 90% of doses, efficacy was 73%.

Vaccine for HPV-related cancers for Australian males?

In November 2010, the Australian Therapeutic Goods Administration (TGA) approved the use of Gardasil vaccine for males aged nine to 26 for the prevention of external genital lesions and

infection caused by human papilloma virus (HPV) Types 6, 11, 16 and 18. A number of vaccine-preventable subtypes of HPV have been associated with the development of several types of cancers, including anal cancer, penile cancer, and oropharyngeal cancers.

In early 2011, the Pharmaceutical Benefits Assessment Committee (PBAC) will consider including Gardasil for young males on the national immunisation program.

Gardasil has been available on the Australian national immunisation program since 2007 for women aged between 12 and 26 to prevent genital warts and cervical cancer. Early results have shown an encouraging fall in diagnoses of genital warts among young women. New data has also shown that Gardasil has reduced the recurrence of HPV-related diseases in women with prior HPV infection.

Extending Gardasil vaccination to young men and boys would further reduce HPV-related genital warts and cervical cancer in Australian women, while providing protection against genital warts, and HPV-related anal and other cancers in men.

In December 2010 the US Food & Drug Administration approved Gardasil for use in the prevention of anal cancer in people aged nine to 26 in the United States.

Study reveals worrying trend among young gay men

Poor understanding of sexual health is placing young Australians at risk of HIV and other sexually transmitted infections (STIs), says Levinia Crooks, CEO of the Australasian Society of HIV Medicine (ASHM).

In a statement made on World AIDS Day 2010, Ms. Crooks warned that 'a dangerous complacency has affected the broader community – a quiet sense that if you are not gay, an injecting drug user or a sex worker, HIV is not a risk for you.'

Results from a 2009 survey conducted for the Department of Health and Ageing found only 52 percent of Australians surveyed aged 15–29 said they had used a condom the last time they had sex, with over 60 percent admitting they had never been screened for STIs. When asked to assess their own likelihood of catching an STI, the majority perceived themselves as 'unlikely' to do so.

Yet rates of chlamydia continue to escalate. The National Centre in HIV Epidemiology and Clinical Research (NCHECR) reported 62,613 new cases in 2009, over 80 percent of which were young people aged between 15 and 29 years. Individuals already infected with an STI such as chlamydia are at higher risk of contracting HIV if exposed to the virus.

'The younger generation has had little contact with HIV so far. Yet as they get older, travel to other countries and have sexual relations with older age groups they face an ever increasing risk of being exposed to HIV. If they are not practising safe sex, they are placing themselves and their peers at risk. STIs are preventable but they are not all curable. Prevention is crucial,' concludes Ms Crooks.

NAPWA Stigma Audit announced

The National Association for People Living with HIV/AIDS (NAPWA) has commenced a new research project in partnership with the National Centre in HIV Social Research. The HIV Stigma Audit is being conducted by a web-based survey and is seeking participants over 18 years who are HIV-positive and living in Australia.

For more information about the Stigma Audit or to participate, please visit www.hivstigma.net.au

NEWS FROM THE ASIA PACIFIC

Global Commission on HIV and the Law

The Global Commission on HIV and the Law will host an Asia Pacific Regional Dialogue meeting on 16–17 February, in Bangkok. The meeting will focus on regional advocacy for the creation of enabling legal environments which support effective HIV responses.

The Global Commission on HIV and the Law recently concluded a consultation about HIV-related human rights and legal issues in the Asia Pacific as part of the Regional Dialogue. See <http://www.hivlawcommission.org> for more information.

New infections in Asia decrease by 20 percent

The recently released UNAIDS *Report on the global AIDS epidemic* indicates a 20 percent reduction in new HIV diagnoses in Asia between 2001 and 2009. At the close of 2009 an estimated 4.9 million people in Asia were living with HIV.

350,000 people were newly infected with HIV in Asia in 2009, a 20 percent reduction from 2001. UN figures indicate that incidence fell by more than 25 percent in India, Nepal and Thailand between 2001 and 2009, and remained stable in Malaysia and Sri Lanka during this period. Prevalence increased in some areas, with a 25 percent increase in Bangladesh and the Philippines during the 2001–2009 period, however each of these countries has relatively low HIV prevalence.

The UNAIDS report estimates that 90 percent of Asian countries have laws which impact on the rights of people living with HIV.

The full UNAIDS report is available from www.unaids.org

HIV in the Cook Islands

In early January the Cook Islands Prime Minister Henry Puna raised the possibility of publicly naming and quarantining or deporting a person recently diagnosed with HIV in the Cook Islands. The National AIDS Committee intervened and the PM and his cabinet decided to take heed of its advice not to do so.

The Pacific Islands AIDS Foundation's (PIAF's) Temo Sasau, says that the incident prompted PIAF staff to recall what some had themselves gone through after diagnosis:

'We can feel the pain and the heart racing, not knowing what to do next and here I see the newspaper with the leaders and decision makers making these statements. Tears were shed and we did a chain-prayer. We reminded each other that we need to continue to remember our friends and people who may come into contact with the PLHIV in Cook Islands.'

Sasau will be in the Cook Islands next week to participate in a timely HIV awareness workshop.

India rejects HIV drug patent

India has rejected the patent application on HIV drug lopinavir/ritonavir, also known as Kaletra, (LPV/r) by the US-based Abbott Laboratories on the grounds that the product did not meet Indian patentability criteria. This will allow low-cost generic versions of the medicine to continue to be sold in India, as well as their continued export to developing countries like Thailand, Brazil and Ecuador.

The decision was based on a lack of innovation, an essential criterion for obtaining a patent in India. According to India's patent regulations, any drug without new innovations will not be given a patent. Data exclusivity remains

a serious issue with respect to the India EU-FTA negotiations and activists continue to fight against this requirement.

Malaysia to host International AIDS Conference

The International AIDS Society (IAS) has announced that the 7th International HIV Conference on Pathogenesis, Treatment and Prevention (IAS 2013) will be held in Asia for the first time – in Kuala Lumpur.

Commenting on Malaysia's bid, Ms Anouk Rey, Conference Director, IAS, said:

'... the conference would only come to Asia once in a decade, we believe that hosting the conference in Kuala Lumpur will benefit both the delegates and the country.'

The conference was previously held in Sydney (2007) and Cape Town (2009). The next is to be held in Rome, in July this year.

Donor funding cuts threaten Cambodia's HIV response

A study by Cambodian government officials, the Joint UN Programme on HIV/AIDS, and a US-based health policy group, has concluded that the loss of foreign donor funding could undermine Cambodia's HIV response over the next two decades, *Agence France Presse* (AFP) reports.

According to the study, 90 percent of Cambodia's HIV funding comes from external partners, which currently contribute around US\$50 million a year. These funds are expected to shrink as a result of the global financial crisis. The study compared several financing scenarios from the present until 2031 that could remedy the potential budget shortfalls.

The logo for HIV Australia, featuring the word "HIV" in large, bold, blue capital letters above the word "AUSTRALIA" in smaller, bold, blue capital letters.

Got something to say?

Your views are important to the success of this publication.

HIV Australia publishes letters and contributions from readers. If you want to respond to something you have read here, or have an idea for an article, please write to us at: editor@afao.org.au



INTERNATIONAL NEWS

2010 UN AIDS Global HIV data released

The 2010 edition of the UNAIDS *Report on the global AIDS epidemic* has been released, including trend data on incidence from more than 60 countries. The report indicates that international efforts to scale up antiretroviral (ARV) treatments are working, with HIV infections declining globally by 19 percent. HIV incidence has also fallen by more than 25 percent in 33 countries since 2001. However, the report also cautions that global investment in the HIV response flattened for the first time in 2009, making continued investment more important than ever.

The report indicates that at the close of 2009, 33.3 million people globally were living with HIV; 2.5 million of these were children under 15 years. 1.8 million people died of AIDS-related conditions in 2009 – an estimated 260,000 being children under 15 years. In 2009, an estimated 2.6 million people were newly infected with HIV.

The full report is available online at www.unaids.org

UN amendment on executions on the basis of sexual orientation passes

The General Assembly of the UN has endorsed, by 93 votes to 55, an amendment condemning extrajudicial, summary and arbitrary executions of people on the basis of their sexual orientation. This effectively ‘overrides’ the recent discriminatory amendment proposed by Benin (on behalf of the Africa Group) which successfully removed (by 79–70) sexual orientation as a specific ground of protection.

The resolution now requires states to: ‘... ensure the effective protection of the right to life of all persons under

their jurisdiction and to investigate promptly and thoroughly all killings, including those targets at specific groups ... because of their sexual orientation ... and to bring those responsible to justice before a competent, independent and impartial judiciary at the national, or where appropriate, international level, and to ensure that such killings ... are neither condoned nor sanctioned by State officials or personnel.’

The amendment represents the strongest protection of LGBTI rights ever endorsed by the United Nations in its history.

India lifts travel ban

India has lifted its entry restrictions for people living with HIV – for both visitors and prospective residents. In dispensing with these requirements India is following the US, and more recently China in the growing number of countries removing entry restrictions for people living with HIV. This highly praised development is one many strategies India is undertaking in its HIV response.

Speaking to the *Times of India*, UNAIDS Coordinator Charles Gilks said:

‘Such regulations were issued by many countries in the 1980s, when little was known about HIV, and there was more confusion and fear about the virus ... [this] move upholds India’s commitment to human rights and dignity of all people, including those who are living with HIV.’

Ethiopia: new five-year plan to halve HIV infections

The Ethiopian government has announced an ambitious plan to halve new HIV infections, quadruple its annual condom distribution and put 85 percent of people in need of

antiretroviral medication on treatment within five years.

According to the government, an estimated 1.2 million Ethiopians are HIV-positive and the national prevalence is 2.4 percent. There are stark differences between urban HIV prevalence, which stands at about 7.7 percent and rural levels of under 1 percent.

Under the five-year plan presented to parliament on 16 December, the government proposes to increase the coverage of antiretroviral therapy from 60 to 85 percent. Close to 400,000 Ethiopians require treatment for HIV. The plan also aims to increase national condom distribution from 97 to 400 million annually.

Stigma clouds true HIV estimates in Sri Lanka

The total number of HIV infections in Sri Lanka could be at least three times greater than official figures suggest, according to a new report by UNAIDS and the Family Planning Association of Sri Lanka, entitled *The People Living with HIV Stigma Index*.

Government statistics suggest that HIV prevalence in Sri Lanka is low – figures from December 2009 indicate 1,196 cases. However, accurate assessment of HIV prevalence is hampered by stigma, which discourages people from testing and hinders public education campaigns. ‘The numbers are probably under-reported,’ David Bridger, UNAIDS country coordinator said in a recent statement to *IRIN* following the report’s release.

The People Living with HIV Stigma Index is available at: <http://www.stigmaindex.org/129/regional-partners/south-asia.html>



Australian criminal law and the sexual transmission of HIV: a contemporary policy response¹

By Sally Cameron

Recent concerns about the intersection of HIV and criminal, civil and public health law have triggered a range of discussions and initiatives by those working in the HIV sector, however, clear strategies to deliver policy or law reform have been slow to develop. That is hardly surprising given the myriad intersecting factors and practices which must be understood and considered across eight jurisdictions. Many of those lie in the practice of law which is outside the expertise of most in the sector.

Similarly, the ethical issues are complex. No one in the HIV sector seeks to minimise the impact of HIV infection. HIV remains likely to trigger serious physical, psychological and social consequences: a reality well understood by HIV service providers and people living with HIV peer-based organisations. Service providers are well

aware there are some (albeit few) who deliberately or recklessly put others at risk of infection, and that there must be measures to address such behaviours. Still, many in the sector are unsettled by the criminalisation of sexual HIV transmission, the possibility of related civil legal action, and concern that public health management systems may not be operating optimally or may be undermined.

The likelihood that individualised legal actions undermine 'mutual responsibility' messages strikes at the heart of successful HIV prevention practice.

The reality that some two or three people are being prosecuted in an environment where more than 900 instances of HIV transmission occur as a result of sexual acts each year suggests an element of arbitrariness in the application of Australia's criminal laws, across

jurisdictions, that is unacceptable. Following detailed analysis of recent criminal cases, the Australian Federation of AIDS Organisations (AFAO) has pulled together an outline of possible strategies to better engage with agencies involved with the implementation of Australian law as it impacts sexual transmission of HIV. That work is soon to be formalised through publication of a discussion paper, which includes possible strategies and actions. The discussion paper, titled *HIV Crime and the Law: Options for Policy Reform* (available at www.afao.org.au), forms the basis of this article.

The list of possible strategies set out in AFAO's discussion paper is in no way intended to be prescriptive; nor is the outline comprehensive. The paper will

continued overleaf

ideally enhance understanding of the issues in each jurisdiction and possibly initiate actions, or changes of direction. The inclusion of possible strategies in the AFAO paper is intended to facilitate focused discussion among AFAO Member Organisations and key stakeholders, so that we are better placed to formulate concrete actions to address core issues – nationally, under the *Sixth National HIV Strategy*, and within each jurisdiction.

Enable detailed discussion and policy development

In August 2008, the *UNAIDS Policy Brief: Criminalization of HIV Transmission*² recommended that civil society:

‘... monitor proposed and existing laws and advocate against those which inappropriately criminalize HIV transmission and impede provision of effective HIV prevention, treatment, care and support services.’

Such advocacy would require the development of sophisticated networks among community, government and academic institutions across all eight state jurisdictions, as well as input from experts in law and public health administration. Further work is required to determine whether community support can drive policy and (possibly) law reform in this area. If so, specific strategies must be developed and clearly articulated.

While ‘human rights, legislation and anti-discrimination’ are grouped as one of four priority areas for action in the *Sixth National HIV Strategy*³, the issue of HIV criminalisation is barely acknowledged. As such, there is no firm government-endorsed national policy directive on the issue. Notably, the Ministerial Advisory Committee on Blood Borne Viruses and Sexually Transmissible Infections has recently established a Legal Issues Working Group, although the potential of that group is as yet unknown.

One effect of related criminal and public health law falling under state jurisdiction has been a lack of movement towards effective harmonisation of such state/territory laws. Further work is required, firstly, to consider whether such harmonisation would be beneficial, and secondly to determine how this work might be carried out. Basic questions remain unanswered, including whether the types and severity of criminal law being applied in each state are comparable, and whether states are now delivering greater consistency and the best possible public health management under the *National Guidelines for the Management of People with HIV Who Place Others at Risk* (close monitoring of which is listed as a priority action in the *Sixth National HIV Strategy*).

Many agencies are likely to be involved in work relating to the intersection

of HIV and law. That work may benefit from the establishment of a focal point for canvassing these issues (possibly AFAO) to collect, analyse and redistribute state-based and international information so that key organisations have access to current domestic and relevant international research and legislative and policy analysis.

Develop mechanisms to learn more about individual cases

Analysis of criminal and civil cases to date is stymied by the absence of mechanisms to collect data on individual cases. Considerable benefit may be gained from the collection and analysis of information about individual trials. This could take a variety of forms including collection of court transcripts, where available (currently a prohibitively expensive endeavour), or training of court observers to attend and provide comment on trials as they proceed.

Research priorities

The application of law in cases of HIV transmission/exposure through consensual sex is currently under-researched. This undermines development of an evidence-based response, including the development of policy priorities. Research is required on the intersection of public health and criminal law mechanisms (including analysis of cases). We also need to better understand the role of gender, ethnicity and other social determinants – by identifying what makes the likelihood of public health intervention or prosecution more likely, and investigating any differential impacts of criminalisation on different communities. There is currently no mechanism to ascertain where and by whom research relevant to criminalisation and public health management is being undertaken. Establishment of a focal point may assist in this area.

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Work with police

Policing policies, procedures and workforce cultures directly influence the experience of accused and witnesses, as well as the likelihood of cases proceeding to court. Anecdotal evidence suggests that in some instances police have instigated cases without consulting Directors of Public Prosecution (or public health authorities), and that investigation of exposure/transmission cases which include investigations of sexual relations are not always undertaken with appropriate levels of care and respect. Anecdotal reports also indicate that investigating police frequently fail to understand the basics of HIV transmission risk and the practice of risk behaviours.

In August 2008, the *UNAIDS Policy Brief, Criminalization of HIV Transmission*, recommended that states: ‘... issue guidelines to limit police and prosecutorial discretion in application of criminal law (e.g. by clearly and narrowly defining ‘intentional’ transmission, by stipulating that an accused person’s responsibility for HIV transmission be clearly established beyond a reasonable doubt, and by clearly indicating those considerations and circumstances that should mitigate against criminal prosecution).’

A review of police handling of HIV transmission cases in each Australian jurisdiction would usefully inform development of improved protocols for gathering evidence, by interacting with health departments, and engaging with witnesses and other stakeholders. Such work has been undertaken in comparable settings. For example, in the UK, the Terrence Higgins Trust in collaboration with the Association of Chief Police Officers, the (London’s) Metropolitan Police and other community groups conducted a review of police handling of cases.⁴ Following the review, new protocols were produced by a working group which included police officers, representatives of

the Crown Prosecution Service, the National Policing Improvement Agency, and the National AIDS Trust to assist police when investigating allegations of criminal transmission of HIV.

Australian state-based protocols would potentially include processes for formal engagement with state health departments and procedures for dealing with complaints in a fair and sensitive manner. They could also include accompanying resources to provide police officers with basic facts about HIV, current scientific, social and behavioural evidence, and the operation of the public health management system.

Work with justice agencies

Directors of Public Prosecutions directly influence whether cases proceed and how they are run. While it is a requirement that prosecution of a criminal case must be in the public interest, it is not known how the ‘public interest’ is determined in the context of criminal cases involving HIV transmission.

UNAIDS Policy Brief: Criminalization of HIV Transmission recommended that governments:

‘Apply general criminal law only to the intentional transmission of HIV, and audit the application of general criminal law to ensure it is not used inappropriately in the context of HIV.’

That is not being done in Australia; cases continue to be pursued against individuals who have intended to have unprotected sex in the absence of any suggestion their aim was to transmit HIV.

When AFAO has endeavoured to discover basic information about concluded cases (including simple questions, like ‘what specific charge was laid?’), some DPP offices have not been forthcoming. This situation contrasts to the UK experience, where the community sector persuaded the Crown Prosecution Service (CPS) to consider advice from the National AIDS Trust and the Terrence Higgins Trust when developing guidelines on prosecutions relating to sexual transmission of HIV. The CPS *Policy for prosecuting cases involving the intentional or reckless sexual transmission of infection*⁵ has clarified issues for the public and has provided important guidance for police and prosecutors. In Ontario, Canada, the HIV sector is also pursuing the development of prosecution guidelines.

Further discussion is required to gauge whether other legal remedies may be appropriately applied to particular instances of HIV exposure or transmission, including the possibility of a renewed focus on public health offences, alternative dispute resolution mechanisms or diversionary programs.

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It would also be useful to undertake a review of laws being applied and the severity of penalties they attract. For example, do penalties attached to assault offences generally reflect the same culpability if harm is caused by a knife attack or as a result of consensual sex? Many international jurisdictions attach lower penalties to cases of HIV exposure/transmission. In India, for example, draft legislation provides that a 'first offence' for failure to disclose HIV status or practise safe sex attracts a fine, with a more severe penalty imposed if the behaviour is not corrected.

Work with public health officials

Input of public health expertise and due regard to public health principles have been noticeably absent from the criminal law response to HIV exposure/transmission. Public health officials and legal officers appear determined to keep their respective fields separate, indicating a commitment to safeguard the integrity (and separation) of their rationale and their processes. Of course, it is essential that public health and criminal law procedures remain distinct. However, considerable benefit would be gained from public health officials engaging with police and justice officials at a senior policy level to inform prosecution practice. Such inter-sectoral exchanges across policing, prosecution, health and social services are not new. For example, such exchanges revolutionised police and prosecution responses to sexual assault and domestic violence in the 1980s and 1990s. The *Sixth National HIV Strategy* offers the potential for an informed cross-government response.

There is a pressing need to develop liaison protocols – both from health to police and police to health. Given at least four state health departments have recently been drawn into criminal law matters relating to HIV exposure/transmission, the observations of those involved could inform development of a best practice police/prosecution response. Further, the impact of prosecutions on public health officials' work must be duly considered.

Consideration should also be given to the effectiveness of current public health responses, particularly the advantages/disadvantages of increasing levels of intervention for those who appear unwilling to alter their risk behaviours and the equity of a system that lacks formal provision of a support person (advocate or witness) for those on whom public health interventions are imposed.

Judges' understanding of HIV

The expertise of lawyers, judges and magistrates directly impacts the course and outcome of matters involving HIV exposure/transmission – affecting scrutiny and analysis of evidence, instructions to juries, sentencing, and future trials (through the use of precedents). Formal judicial education is now well-established in Australia, with specialist judicial education organisations providing education on a wide range of subjects. There is clearly a need for judicial education regarding HIV.

Developing the response

The criminalisation of HIV transmission and its intersection

with other areas of law requires a sophisticated response involving both the government and community sectors, informed by behavioural and scientific research. Some in the HIV sector and law reform circles may argue that given the small number of HIV related criminal cases, this work should not be prioritised. But the number of criminal cases running at any time in Australia is not the point. The point is that the criminal law in some Australian jurisdictions is ambiguous in terms of HIV transmission, and is arbitrarily applied, and this undermines the public health response for which Australia is renowned.

In short, this is not an issue for simplistic slogans or a single political line. It needs careful analysis, an evidence base and practical actions.

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- 1 Thanks to Linda Forbes and Abi Groves (AFAO), John Rule (NAPWA), David Scamell (ACON), and John Godwin whose editorial assistance and collaborative efforts on this and earlier pieces of work inform the drafting of this article.
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Input of public health expertise and due regard to public health principles have been noticeably absent from the criminal law response to HIV exposure/transmission.

Sally Cameron is a consultant and former policy analyst at AFAO. She is currently undertaking a project on criminalisation for AFAO.



HIV transmission and the criminal law: a discordant relationship

By Sean Slavin

In the early years of the epidemic, the Australian response to HIV was characterised by a progressive law reform agenda that aimed to support a public health response to the virus. This response prioritised education and the engagement of affected communities over punitive legal sanctions. The legislative framework included anti-discrimination legislation that protects people living with HIV and the decriminalisation of homosexuality in the jurisdictions where such laws existed.

Public Health Laws

Various public health laws have been enacted across Australian states and territories. *National Guidelines for the Management of People with HIV Who Place Others at Risk* were endorsed by the Australian Health Ministers' Conference

in 2008.¹ These guidelines are intended to promote national consistency and to provide a formalised, government regulated, expert system to address instances of people with HIV who place others at risk of infection.

The guidelines are based on the principles that:

- The human rights of people living with HIV should be respected.
- There is an equal responsibility for HIV prevention among all people regardless of HIV status.
- When dealing with HIV-positive people whose behaviour poses a risk of infecting others, a graduated scale of interventions should be used – beginning with education and counselling and only employing more interventionist strategies if these have been demonstrated to be ineffective,

or if it is believed more moderate strategies are unlikely to succeed.

- At the end of the scale of interventions there is a capacity, through public health legislation, to detain people involuntarily and to refer cases to police where there is behaviour that recklessly or negligently endangers or causes serious harm.

The guidelines are intended to shape public health law, which is a state/territory responsibility. They recommend a five-tiered, graduated approach to management.

1. Counselling, education and support – usually by the client's primary health care provider, with the assistance of specialist HIV case workers, as appropriate.

continued overleaf

2. Counselling, education and support under advice from the HIV Advisory Panel (a panel of public health, clinical and community-based HIV experts) or the Chief Health Officer or equivalent – with management in the community provided under recommendations from the Chief Health Officer or equivalent and/or the HIV Advisory Panel, but without a formal behavioural order.
3. Management under a behavioural order.
4. Detention and/or isolation.
5. Referral to police – to be investigated according to state/territory criminal laws.

These guidelines recognise that in most cases there are various reasons to eschew criminal sanction and use alternative forms of management.

Problems with the criminalisation of HIV exposure or transmission²

Criminalisation of HIV exposure or transmission undermines prevention efforts: It creates fear and distrust among people living with HIV and those at risk of HIV. It discourages HIV-positive people from disclosing their status to sexual partners, and those at risk of HIV from seeking testing. It may discourage people from accessing clinical care if they fear their status will not remain confidential or their behaviour will be scrutinised unreasonably.

Criminalisation of HIV exposure or transmission promotes the stigmatisation of people living with HIV: It reinforces the stereotype that people with HIV are immoral and dangerous and that people without HIV are their potential victims.

Laws that criminalise HIV exposure or transmission often impact selectively and unfairly on those who are most socially marginalised: Migrants, refugees or others perceived as ‘foreign’, sex workers, men who have sex with men and transgender people are particularly vulnerable. Notably, a disproportionate number of prosecutions in Australia have targeted male immigrants from sub-Saharan Africa.³ The over-representation of heterosexual men among Australian prosecutions reflects, perhaps, societal anxiety about heterosexual sexual violence and normative gender constructions that position men as perpetrators and women as victims of violence.

Criminal law is arguably not adept at taking into account the subtle gradations of HIV risk or the changing implications of an HIV diagnosis: In the current era of effective antiretroviral treatment, a person with HIV whose virus is effectively controlled with treatments is much less infectious than someone not receiving treatment, and arguably, someone who does not know they are infected. Even the risk among men who

have sex with men varies considerably, depending on viral load and the particular sex act involved.⁵

When prosecutions do occur they often rely on laws relating to grievous bodily harm. The use of such laws does not take into account the significant advances in the treatment of HIV over the past 15 years. HIV is no longer regarded as a fatal infection but one that is chronic and treatable. People living with HIV in the developed world can now expect similar life spans as people in the general population.⁶

Criminal prosecutions for HIV exposure or transmission in Australia

Despite comprehensive public health measures for the management of HIV-positive people who place others at risk, criminal law is still used in circumstances where it is unwarranted or of little benefit. Criminal law is a matter for the states and territories in Australia and laws vary considerably across the country. Generally states have applied laws relating to causing grievous bodily harm, grievous bodily disease, serious harm or injury, or endangering life. The only jurisdiction with an HIV-specific law is Victoria where, although framed in terms of intentionally causing a very serious disease (section 19A of the *Crimes Act*), ‘very serious disease’ is defined as HIV only. This contravenes the recommendations of the *International Guidelines on HIV/AIDS and Human Rights*.⁷ Three jurisdictions, Victoria, South Australia and the Northern Territory provide endangerment offences (where no transmission has occurred).⁸

Since the first charge of HIV transmission/exposure in 1991, there have been at least 30 criminal prosecutions in Australia. There has been a trend toward increasing numbers of prosecutions in recent years and a disproportionate number of these have occurred in Victoria.⁹ All prosecutions

Despite comprehensive public health measures for the management of HIV-positive people who place others at risk, criminal law is still used in circumstances where it is unwarranted or of little benefit.

have been of men and the 'victims' have been a mix of men and women. A disproportionate number of men from sub-Saharan Africa have been prosecuted. This trend is of considerable concern and seems to be occurring independently of the workings of the public health mechanisms detailed above. This raises the question of what is needed to strengthen the public health approach further and decrease reliance on criminal law.

A number of strategies are worth exploring. These include:

- Education of police and prosecutors of the existence and workings of the public health mechanisms for managing people living with HIV who place others at risk of infection.
- Law reform that includes the removal of all HIV-specific laws that criminalise transmission, exposure or failure to disclose status.
- Inclusion of the use of condoms or other risk reduction strategies as a possible defence.
- Education of prosecutors about the relatively low risk of various activities that do not warrant prosecution.
- Education of the legal sector more broadly about the negative public health impact of criminal prosecutions of HIV transmission and/or exposure.

Conclusion

Australia has taken an effective and progressive path in devising a public health mechanism for the management of HIV-positive people who place others at risk of transmission. There is nonetheless room for improvement in the use of those laws in preference to the criminal law. There is further work to be done to repeal HIV specific transmission/exposure laws and to educate the legal sector about the public health alternatives. Importantly, the stigmatising effects of HIV criminal

prosecutions on all people living with HIV must be acknowledged. These cases create fear and thus impact on the wellbeing of people living with HIV and affected communities. They also hamper prevention efforts; people with HIV are less likely to disclose their status to sexual partners and less likely to actively and openly engage with clinical care.¹⁰

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- 9 Cameron and Rule. op. cit., 21–22.
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Importantly, the stigmatising effects of HIV criminal prosecutions on all people living with HIV must be acknowledged.



Don't ask: don't tell – Act right: play safe!

By Iain Brady

The world leading response to the HIV epidemic that Australia has pioneered has from the start been based on bipartisan political action and the collaboration of the community based HIV sector, governments and health departments. This partnership has been fundamental to developing and delivering public health policy and services, and the shaping of laws relating to HIV. It has ultimately been responsible for the effective containment of the spread of HIV in Australia, delivering one of the lowest prevalence rates in the world. This partnership appears to be alive and well; it looks soon to produce a major step forward for NSW law, with the reformed Public Health Act 2010 (the 2010 Act) having passed both houses of parliament and receiving royal assent on 7 December 2010. It is yet to enter into force.¹

Criminalisation – the legal view

Disclosure laws have long been a bugbear for people living with HIV

(PLHIV) and for public health policy. Many countries have laws requiring HIV-positive people to disclose their status to others in a range of situations, core among these being prior to having sex. Papua New Guinea, for instance, in its reasonably progressive *HIV/AIDS Management and Prevention Act 2003*, requires disclosure prior to sex by an HIV-positive person.² In Australia, the only jurisdiction to still require such disclosure prior to sex is NSW, albeit with a tandem exculpatory defence introduced in the new 2010 Act.

The rationale for the approach is simplistic; it is thought that if the law requires people living with HIV to tell sexual partners their HIV status, they will and that as a result they will either not have sex, or they will practise safe sex. The hope is that the rate of new infections will be lowered as a result.

Criminalisation in practice

The reality is starkly different. HIV stigma is ubiquitous and insidious. The

predictable result of forced disclosure of HIV status is to engender anonymous sexual encounters, to harbour HIV denialism and foster reticence towards testing and knowledge of HIV status. Such laws detract from safe sex health messages which encourage self-care and care for sexual partners, while also undermining health care workers' engagement with HIV-positive patients as they require counseling of unpalatable impositions. They undermine trust and confidence in relationships between practitioners and HIV-positive patients.

Disclosure requirements have been in force in NSW since the passage of the *Public Health Act 1991* (the 1991 Act).³ Under section 13 of the 1991 Act, an HIV-positive person must tell their sexual partner prior to having sex that they have the condition and that there is a transmission risk by having sex.⁴ While the penalty for failure to observe this requirement has been modest, with a \$5,500 maximum, the impacts

of these disclosure requirements have been far-reaching; they undermine the work of healthcare workers and public health messages regarding safe sex, and stigmatise HIV.

Legally, section 13 has had limited impact but its existence has been a constant source of friction and concern within the sector. There have only been two prosecutions under the section since it was introduced.

One was dismissed. The other, rightly, was dealt with by a bond and no conviction.⁵ Its impacts resonate at a deeper level – there is a general stigmatising impact of such legislation, no matter whether the law is rarely applied. The disclosure requirement serves to reinforce fears of *contagion*.

Moreover there has been a dulling effect, which counters public health messages. People conscious of the requirement for disclosure have been comforted that they will be told of HIV status, as the law requires it. The requirement has given air to the question, ‘Are you positive?’ prior to sexual encounters, as if the answer should change behaviours. In our practice we have seen numerous people who have been infected after having been lulled into a false sense of safety within the construct created by the disclosure requirement.

We have seen other negative effects of this law in our practice. Recently we have seen two clients with problems emanating from this law. Both had sex without disclosure. One had safe sex. The other had unsafe sex in a park: there was little discussion. Afterwards each client was being blackmailed by their sex partner. The HIV status of the sex partner was unknown in both cases.

In one case, when the safe sex led to a possible transmission risk, our client disclosed and suggested post-exposure prophylaxis (PEP) to their sex partner. The client took him to hospital and paid for some medications. More money was then demanded in order to fix the problem. The other case involved unsafe casual sex; the HIV-positive client was quite drunk and the sex partner was quite eager to be penetrated. The threatening text messages over the following days

indicated that a police complaint was on the cards. The receptive partner was pressing for disclosure – only after the fact, and having ignored recommendations to seek PEP and testing.

These cases speak more of the chilling effect of the disclosure requirement law, rather than an encouragement to comply with safe sex practices.

Law reform advocacy

In 2005, the NSW Government initiated a review of the 1991 Act, with a view to renovating it generally. That review led to a new draft legislation, the *Public Health Bill 2010 Consultation Draft* which was released for public comment in February last year. The consultation draft was disappointing. It contained many deleterious proposals for changes to the 1991 Act in respect of HIV management and privacy. The proposal for Section 13 was for renumbering, a clearer title, and higher penalties.⁶ Despite extensive HIV sector efforts during the review process from 2005 onwards, it seemed there was to be only deleterious change to the 1991 Act.

The partnership between the community-based HIV sector, the NSW Health and the bipartisan engagement of politicians came into play again powerfully. The community and professionally-based HIV sector made submissions and representation jointly and individually. Australasian Society of HIV Medicine (ASHM), the Australian Federation of AIDS Organisations (AFAO) and ACON notably headed a strong joint submission focused on section 13, which was largely adopted by the Ministerial Advisory Council.⁷ They provided a Sondheimian chorus calling for positive change to the consultation draft. They jointly vocalised the span of arguments and positions against the 1991 Act disclosure provisions.

The thrust of the community-based HIV sector and Ministerial Advisory Council recommendation was for the adoption of best practice legislation such as expressed in the *Victorian Public Health and Wellbeing Act 2008*. Its section 111 states:

*“111. Principles
The following principles apply to the management and control of infectious diseases–*

- (a) the spread of an infectious disease should be prevented or minimised with the minimum restriction on the rights of any person;*
- (b) a person at risk of contracting an infectious disease should take all reasonable precautions to avoid contracting the infectious disease;*
- (c) a person who has, or suspects that they may have, an infectious disease should–*
 - (i) ascertain whether he or she has an infectious disease and what precautions he or she should take to prevent any other person from contracting the infectious disease; and*
 - (ii) take all reasonable steps to eliminate or reduce the risk of any other person contracting the infectious disease.”*

It is to the great credit of the NSW Government, NSW Health and the Health Minister, Carmel Tebbutt that the process of public exposure and consultation was genuine and responsive. By around the middle of 2010, there was finally agreement with NSW Health that the Consultation Draft would be amended to reflect the views of the sector and re-engage the successful partnership of Government, NSW Health and community sector agencies, with bipartisan support.

The devil is as always in the detail.

The amended Bill was introduced to Parliament on 23 November and has passed both houses, being assented to on 7 December 2010. The new provisions contained in Section 79 are, relevantly:

‘79 Duties of persons in relation to sexually transmitted infections

- (1) A person who knows that he or she suffers from a sexually transmitted infection is guilty of an offence if he or she has sexual intercourse with another person unless, before the intercourse takes place, the other person:*
 - (a) has been informed of the risk of contracting a sexually transmitted infection from the person with whom intercourse is proposed, and*

continued overleaf

(b) has voluntarily agreed to accept the risk.

Maximum penalty:

50 penalty units.

and;

(3) ***It is a defence to any proceedings for an offence under this section if the court is satisfied that the defendant took reasonable precautions to prevent the transmission of the sexually transmitted infection.***
(Author's emphasis)

The Minister's second reading speech addressed the reforms, stating:

'The bill before the House provides in clause 79 (3) that a person charged with such an offence has a defence if he or she satisfies a court that he or she took reasonable precautions to prevent the transmission of the sexually transmitted infection. The availability of this defence is an important inclusion. It is important to encourage individuals to take reasonable precautions. Reasonable under the Act will be measured on an objective standard and will include safe sex practices, protecting the people using them from liability just as it will protect them and their partners from disease transmission. It is essential to recognise that this type of positive physical and behavioural precaution is far more effective in protecting public health than the verbal disclosure of an infection. However, where there is a malicious or criminal intent associated with the transmission of a sexually transmitted infection, there are provisions in the Crimes Act that allow for criminal prosecution.'

Current legal landscape of HIV transmission

While there is essentially no change to the lead directive provision of the section, i.e., the requirement to disclose, there is now a defence. This broadly means that the NSW legal position conforms with the best practice model proposed by the community-based HIV sector; the new provisions do

loosely conform with the health message of self care and care for others. Although they fall short of the principled statement in the Victorian Act, they will allow health care workers to appropriately and legally advise HIV-positive people in accordance with best practice in public health. They will avoid the patient alienation engendered by the previous unworkable provision.

The downside is that better, principled public policy affirming change has been deferred. These provisions, because they camouflage the faults, may be difficult to amend. They will likely be seen as a sufficient compromise, although not the best we can do. The stigmatising effect remains, as does the false security generated by the requirement for disclosure. The provisions leave HIV-positive people open to a charge of failing to disclose their status prior to sex. The defence would have to be raised in court. The stress of that process, the jeopardy and the potential shaming effect continues the stigma of the provision. It fails to engage appropriate and shared commitments to safe behaviours.

The 2010 Act allows the Government to maintain the position that HIV-positive people are required to disclose their status prior to having sex, placating persistent fears by conservative elements unfamiliar with the public health policy realities and considerations. In this sense, the drafting of the Act is a deft political move to effect positive change without resistance, though there is still further to go from a public health legal perspective.

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- 1 As at 20 December 2010.
- 2 *HIV/AIDS Management and Prevention Act 2003* [PNG] Section 24: REASONABLE CARE, states: 'A person who is, and is aware of being, infected with HIV shall –
(a) take all reasonable measures and precautions to prevent the transmission of HIV to other, including the use of condom or other effective means of protection from infection during sexual intercourse; and

(b) be inform any intended sexual partner or any person with whom a skin penetrative instrument is to be shared, in advance of the sexual intercourse or sharing of the skin penetrative instrument, that he is infected with HIV, and the taking of those measures and precautions and the giving of that information shall constitute the taking of reasonable care within the meaning of Section 286 of the *Criminal Code Act 1974*.'

- 3 *The Public Health Act* was assented in 1991, commencing on 18 November 1991.
- 4 The Act, Section 13 relevantly states: '(1) A person who knows that he or she suffers from a sexually transmissible medical condition is guilty of an offence if he or she has sexual intercourse with another person unless, before the intercourse takes place, the other person:
(a) has been informed of the risk of contracting a sexually transmissible medical condition from the person with whom intercourse is proposed; and
(b) has voluntarily agreed to accept the risk.'
- 5 The maximum penalty for the offence was set at 50 penalty units, currently equivalent to \$5,500.
- 6 Application of Section 10 (1) (b) of the *Crimes (Sentencing Procedure) Act NSW 1999*
The new section was to read:
'76 Persons with sexually transmitted diseases to inform sexual partners
(1) A person who knows that he or she has a sexually transmitted disease is guilty of an offence if he or she has sexual intercourse with another person, unless before the intercourse takes place, the other person:
(a) has been informed of the risk of contracting a sexually transmitted disease from the defendant, and
(b) has voluntarily agreed to accept the risk.
Maximum penalty: 100 penalty units or imprisonment for 6 months, or both.'
- 7 The submissions by interested parties may be obtained from NSW Health.

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Closed courts for open justice

By Melissa Woodroffe

The legal system in Australia is based on the long-standing principle of open justice. As such, the business of our courts is open to the public (and hence the media) – who may attend, with very limited exceptions.

Clearly this has implications for people living with HIV who come before the court system, either as offenders or as victims. When a person's HIV status is to be raised in a court or tribunal, what protections exist to prevent this information being more widely circulated to members of the public and to the media?

Why is suppression of a person's HIV status important in the court system?

HIV remains a condition that is subject to stigma and discrimination in society and many people living with HIV are very careful about when and to whom they disclose their HIV status. It should be remembered that there are only very

limited circumstances in which a person is required to disclose their HIV status. Thus, many people choose to keep the information private and do not inform their employer, and sometimes do not even tell friends or family.

Where a person has been treated badly due to their HIV status, for example, discriminated against or vilified, it is important that they are able to come forward and make a complaint. Clearly people are going to be discouraged from making a complaint if it causes their HIV status to become widely known via media reports, or through members of the public attending Court. Hence the importance of suppression orders in such matters.

The existence of a supportive legal system has assisted Australia's response to the HIV epidemic by fostering an environment where the rights of HIV-positive people are respected and protected. This supportive legal environment extends

to the maintenance of confidentiality regarding a person's HIV status in the court system and other areas of life.

Recent court cases related to HIV transmission have aroused considerable media interest. The reporting of such cases by the media is often sensationalised and designed to engender fear and panic in the reader. Such reporting has the potential to jeopardise and undermine successful public health measures by negatively affecting public perception of HIV and HIV-positive people.

Under what circumstances might a person's HIV status be raised in court?

The laws relating to HIV transmission and disclosure of positive status differ across Australian states/territories, with some jurisdictions including provisions regarding disclosure in both criminal

continued overleaf

and public health statutes. In NSW, for example, the *Crimes Act 1900* provides for offences in relation to the deliberate or reckless transmission of HIV, and the *Public Health Act* makes it an offence to fail to disclose one's HIV status prior to sexual intercourse. Furthermore, across jurisdictions, a person's HIV status may be relevant to the sentencing process, as either an aggravating or mitigating factor.

There will be many instances where the person living with HIV is the victim, by virtue of experiencing discrimination or vilification, for example. It is important that in such circumstances, a person who has been discriminated against or vilified on the basis of their HIV status, or perceived HIV status, is able to come forward and make a complaint and seek an appropriate remedy without worrying that their HIV status will become public knowledge during a hearing or be reported in the media.

The legal situation regarding suppression of information heard in a court or tribunal

Some powers to make suppression orders are clearly articulated within a statute (for example the *Public Health Act* and the *Administrative Decisions Tribunal Act* provide powers to close a court and to make suppression orders). In other instances, powers to make suppression orders are provided to courts by the common law.

There are three main types of protection under the umbrella of 'suppression orders':

- to close the courtroom to the public;

- to prohibit any publication of the details of the matter; and
- to provide for the use of pseudonyms for all parties and for the exclusion of any other identifying information, so that when the decision is published or reported in the media the HIV-positive person cannot be identified.

Inherent power of the courts to make suppression orders

Suppression orders on their own do not prevent the public or media from attending a court hearing and listening to and observing proceedings. While penalties exist for breaches of suppression orders, often the damage will already have been done in terms of disclosure of the information. The courts ultimately have to balance the competing interests of the public interest in open justice and the importance of maintaining the confidentiality of a person's HIV status.

A closed court, with associated use of pseudonyms in any published decision provides the greatest level of protection to the privacy of an HIV-positive person. However, a closed court impacts to the greatest extent on the principle of open justice.

Inherent power of the courts to make suppression orders

In the absence of any statutory authority, under common law the power to make suppression orders is part of the implied power of the court. The courts have power to make such orders as are reasonably necessary to secure the

proper administration of justice in the proceedings before them.¹

The test is one of necessity, namely, whether it is 'really necessary to secure the proper administration of justice' in the proceedings.² The necessity for such measures would arise only in 'wholly exceptional' circumstances, not merely in situations where such measures would be useful or desirable³ or would save embarrassment, distress or financial loss⁴.

Statutory powers to make suppression orders

Public Health Legislation

Section 13 of the *Public Health Act 1991* (NSW) makes it an offence to fail to disclose one's HIV status prior to sexual intercourse, irrespective of whether safe sex practices are used. Section 37 of the Act allows for the local court to be closed when alleged offences under this section are heard. This is particularly important given that without such protection, even a person found not guilty of the charge would still have lost control over who had knowledge of their HIV-positive status.

Equivalent legislation in Victoria is broader in scope and more sophisticated. Section 133 of the *Public Health and Wellbeing Act 1998* (Vic) provides that a court or tribunal *should* make an order to close the court where evidence is proposed to be given in a matter before a court or tribunal of any matter relating to HIV, and where the court considers that the disclosure of the information would cause adverse social or economic consequences to the person.

Anti-Discrimination Legislation

The *Administrative Tribunal Act 1997* gives the Administrative Decisions Tribunal the discretion to make suppression orders if the tribunal is satisfied that it is desirable to do so due to the confidential nature of the matter, or for any other reason. This is an important protection for people who have been discriminated against, victimised, or vilified as a result of their HIV-positive status.

There will be many instances where the person living with HIV is the victim, by virtue of experiencing discrimination or vilification, for example.

What examples are there of suppression orders being used in respect of a person's HIV status?

Our centre has made a number of applications for suppression orders on behalf of HIV-positive clients. One example concerned a man who had been discriminated against on the basis of his HIV status in the course of his employment at a hotel in a small town. An application was made to close the court to the public. Orders were made to anonymise the names of all the parties, including witnesses, and to remove any mention of the name of the town or hotel involved so that the complainant could not be identified. Similar orders were obtained for a case of HIV vilification against a gay, HIV-positive couple in another NSW town.

In *X v Y*, a UK case, an injunction was sought to prevent a newspaper from publishing the names of two HIV-positive doctors working in a hospital.⁵ The paper had obtained the information from confidential hospital records, and argued that there was an overriding public interest in disclosing the information, because the public was entitled to know that the doctors had HIV. The court held that the public interest in preserving the confidentiality of hospital records outweighed the public interest in the freedom of the press to publish the information, because people with HIV must not be deterred from seeking appropriate testing and treatment. The court recognised that confidentiality in relation to a person's HIV status is important – to protect the interests of the person themselves and also to reinforce public health strategies to encourage testing.

Suppression orders have been obtained in a number of Australian criminal cases, protecting the identity of victims and (at times by default) the accused. However, in the case of *Mwale*, suppression orders were not allowed. Mwale was charged with deliberately infecting a number of partners with HIV. It was held that the public interest in alerting possible sexual

partners of the accused (so that they could seek immediate medical advice and testing) outweighed the public interest in preserving the confidentiality of the accused's medical condition.

A recent case in Sydney involved a taxi driver who was charged and convicted of sexual assault. The judge took into account the accused's HIV status in determining his sentence (at the time of the offences the defendant was HIV-negative, so it had no bearing on the assaults). The Supreme Court of Criminal Appeal agreed with the District Court decision to not allow suppression on the basis that the public interest in hearing the reasons for sentencing outweighed the interest in maintaining the confidentiality of medical information. After the sentencing, where the man's HIV status was revealed, the media picked up on the HIV aspect of the case to make sensationalised headlines that completely misled the readers as to the nature of the case, for example:

*'A cruel discovery for victims – taxi driver who raped them had HIV.'*⁶

Clearly the man's HIV status had no relevance to the offences, since he did not have HIV at the time of the offences. The headlines served no purpose other than to further stigmatise HIV and people who live with HIV.

In summary, the availability of suppression orders is an extremely important power of the court. Without the availability of these orders to protect the confidentiality of complainants' HIV status, they would in many instances be extremely reluctant to proceed with their

complaints. However, in the absence of any statutory authority to make suppression orders, the courts will make a judgement by balancing the public interest in favour of open justice and the public interest in protecting confidential medical information.

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- 1 *John Fairfax & Sons Pty Ltd v Police Tribunal of NSW* (1986) 5 NSWLR 465 per McHugh JA at 477; *John Fairfax Group Pty Ltd v Local Court of NSW* (1992) 26 NSWLR 131 at 160; *Attorney-General (NSW) v Mayas Pty Ltd* (1988) 14 NSWLR 342 per Mahoney AJ at 345; *John Fairfax Publications Pty Ltd v District Court of NSW* (2004) 61 NSWLR 344 at 24–37.
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It was held that the public interest in alerting possible sexual partners of the accused ... outweighed the public interest in preserving the confidentiality of the accused's medical condition.



HIV and consent: when yes means no

By Indraveer Chatterjee

Laws – even if they exist only on statute books – have significant power to adversely affect human behaviour. This is a matter of particular concern in areas relating to public health, especially where ambiguous laws impact upon the everyday rights of people.

The criminalisation of HIV transmission is a case in point. While the transmission of HIV might be properly considered ‘criminal’ in certain circumstances, say where a person intentionally seeks to infect another person, current criminal laws arguably criminalise **all** acts of HIV transmission, even where such transmission occurs as the result of informed and consensual sexual behaviour.

This is the result of using old laws – and outdated criminal concepts – to cover new issues. Even where parliament has specifically turned its collective mind to the issue – as in NSW¹ – there remains a singular lack of clarity as to the boundaries of what ‘criminal’ HIV transmission is. The boundaries are even more confused where the applicable criminal provision does not

even require the ‘criminal’ actions to be ‘intentional’ or ‘reckless’; a number of criminal laws simply penalise the *negligent causing* of actual or grievous bodily harm².

The same issue (which could be referred to as ‘over-criminalisation’) arose in the 1992 United Kingdom House of Lords case, *R v Brown*³, which criminalised private, consensual sado-masochistic conduct. English criminal law proved incapable of comprehending adult defendants who ‘positively wanted, asked for, the acts to be done to them’⁴, given the long standing legal principles that denied an individual the ability to ‘consent’ to assaults.

As a result, the House of Lords held, three to two, that sado-masochistic conduct could not ever be lawfully consented to. All the Lords accepted as good law that individuals could generally only ‘consent’ to a certain level of harm, referred to by Lord Mustill as the *critical level*. The three Lords in the majority found that level to be *actual bodily harm*⁵, Lord Slynn (in the minority) at *grievous bodily harm*⁶, while

Lord Mustill (also in the minority) appeared to draw the line at death.

The problem here is that the transmission of HIV would certainly fall within *actual bodily harm*, if not the more serious offence of *grievous bodily harm*. The decision in *Brown* – and the various (often antique) authorities it refers to – effectively deems consent irrelevant, and is likely to be highly influential on the Australian Courts. If accepted undiluted, this would potentially collapse the distinctions between consensual, negotiated sex and its public health nemesis, high risk/non-disclosure sex. It would rob consenting adults of the ability to take risks, and consent to any harm that eventuated from them.

Brown also held, however, that in certain limited circumstances (surgery, sporting activities etc.) a defence of consent could be raised even if significant harm resulted. These *special situations*⁷ existed due to the greater ‘public interest’ in allowing these harms, and the Court seemed reluctant to expand these categories. This approach

in *Brown* has attracted considerable criticism, both in the judiciary and in academic literature, for the lack of any clear basis upon which such ‘special situations’ could be identified; indeed Lord Mustill in his dissenting judgment attempted to formulate some such legal theory and gave up, noting that he *found that the task is almost impossible*.

Even within such ‘special situations’ the consent a ‘victim’ can provide is limited and cannot operate as a blanket defence for an accused. For example consent on the rugby field to injuries would generally be limited to the sort of injuries and actions consistent with the sport.

Post-*Brown* the simple act of unprotected sex between a sero-discordant couple became arguably unlawful as it involved the negative partner accepting a risk of harm that at law they could not consent to. A later English case, *Dica*⁸, provided some clarification of the English common law in relation to HIV transmission. *Dica* appeared to broaden the categories of ‘special situations’ that allowed the defense of consent, to include *consensual acts of sexual intercourse* [...wherein...] *there may be a known risk to the health of one or other participant*.

Dica however provided little further clarity on this expansion. While the case itself concerned a man who allegedly infected two women while fraudulently misrepresenting his status, the Court (confined as it was to the abstract question of law) dealt with the issue in abstract, using a number of illustrative examples. The hypothetical relevant to HIV – concerning a Roman Catholic serodiscordant couple who were unable to use contraception due to their religious belief – was hardly typical. The problem with this model of legal thinking is the continuing necessity of ‘public interest’ for the creation of ‘special situations’ leading at least one commentator to question whether any such category would extend beyond married couples⁹.

The majority of the ‘special situations’ raised in *Brown* (sporting, surgery

etc.) already exist at law in Australia; the circumstances contemplated by *Dica* have not yet been the subject of Australian jurisprudence. Barring the existing ‘special situations’ (which are unlikely to cover the transmission of HIV), the availability of consent as a defence remains open to question. The High Court has clarified the upper limits of this defence – consent is not available where death results¹⁰ – but beyond this the question of whether the defence of consent is available lies in a legal void.

The New Zealand Court of Appeal in *The Queen v Lee*¹¹ undertook an extensive review of the applicability of consent to the criminal law and effectively broke away from the English jurisprudence. It held that the availability of consent was not *results-based* (i.e. regardless of the harm caused, consent may still be available). Importantly, the Court moved away from the concept of consent as a defence only being available in ‘special situations’ prescribed by the public interest, choosing rather to allow for consent except in certain prescribed circumstances (such as street fighting).

Australia needs such a clear judicial statement, analysing the various (often contradictory) authorities; in its absence we will only have doubt and indecision. Arguments may be made that currently, prosecutorial discretion means that only intentional or highly reckless transmission matters are brought before Courts. This is problematic because prosecution trends change over time. To leave the choice of prosecution on such offences to unfettered discretion seems to be inappropriate public policy.

In Australia there has been a noted increase in the number of prosecutions relating to HIV transmission/exposure offences.¹² Internationally too there seems to have been a steady increase in HIV transmission prosecutions.¹³ Concurrent to this have been significant medical improvements reducing both the harmful impacts of HIV infection and arguably the stigma associated with the disease. We suggest the trends therefore reflect a change in prosecution interests rather than transmission behaviours or impacts. This leaves sero-discordant couples and particularly HIV-positive persons with legal uncertainty.

In the absence of clear authority that consenting adults can take such risks, HIV-positive people in long term monogamous relationships may find themselves at the whim of prosecutorial discretion. The uncertainty infringes basic civil and political rights. Such stress increases the further we proceed from mainstream notions of sexual relationships and the inherent risks associated with sexual activity. Globally, HIV has often been an unfortunate story of already vulnerable sexual minorities being further targeted by the state and civil society. The Australian HIV epidemic is overwhelmingly based within the gay male population where sexual practices are often divergent from community ‘standards’. Our criminal laws should be based not on facile morality and obtuse notions of public interest, but rather enshrine a clear notion of criminal culpability.

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The practical problems with legal ambiguity extend beyond the lives of HIV-positive people, to the delivery of health care services, advice and counseling. It also extends to scientific studies of the behaviours of HIV-positive people and implications of collection of medical and other information in relation to their behaviours by practitioners and researchers. If the very act of sex between an HIV-positive and an HIV-negative person is criminal where transmission occurs, how can a sero-discordant couple safely engage with health service providers or researchers without fear of future prosecution?

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- 3 *R v Brown* [1992] UKHL 7
- 4 See Lord Slynn, *Ibid*.
- 5 Defined as hurt or injury [...] more than merely transient or trifling, *ibid*, citing from the judgement of Swift J, *Rex v Donovan* [1934] 2 K.B. 498 at page 509.
- 6 Defined somewhat unhelpfully as bodily harm that is really serious, *ibid*, citing *Director of Public Prosecution v Smith* [1961] A.C. 290.
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RESOURCE PROFILE

Resources related to HIV and criminal transmission

A selection of material highlighting the impacts of legal frameworks on the HIV response in Australia and internationally

RESOURCES ON HIV AND INTERNATIONAL CRIMINAL LAW

Global Criminalisation Scan Report 2010: Documenting trends, presenting evidence (Global Network of People Living with HIV/AIDS)

A report giving a global overview of the extent to which criminal and other laws have been used to prosecute people living with HIV for HIV transmission and exposure.

DOWNLOAD http://www.gnpplus.net/images/stories/Rights_and_stigma/2010_Global_Criminalisation_Scan.pdf

Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health (UN Human Rights Council 2010)

A report examining the relationship between the right to the highest attainable standard of health and the criminalisation of forms of private, adult, consensual sexual behaviour.

DOWNLOAD <http://www2.ohchr.org/english/bodies/hrcouncil/docs/14session/A.HRC.14.20.pdf>

Criminalisation of HIV Transmission: UNAIDS Policy Brief (UN AIDS 2008)

A paper providing an overview of key issues in relation to the criminalisation of HIV exposure and transmission, which includes a range of recommendations for governments, international partner organisations and civil society.

DOWNLOAD http://data.unaids.org/pub/BaseDocument/2008/20080731_jc1513_policy_criminalization_en.pdf

Legal Environments, Human Rights and HIV Responses among MSM and Transgender People in Asia and the Pacific 2010

A study of legal environments affecting HIV responses among men who have sex with men (MSM) and transgender people in 48 countries and territories of the Asia and Pacific region, informed by consultations with community representatives, legal experts and UN agencies.

DOWNLOAD <http://regionalcentre.bangkok.undp.or.th/practices/hivaid/MSMLegalStudy.html>

Enabling Legal environments for effective HIV responses: A leadership challenge for the commonwealth. (International HIV/AIDS Alliance 2010)

A report produced jointly by the Commonwealth HIV and AIDS Action Group, the International HIV/AIDS Alliance and the Commonwealth Foundation, which describes legal environments affecting people living with HIV and at-risk populations.

DOWNLOAD <http://www.aidsalliance.org/includes/Publication/Enabling-legal-environments-for-effective-HIV-responses.pdf>

HIV and Criminal Law resource (NAM 2010)

A resource exploring the full range of issues relating to the criminalisation of HIV exposure and transmission, with information on current international laws and practices.

DOWNLOAD <http://www.aidsmap.com/law>

HIV non-disclosure and the criminal law: Establishing policy options for Ontario

A paper produced as part of a project funded by the Ontario HIV Treatment Network. It is the most up-to-date analysis of the issue in Canada.

DOWNLOAD http://orders.catie.ca/product_info.php?products_id=25769

RESOURCES ON HIV AND AUSTRALIAN CRIMINAL LAW

HIV, crime and the law: options for policy reform (Australian Federation of AIDS Organisations 2011)

A discussion paper providing a detailed analysis of the application of Australian criminal law to sexual transmission of HIV, and exposure. It examines intersecting public health legislation and policies across jurisdictions, setting out practical options for policy reform.

DOWNLOAD www.afao.org.au

The Criminalisation of HIV Transmission in Australia: Legality, Morality and Reality (NAPWA 2009)

A monograph published by the National Association of People Living with HIV/AIDS (NAPWA) addressing the issue of criminal prosecutions relating to the sexual transmission of HIV in Australia.

DOWNLOAD <http://napwa.org.au/papers/2009/the-criminalisation-of-hiv-transmission-in-australia-legality-morality-and-reality>

Criminal Prosecution of HIV transmission: the policy agenda (AFAO 2009)

A discussion paper produced by the Australian Federation of AIDS Organisations (AFAO) which provides information on criminal prosecution cases up to 2009 involving sexual transmission of HIV in Australia and overseas.

DOWNLOAD http://afao.com.au/library_docs/policy/DP09_Criminal_Prosecution.pdf

HIV is a Virus not a Crime: Joint Statement by Australian HIV-Related Organisations (AFAO 2008)

A brief joint agency statement by the Australian Federation of AIDS Organisations, some of its members ARCSHS and NCHSR asserting that criminalisation is not and has never been an effective public health response to HIV prevention, and that the Australian response to HIV must be based on agreed public health principles, laws and guidelines.

DOWNLOAD http://www.afao.org.au/library_docs/policy/HIV_is_a_virus_not_a_crime.pdf

Criminal Transmission of HIV: A guide for legal practitioners in NSW (HALC 2009)

A guide providing an overview of key legal issues associated with prosecutions for HIV exposure and transmission, including notes on risk reduction and viral load, consent, disclosure, scientific evidence, human rights, and the media.

DOWNLOAD http://www.halc.org.au/downloads/crim_transmission.pdf

Guide to Australian HIV Laws and Policies for Healthcare Profession (ASHM 2010)

An online resource produced by the Australasian Society for HIV Medicine (ASHM) providing health care workers with information on legal and ethical responsibilities under various laws and regulations related to HIV.

DOWNLOAD <http://www.ashm.org.au/HIVLegal/Default.asp?PublicationID=2>

LEGAL RESOURCES FOR SEX WORKERS

Australian Sex Industry legislation – State laws in Australia (Scarlet Alliance 2010)

Scarlet Alliance, Australian Sex Workers Association, the national peak sex worker organisation in Australia provides comprehensive information on current sex industry legislation operating in Australia, listed by State. The Scarlet Alliance law pages include basic legal information, information about rights and responsibilities as well as visa information, available in English, Thai, Chinese and Korean.

DOWNLOAD <http://www.scarletalliance.org.au/laws/>

Sex Industry Legal Kit (SWOP 2010)

A resource produced by the Sex Workers Outreach Project (SWOP) with financial assistance from the Law and Justice Foundation. The focus of the resource is to help sex workers understand their legal rights and responsibilities.

DOWNLOAD http://www.swop.org.au/sites/default/files/legal_kit_single_pg.pdf

LEGAL RESOURCES FOR INJECTING DRUG USERS

Legislative and Policy Barriers to Needle and Syringe Programs and Injecting Equipment Access for People Who Inject Drugs (AIVL 2010)

A national policy discussion paper developed and published by the Australian Injecting and Illicit Drug Users League (AIVL) providing an overview of the legislative and policy barriers which currently restrict access to needle and syringe programs and new injecting equipment for people who inject drugs.

DOWNLOAD http://aivl.org.au/files/29057-AIVL-book-text_FA.pdf



Whose safety? Regulation of the sex industry in Western Australia

By Scarlet Alliance, Australian Sex Workers Association

In 2008, the Carpenter Labor Government attempted to introduce legislation that would have decriminalised Western Australia's sex industry. The legislation was the result of an extensive review conducted by a working party that valued transparency and accountability, and incorporated a lengthy process of consultation with a wide variety of key stakeholders. The consultation process involved input from sex workers; an approach that most would consider obligatory, but is in fact rarely adopted.

The interaction with the sex industry ensured Labor's proposed laws would have prioritised the health, safety and wellbeing of sex workers, addressing issues that were of actual concern, rather than being guided by myths and

stereotypes. It can also be assumed that the high levels of input by the sex industry would have most likely resulted in higher levels of compliance.

During the course of parliamentary debate, Liberal MPs fought tooth and nail against the draft legislation. Much of their argument was based on dated ideas of morality and chastity, but the real venom was directed at perceived third-party exploitation. The opposition debate centred on the need to 'save sex workers', understanding us as without agency and at risk of exploitation. Sex workers were referred to as 'prostituted women' and words like 'pimps' and 'sexual slavery' were bandied about as the key issues for the industry. Issues of concern to sex workers, including improved occupational health and safety,

alongside civil, human, legal and health rights, were disappointingly left out. Sex Industry businesses able to operate effectively with supportive regulation were reduced to dens of inequity.

Over to the Coalition ...

Despite this open hostility towards brothels whilst in Opposition, the Liberal/National Government, now in power, plans to introduce legislation making brothels the *only* viable choice of sex industry workplace for most sex workers, removing the ability to work privately from residential areas and forcing sex workers to work for third parties or be relegated to industrial zones – both unsafe and unlikely.

For the first time in Western Australia's history, if the government's proposal

is successful, all sex work involving consenting adults, except that which occurs within a small number of state-sanctioned brothels in a handful of industrial areas, will be *illegal*.

Staff at those sanctioned brothels will be registered; branding them as known sex workers and putting their children, relationships, housing, future employment and physical safety at risk. The information collected in order for sex workers to become registered will remain well after the person has left the industry, an impact that's experienced for a lifetime. Those who don't secure work in legal brothels, through personal choice or as a result of work options limited by this law, will become criminals, thus limiting their access to health and welfare services and removing their access to justice.

Individual sex workers, along with Managers and Operators, would be fingerprinted under the proposal. This aspect goes unexplained but clearly stands in opposition to Australia's history of upholding the human rights of sex workers. Sex workers and those in other roles in the sex industry are being treated as criminals without reason or evidence to warrant this extreme approach.

A 20 October 2010 media release by Christian Porter, Western Australia's Attorney-General, suggests community safety is put first by the proposed laws which would heavily strengthen police powers. In his doorstep media statements the Attorney-General referred to the industry being heavily policed. As Western Australians are already experiencing the impact of a police service whose resources are tightly stretched, the additional role of regulating the operation and location of sex industry businesses and individual sex workers will only aggravate the pressure on resources. Community safety will surely be lost as police resources are diverted away from crime and on to this new role of regulating sex workers' workplaces.

The Attorney-General refers to the proposed model as similar to that of

Victoria and Queensland. As many will be aware, this model has resulted in ongoing issues for both states as it creates a 'two tiered' industry; the smaller component being the licensed brothels and the larger being those unable to comply. The Prostitution Licensing Authority in Queensland publishes annual reports which show the model costing more than \$6 million in the ten years it has operated – an expense to taxpayers that has resulted in only 25 licensed brothels throughout the state and a high percentage of non-compliant sex industry businesses. This cost is in addition to the team of Police within the purpose created Prostitution Enforcement Task Force (PETF), formed to address non-compliance: a result of the model rather than the result of a desire to operate outside of the law.

The Attorney-General's promise to release a 'green bill' draft, enabling community and industry consultation on the government's proposed new approach to regulating the sex industry has seemingly been replaced by the 25 November 2010 announcement in parliament of the government's general intention.¹ Although the announcement in *Hansard* captures only broad statements, the devil truly is in the detail of sex industry regulation, and some issues are already clear. The proposed Western Australian laws will violate the human and civil rights of sex workers through fingerprinting and

individual registration, putting health and safety at risk through reduced workplace options and the likely fostering of a two tiered industry. Many will have little option but to work from unlicensed sex industry businesses, and the regulatory model will cost the WA community heavily through a regulatory framework with excessive operation and compliance costs. Health promotion delivery is impacted as non-compliant brothels and private workers attempt to avoid detection. Most problematic is the establishment of police in a regulatory role – a model abandoned in other states like NSW after resulting high levels of police corruption were identified.

Policy development shrouded in secrecy

In contrast to the open and accountable methods adopted by the previous government, we do not know who was on the inter-governmental working party that developed this model, or what information they have requested or received. Media statements suggest the Terms of Reference of the inquiry were skewed towards a particular outcome and that anyone with alternative or differing views was not welcome to address the working party.

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Most problematic is the establishment of police in a regulatory role – a model abandoned in other states like NSW after resulting high levels of police corruption were identified.

In particular, the Attorney-General has ruled out meaningful consultation with the sex industry, saying in the media that:

'[his] ... fundamental concern is not, and has never been, to fulfil the wishes of those who operate commercial prostitution. They are not the key driver for this legislation.'

This approach stands in opposition to Australia's own successful partnership approach to the prevention of HIV whereby sex workers should inform sex industry regulation. Sex workers, as a community with low rates of HIV but who continue to be a community affected by HIV, are recognised as playing an essential role, in partnership with governments to ensure the continued successful response to HIV. Sex workers are recognised as playing a role as the safe sex educators of their clients, implementing safe sex practices into their workplaces; sex workers success in this area is threatened by legal frameworks that undermine public health outcomes.

Model frameworks

While the former Labor Government's model was a result of careful consideration of the impacts of the different models of regulation, both in Australia and internationally, it derived its proposed framework primarily from the New Zealand model. New Zealand decriminalised its sex industry in June 2003 and released an evaluation report documenting the effects of decriminalisation after the fifth year. The Prostitution Law Review

Committee's review of the operation of the *Prostitution Reform Act 2003* is based on research undertaken by the Christchurch School of Medicine and Victoria University's Crime and Justice Research Centre. The report finds the model to be an overall success and describes an industry with significant improvements for sex workers, noting that the fears expressed by conservatives leading up to the decision to decriminalise have not resulted in a growth of the industry, or the many other perceived 'risks'.²

Closer to home, a comparative study undertaken by Basil Donovan, et al.,³ considered the impacts on sex workers and rates of STI incidents under different models of sex industry regulation in three different states of Australia. Western Australia, NSW and Victoria were considered. Importantly the outcome demonstrated that sex worker's sexual health was good in NSW, where the industry is regulated through a partial decriminalisation model, and had better outcomes than Victoria. Victoria is currently regulated by a model similar to that outlined by the Western Australian Attorney-General for introduction there. In addition, the study found that the Victorian model was even less effective than that currently in place in Western Australia. A Western Australian report from the project recognised decriminalisation as the preferred model of regulation for the state.

In conclusion, as we enter 2011, the Western Australian Government's decision on regulation of the sex

industry is at an interesting time in history, coinciding with mounting evidence for the decriminalisation of sex work. In the most basic of terms, the evaluation of the New Zealand model demonstrates decriminalisation can be successful. Australian research shows the sexual health of sex workers in NSW (the only Australian state with a partial decriminalised industry) as good (with low rates of STIs) when compared to other states with different models of regulation and there is growing global recognition of decriminalisation as the best practice model of sex industry regulation for both human rights and HIV prevention outcomes.

In the balance, what benefit is there for Western Australia in implementing a model shown to be costly and which promotes non-compliance?

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... as we enter 2011, the Western Australian Government's decision on regulation of the sex industry is at an interesting time in history, coinciding with mounting evidence for the decriminalisation of sex work.

Scarlet Alliance, Australian Sex Workers Association, is the national peak sex worker organisation in Australia.



Punitive laws that harm HIV responses: a CHOGM priority?

By John Godwin

The Commonwealth Heads of Government Meeting (CHOGM) is to be held in Perth in October 2011. This provides an opportunity to call for action to repeal punitive laws that stand in the way of effective HIV responses.

There is an alarming trend, particularly evident in some African and Caribbean countries, towards use of draconian legislation targeting people living with HIV, men who have sex with men (MSM), sex workers and people who use drugs. As CHOGM host, Australia can play a leadership role in responding to these developments through diplomatic and political interventions.

Countries of the Commonwealth of Nations have a common legal heritage. Most Commonwealth countries have similar Penal Codes, with many provisions copied directly from English legislation of the colonial era. The vast majority of Commonwealth countries

retain highly punitive provisions – little changed since the 19th century – that criminalise sex between men and the sex industry.

Sodomy offences

Forty-two of the 53 Commonwealth countries criminalise sex between men, including Papua New Guinea (PNG) and a number of our Pacific neighbours (Tonga, Samoa, Cook Islands, Nauru, Kiribati and Tuvalu). Very few Commonwealth countries have legal protections from discrimination on the grounds of sexual orientation or gender identity.

In an extraordinary development, the Kenyan Prime Minister voiced support for his country's sodomy laws and called for the arrest of gay men at a public rally in November 2010.¹ This is symptomatic of a broader phenomenon of institutionalised homophobia evident in a number of African countries. At

least in some countries the intention is clearly that these laws be enforced. Regardless of whether prosecutions actually occur, the mere existence of offences, combined with the threat of enforcement and public exposure, leaves the door wide open for extortion, blackmail and police harassment.

In Malawi, a man and his transgender partner were sentenced to 14 years imprisonment for sodomy in 2010. The couple were released after a presidential pardon.² In Zambia, the maximum penalty for unnatural sex was increased from 14 years to life imprisonment in 2005. In Uganda, draconian penalties were proposed in draft legislation in 2009, including a provision of the *Anti-Homosexuality Bill* for the death penalty for HIV-positive people who engage in homosexual conduct. Fortunately,

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bowing to international pressure, a government Committee recommended that the Bill be withdrawn.³

Maximum penalties for sodomy offences can be severe. Legislation of eight Commonwealth countries imposes a maximum sentence of life imprisonment.⁴ In some countries, penalties under *Sharia* law include whipping (in Maldives, Malaysia, Brunei and parts of Nigeria and Pakistan) or even death (in parts of Nigeria and Pakistan). Singapore continues to convict men arrested at beats for consensual sex, with gross indecency between men attracting a maximum penalty of two years imprisonment.⁵ In several Caribbean countries the penalties for sodomy offences have increased in recent years.⁶

Gay law reform made an important contribution to Australia's HIV prevention successes. Decriminalisation of homosexuality set a favourable legal context for mobilisation of the gay community to provide leadership in HIV prevention and care. The introduction of anti-discrimination laws further supported the response. In the lead up to CHOGM, Australia has the opportunity to call on Commonwealth institutions to adopt a much stronger stance on decriminalisation of homosexuality – as a public health and human rights priority. We can point to our own experiences as well as the wisdom of judicial leadership in Delhi, India, where sex between men was decriminalised in 2009 (see breakout box above right).

Sex work

New Zealand and New South Wales are the only Commonwealth jurisdictions that have decriminalised sex work. The vast majority of Commonwealth countries retain highly punitive sex work laws. Even the UK, Canada and South Africa continue to criminalise the sex industry.

Justice Shah calls for an end to structural discrimination

Discriminatory laws were the focus of the World AIDS Day Commonwealth lecture held in London on 30 November 2010. The lecture was given by Justice Ajit Shah, who created shockwaves when he decriminalised homosexuality in Delhi, India in 2009. In his speech, Justice Shah posed the question: how far is it permissible for the state to legislate on the grounds of public morality? He concluded:

*'... public health trumps public morality. The message behind this story of triumph of public health over public morality is relevant across the world. It concerns the rights of not just sexual minorities, but all vulnerable groups where systemic discrimination – often legitimized by the arms of the law and under the guise of public morality – hinders HIV/AIDS initiatives. It is increasingly being recognised that many vulnerable social groups, be they sex workers or homosexuals or drug users, face great prejudice (often backed by harsh penal laws) ... Structural discrimination against those who are vulnerable to HIV such as sex workers, sexual minorities and drug users must be removed and our present laws must be appropriately tempered if HIV prevention, care and treatment programs are to succeed.'*⁷

Australia can play a well-informed role on sex work law reform because it can report the experiences of states and territories in implementing different models of regulation and decriminalisation. We now know that full decriminalisation is associated with better coverage of health promotion programs for sex workers than other regulatory models.⁸ Australia's *Sixth National HIV Strategy* refers to evidence that under a decriminalised and deregulated legislative framework, sex workers have increased control over their work and achieve similar or better health outcomes without the expense and invasiveness of mandatory screening.⁹

Criminal offences of Commonwealth countries typically focus on a range of people associated with the sex industry. Some countries directly criminalise the act of sex work itself, and many countries apply vagrancy and public order offences against sex workers. In PNG, sex work itself was criminalised as a result of a court decision that interpreted the offence of 'living on the earnings of prostitution' to include sex workers, as well as pimps and

others who profit from employing sex workers.¹⁰ A review of Caribbean sex work laws identified a trend towards more severe penalties for sex work or involvement in the sex industry.¹¹

In some Commonwealth jurisdictions there are strict prohibitions on sex work under *Sharia* law, with corporal punishment (whipping) available as a penalty.¹²

In South Asia most aspects of the organised sex industry are illegal. In Pakistan any form of extra-marital sex is illegal. In 2009 two judges of the Indian Supreme Court suggested that legalising the sex industry may assist in addressing issues of concern to governments:

*'When you say it is the world's oldest profession and when you are not able to curb it by laws, why don't you legalize it? You can then monitor the trade, rehabilitate and provide medical aid to those involved.'*¹³

Two recent case law developments are also encouraging:

- In September 2010, a Canadian court found that criminalisation of the sex industry violates human

rights.¹⁴ The Superior Court of Justice, Ontario, held that criminalisation creates dangers for sex workers that amount to a severe deprivation of the right to security of the person, in violation of Canada's *Charter of Rights and Freedoms*. The judgment is being appealed but if upheld, the case is likely to set an important precedent for other Commonwealth countries with similar constitutional human rights protections.

- In South Africa, although sex work is illegal, in May 2010 the Labour Court recognised sex workers as having employment rights. The Court held that a sex worker enjoys the right to fair labour practices and the protection of labour legislation. The ruling means that sex workers in an abusive or exploitative environment can assert their rights.¹⁵

Criminalisation of people living with HIV

There is a trend across the Commonwealth towards greater use of the criminal law against people living with HIV. There have been numerous prosecutions in recent years in Canada, Australia, New Zealand and the UK for offences relating to non-disclosure of HIV status, HIV exposure or transmission. At least 20 African countries have introduced HIV-specific offences for exposure to or transmission of HIV since 2000. There are also examples of HIV-specific offences in the Caribbean (Bahamas and Bermuda).¹⁶

In PNG, it is an offence for HIV-positive people to fail to disclose their HIV status to sexual partners. In highly patriarchal societies, such provisions are particularly problematic for women who have little negotiating power in sexual relationships, and who risk violence and ostracism if their HIV status is disclosed.

Often exposure offences are applied in situations where there is negligible risk of harm. In Singapore a man was prosecuted for exposing his partner to risk of HIV transmission through oral sex, despite lack of actual transmission of the virus.

On the whole, Australia does not set a good example in this area. There have been 16 prosecutions for offences relating to HIV exposure or transmission in the last five years. The damaging public health impacts of such prosecutions are poorly understood. However, it is clear that in some of these cases public health management options far less drastic than prosecution were available and would have been preferable. Australia could benefit from applying lessons from Canada, the UK and New Zealand by, for example, developing prosecution guidelines which include how factors such as condom use and viral load should be taken into account.

Australia's *National Guidelines for the Management of People with HIV Who Place Others at Risk* provide a framework based on graduated levels of intervention, underpinned by the principle that preference should be given to strategies that are least restrictive of liberties, as these will be most effective in changing behaviours in the long term.¹⁷ Prosecution is a last resort. The preference is to use counselling, education and support and convening of panels of experts who can provide support to health care providers to provide alternatives to prosecution. These Guidelines, although not yet consistently implemented in Australia, may be a useful precedent for other countries.

Harm reduction and drug law reform

Australia, Canada and the UK are providing leadership on harm reduction in the Commonwealth. These

countries have well-established needle and syringe programs, methadone maintenance programs and (in Vancouver and Sydney) medically supervised injecting centres. However, when it comes to the more fundamental challenge of decriminalisation of drug use, no Commonwealth country is providing a strong lead.

Nicholas Cowdery QC, Director of Public Prosecutions for NSW, recently called for decriminalisation of possession, use and trafficking of small quantities of illicit drugs.¹⁸ His call is yet to find support from Australian governments. Trials of heroin prescription in Canada and the UK have been conducted that demonstrate the public health benefits of this approach, although this has not translated into a policy shift.

Outside the Commonwealth, many Latin American countries (including Brazil, Mexico, Argentina and Colombia) have decriminalised possession of drugs for personal use. Spain, Portugal and Italy do not consider possession of drugs for personal use to be a punishable offence. By contrast, Commonwealth countries continue to pursue a 'war on drugs' approach, characterised by harsh criminal sanctions for possession, use and supply. Some Commonwealth states retain the death penalty for drug offences, including Bangladesh, India, Malaysia, Pakistan, Singapore and Sri Lanka; the death penalty has recently been proposed for Mauritius.¹⁹

Australia, leadership and the Commonwealth

The Commonwealth shares a legal tradition. It also shares a disproportionate burden of the global HIV epidemic. Although the Commonwealth represents only 30 percent of the world's population,

continued on page 46



HIV and criminal law: global advocacy for justice

By Edwin J Bernard

The criminalisation of HIV non-disclosure, potential exposure and non-intentional transmission is a growing international concern. The Global Network of People Living with HIV (GNP+)¹ estimates that since 1987 more than 40 countries around the world – most of them in high-income countries in Australasia, Northern and Western Europe, and North America – have convicted at least 600 people with HIV for these so-called ‘HIV crimes’. In addition, 63 countries have enacted HIV-specific criminal laws (see Figure 1).

For the past few years I have been following developments on HIV and the criminal law from around the world. I also keep a blog that tries to put these ‘HIV crimes’ into perspective.² Based on my observations it is very likely that there have been hundreds more arrests

and cases that have gone unreported. Much of what is known about individual cases, and even some of the laws themselves, is gleaned from media reports which are selective at best and inaccurate at worst. It is particularly difficult to know what goes on in countries where media reporting is not free of state interference.

Since 1998, UNAIDS and the Office of the United Nations High Commissioner for Human Rights (OHCHR) have recommended that states should not create and enforce HIV-specific criminal laws because they stigmatise people with HIV, and often lower the evidentiary burden so that all four of the required elements to ‘clearly and legally establish’ culpability – foreseeability, intent, causality and (non)consent – are not always met.³

At the turn of the 21st century, no country on the African continent had an HIV-specific law. It now leads the way with 27 countries, followed by Asia (13), Latin America (11), Europe (9), Oceania (2) and North America (1).

The rapid spread of new HIV-specific criminal laws throughout sub-Saharan Africa is primarily the result of a model law developed by Action for West Africa Region–HIV/AIDS (AWARE–HIV/AIDS) at a 2004 workshop in N’Djamena, Chad.⁴ Conceived as human rights legislation, with many of its provisions touted as protecting women’s rights, the ‘wilful transmission’ statutes adapted by 18 countries from the AWARE–HIV/AIDS model law are often vague and overbroad, potentially criminalising people with HIV who practice safer sex; women

with HIV whose children acquire the virus via mother-to-child transmission despite their best efforts to prevent this from occurring; and even individuals with HIV who are undiagnosed.⁵

Conversely, some HIV-specific laws – particularly those in the United States – are too specific. Some outlaw practices that are not risky or harmful (e.g. sharing sex toys, spitting, performing oral sex) and others mandate disclosure of known HIV-positive status regardless of whether or a not condom or other risk-reduction methods are used.⁶

Only 17 of the 63 countries with HIV-specific laws appear to have prosecuted individuals under these laws. Most prosecutions have taken place using existing laws, and most commonly using variants of physical or sexual assault statutes. Europe leads the way, with 21 countries having prosecuted individuals for not disclosing their known HIV-positive status before allegedly exposing or transmitting HIV during non-coercive sex.

Notably, just three European countries – Austria, Sweden and Switzerland – account for more than half of the total convictions in Europe, each having prosecuted more than 30 individuals since 1990, 1987 and 1998, respectively.⁷ (See Figure 2.)

Europe is followed by Asia (9), Africa (4), Latin America (3), North America (2) and Oceania (2). However, the two countries of North America account for the vast majority of global prosecutions. In Canada, where the law characterises non-disclosure of known HIV-positive status prior to sex that carries a ‘significant risk’ of harm as rape, there are, on average, ten prosecutions a year.⁸ In the United States a new case is reported almost every week. About a quarter of all US HIV-related prosecutions between 2007 and 2009 were for spitting or biting.⁹ Despite it being impossible for spitting (and virtually impossible for biting) to transmit HIV, the police and courts take these threats as seriously as if the person with HIV had a loaded



Figure 1: Countries with HIV-specific criminal laws



Figure 2: Countries where prosecutions for non-disclosure, alleged exposure and transmission have taken place

weapon, and it is not uncommon for such individuals – often homeless or poor with no good defence lawyer – to be sent to prison for decades, and sometimes for life.¹⁰

Most of the cases prosecuted around the world have not actually focused on criminal HIV *transmission*, but rather on *exposure to the risk of transmission*.¹¹ These cases often hinged on whether or not someone with HIV had informed their sexual partner – sometimes a one-night stand, sometimes a long-term partner or spouse – that they were HIV-positive before having sex that may – but may not – have risked HIV transmission.

In only a few exceptional cases have criminal sexual HIV exposure or transmission cases involved defendants who truly intended to harm their

sexual partners. Intention to harm is the criterion that international experts have agreed fulfil the criteria of when it is justified to prosecute allegations of criminal HIV transmission.¹²

The impact of such laws and prosecutions can go much further than the few individuals with diagnosed HIV who have been singled out by the criminal justice system. For people living with HIV, they can create a climate of fear and uncertainty and media reporting of such cases does nothing to reduce HIV-related stigma, arguably the greatest non-health-related challenge for those living with HIV. For everyone else, these laws and prosecutions are creating a distorted picture of HIV-related harm, risk and responsibility.

continued overleaf

In middle- and high-income countries, HIV is certainly no longer the proverbial 'death sentence' for people with timely access to antiretroviral treatment, despite the fact that some jurisdictions, such as Brazil and Canada, charge individuals with attempted murder for not disclosing they are HIV-positive prior to unprotected sex.¹³

Few courts have concerned themselves with the actual risk of transmission, but those that have paid attention to the science of transmission – notably in Canada¹⁴, The Netherlands¹⁵ and Switzerland¹⁶ – have reduced the possibility of miscarriages of justice in these jurisdictions.

Research suggests that most HIV transmission takes place during sex between two consenting adults, neither of whom is aware that one of them is living with HIV.¹⁷ And yet, lawmakers and those who make the decisions in the criminal justice system appear to believe that prosecuting a few unfortunate people who come to their attention – often in a completely random way – will have a positive impact on new infections. In fact, most people aware they are living with HIV already do their best to protect their partners¹⁸ and limited studies currently suggest no difference in sexual behaviour between individuals with HIV who are aware, or unaware, of their legal obligations under the law.¹⁹

By focusing on non-disclosure, however, such laws and prosecutions may lull individuals at risk of HIV into a false sense of security. This is because – notwithstanding the limited success of serosorting as an HIV prevention strategy amongst some gay men²⁰ – relying on disclosure does not necessarily protect someone from HIV if their partner has undiagnosed HIV or difficulties with disclosing their known HIV-positive status.

Frustratingly, there is a paucity of data confirming or denying many of these concerns. Although research continues – notably in Australia, Canada, the United Kingdom and United States – we currently do not know whether or not such laws and prosecutions:

- deter or increase HIV-related risk behaviour (or have no impact at all);
- reduce or increase disclosure of known HIV-positive status to sexual partners (or have no impact at all);
- create a false sense of security for people at risk of HIV (or have no impact at all); and/or
- are an added disincentive to knowing one's status above and beyond all of the other reasons not to take an HIV test.²¹

An ongoing, five year multi-state study examining the impact of different constructions of the law on people living with and at risk of acquiring, HIV may begin to provide some answers soon.²²

Regardless of the public health impact of laws and prosecutions, participants at a satellite meeting co-convened by NAM, GNP+, and the Canadian HIV/AIDS Legal Network, held in Vienna just prior to the XVIII International AIDS Conference in July 2010, heard that that the criminal justice system is ill-equipped to deal with the complexities of individual cases. It concluded that the overly-broad use of the criminal law to manage and control the behaviour of people living with HIV is ineffective, discriminatory and unfair.

Advocacy against the inappropriate and overly broad application of the criminal law to HIV non-disclosure, alleged exposure and non-intentional transmission requires both committed and influential individuals and broad stakeholder collaboration. The aim is

not necessarily law reform. Justice can be better achieved when legal decisions are based on good science, best practice guidelines for police and prosecutors are in place; and people with HIV accused of such 'crimes' have improved access to justice.

At the meeting, I suggested a framework (the five Es) for a way forward:

- Gathering further and more complete **evidence** of laws and prosecutions and their intended and unintended impact;
- **Engaging** key stakeholders in connecting science with justice;
- **Educating** individuals working in and with the criminal justice system about HIV, and those working in HIV about the law;
- **Empowering** people living with HIV to protect themselves from the impact of the law, and others from the potential of HIV exposure; and
- A concerted international group **effort** in the form of networking to share advocacy experiences.

Since then (and, no doubt, incidentally) anti-criminalisation advocacy appears to be accelerating. In the United States, the Positive Justice Project, a campaign of the Center for HIV Law and Policy, was launched in September 2010.²⁴ The Project is the first coordinated, multi-organisational and cross-disciplinary national effort in the United States to combat HIV-related stigma and discrimination against people with HIV by the criminal justice system. Its primary focus is the repeal of laws that create HIV-specific crimes or which increase criminal penalties for people with HIV-based solely on their HIV-positive status. The Project gained a boost from the Obama administration's new National HIV/AIDS Strategy, which includes recommendations for states to review such problematic laws. The Strategy

report notes, 'In many instances, the continued existence and enforcement of these types of laws run counter to scientific evidence about routes of HIV transmission and may undermine the public health goals of promoting HIV screening and treatment.'²⁵

In Canada, a new campaign for prosecutorial guidelines was launched in September 2010²⁶; advocates in Ukraine were successful in removing the obligation to disclose in changes to their country's HIV-specific law in November 2010²⁷; and the Government of Norway, in collaboration with UNAIDS, recently launched its Committee on HIV Transmission and Law. The results of its findings will be fed into the Global Commission on HIV and the Law, convened by UNDP and UNAIDS, which is expected to deliver its report at the end of this year.²⁸

With increasing numbers of advocates, clinicians, scientists, lawyers and policy experts working together to figure out what, if any, role the criminal justice system should play in order to protect the public health as well as be fair and just in its dealings with people living with HIV, 2011 could well be the year that giant strides are made towards HIV justice for all.

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A review of *HIV & the criminal law* appears on page 44.

Sex work: equal justice under law

By The Hon Michael Kirby AC CMG

On 15 October 2010, the first ever Asia-Pacific consultation on HIV and sex work was held in Pattaya, Thailand. This landmark event brought together delegates from eight countries across Asia and the Pacific to discuss discriminatory policies, and laws that violate human rights and prevent sex workers from accessing HIV and other health services. The event aimed to initiate national action plans and country-level partnerships to facilitate the scaling up of the response to HIV across the region, informed directly by the experiences of sex workers. Following is an extract of the address made by the Hon Michael Kirby AC CMG (pictured) at the event.



To some, it may seem strange that I, a former judge, am speaking on this occasion. Are not judges the enemies of sex-workers? Are they not the enforcers of punitive law? Are they not part of the problem in ensuring the dignity, equality and capacity for self-protection that is a vital element in the strategy to reduce the spread of the human immuno-deficiency virus (HIV) amongst sex workers – the virus that causes the acquired immuno-deficiency syndrome (AIDS).

Not necessarily. Of course, judges must obey and give effect to the law. The law on sex work is usually made by legislatures. Often, it is designed to reflect public understandings of religious and moral instruction. Where the law is clear, judges have little or no leeway. They must give effect to the rules that are democratically made. However, judges are the guardians of fairness and fundamental human rights. My own experience with the epidemic has made me alert to the problems that the law sometimes causes for a successful strategy to prevent the spread of HIV.

So I stand with you in addressing the over-reach of the law and the need for widespread legal and attitudinal change. But how is this change to be secured? In my opinion, it will only be achieved by attending to the ten commandments

which I will now proclaim. Those commandments should go from here to every corner of our region and of the world. They should be taken up by us and by the United Nations. Great movements have to start with a single step. That step begins here in Pattaya.

The Ten Commandments of Pattaya

1. Empowering sex workers: The first commandment is to listen to the voices of those who are most affected. This includes empowering and listening to the voices of sex workers, their clients, supporters, doctors, families and friends. In the context of the global epidemic of HIV, advances are not produced by imposing rules from the top down. Good results require attention to the voices of those who are on the front line.

In this conference, during the presentation by Dame Carol Kidu (PNG), the sole woman member of the Parliament of Papua New Guinea, in a dramatic moment, the participants from that country cried out one by one: 'Who will speak for us?' ...

From the beginning of the global response to HIV, the agencies of the United Nations, have reached out to engage with the communities most affected. Great leadership was given

here by the inaugural director of the Global Programme on AIDS (GPA) of the World Health Organization (WHO), Dr Jonathan Mann. He always insisted upon participation of speakers for the vulnerable and those at greatest risk. He always involved homosexuals and people living with HIV and AIDS. So have his successors at UNAIDS, Peter Piot and Michel Sidibé. We must continue to draw strength from their instruction and example. Progress is made not by speaking *at* people, but by talking *with* them. And listening and learning from them. Who will speak for the voiceless? We must all do so.

2. Law as friend not foe: The second commandment is that we must maximise the capacity of law to be of help in dealing with HIV; and minimise the obstructive and damaging effects of the law.

Law can be of support in the struggle of HIV and AIDS. Anti-discrimination laws, and giving full effect to constitutional protections of equality, privacy and citizenship can reduce the operative barriers of law to spreading the messages about safer conduct and self-protection. Law can help remove the sources of stigma. Law can encourage a new, supportive public morality. It can do this through wise legislative action and informed judicial opinions, such as the recent decision of the Delhi High Court in India in *Naz Foundation v Union of India*¹. The corrosive effect of stigma upon the outreach of public health campaigns was recounted to this conference by a male sex worker from India. Likewise, other participants have explained the damaging consequences of naming sex workers in the media, and thereby casting shame and stigma upon them and their families and children.

Law does not have to be part of the problem. It can be part of the solution.

3. Law is not enough: The third commandment is that we must all appreciate that reforming the letter of the law is not itself enough to change social attitudes.

Dr Cheryl Overs (Australia) explained to the conference the way policy and societal conduct can impede the safer conduct messages, although they may have no foundation in the letter of law. Harassing sex workers because they do not have the 'right papers' is one of many oppressive strategies that impact on the global struggle against HIV. Several participants described oppressive police conduct, extending even to instances of rape and other unconsensual sexual liberties imposed on arrested sex workers before they are freed. One lesson of the conference is the importance of educating police and public officials everywhere in the realities of HIV. And how it is in the interests of everyone in society that sex workers should be in empowered to insist upon the use of condoms, especially for every insertive sexual act.

4. Dialogue amongst sex workers: The fourth commandment is that sex workers must themselves engage as part of a 'team effort' to respond to the spread of HIV ... To raise their voices in society, they must make common ground with supporters and with other vulnerable communities, including men who have sex with men (MSM) and injecting drug users (IDUs).

Sex workers must also engage, individually and through their representative associations, with police and other public officials. They must explain that one consequence of utilising the presence of condoms as evidence that an accused person is engaged in prohibited sex work will be the temptation not to have condoms on the person. This will lead to unacceptable risks of unprotected sexual conduct. This, in turn, can only escalate the spread of HIV to the great danger not only of sex workers and their families but also their clients, the clients' sexual partners and other groups in society.

Likewise, closing brothels will not generally eliminate the existence of paid sex work. Such work has been present in virtually all societies, ancient and modern, for millennia. If sex

workers are driven from brothels, where they may be empowered and supported in safer sex practices, the result will often be their transfer to work on the streets, in riskier and often dangerous environments and with less prospect of self- and client protection.

5. Limiting over-reach of trafficking law: There can be no contest about the unacceptable character of international human trafficking for sex or other work. In many lands, particularly in developing countries, documented evidence demonstrates many cases where young people (mostly girls) are sold into a modern form of slavery and forced against their will to engage in sex work. The trans-national features of such activities have resulted in a series of international treaties designed to suppress such wrongs² and the enactment of local laws designed to give effect to such international treaties and to suppress forms of sexual servitude akin to slavery³. ...

Still, there are groups in the world today who seek to press such international and local laws beyond their legitimate and proper reach. For some governments and people, the very notion of voluntary sex work is intolerable. They assert that it is a contradiction in terms. In part, this attitude derives from conceptions of sexual morality grounded in religious understandings. ...

Some feminist advocates denounce any attempts to de-criminalise (still more to legalise) the consenting adult activities of commercial sex workers. They insist on adoption of the so-called 'Swedish model' to criminalise the clients of sex workers on the footing that, necessarily, they denigrate the human dignity of women. Such attitudes too are not universal. ...

Amongst some sex workers, attempts are occasionally made to avoid this debate by defining 'sex work' as restricted to *legal* activities falling outside international and national

continued on page 47



The Vienna Declaration: full-on global drug prohibition versus HIV control

By Dr Alex Wodak

The Vienna Declaration was launched at the XVIII International AIDS Conference in July 2010. The text notes that ‘the criminalisation of illicit drug users is fuelling the HIV epidemic and has resulted in overwhelmingly negative health and social consequences. A full policy reorientation is needed’.

The international system of drug prohibition is under increasing challenge these days. It is now being confronted by a Declaration which says quite unambiguously that the international system of drug prohibition undermines international efforts to slow the spread of HIV among and from injecting drug users.

The sharing of needles and syringes among injecting drug users accounts for 10% of new global HIV infections and about a third of new HIV infections outside sub-Saharan Africa. The Declaration notes that in some

countries 70% of injecting drug users are infected with HIV and 80% of new HIV infections are attributed to injecting drug users. But the entrenched and long standing support for global drug prohibition has delayed and slowed the implementation of proven HIV prevention strategies for injecting drug users.

The Vienna Declaration (see <http://www.viennadeclaration.com/>) has been signed by some very senior international figures. These include: Nobel Laureate Professor Françoise Barré-Sinoussi, co-discoverer of HIV; Professor Michel Kazatchkine, Executive Director of The Global Fund to Fight AIDS, TB and Malaria; Professor Julio Montaner, President of the International AIDS Society; and Professor David Nutt, former Chairman of the UK Advisory Council on the Misuse of Drugs. Almost twenty thousand people from many

countries around the world signed the Declaration at the Vienna conference or online.

Vienna was chosen as the site for the 2010 International AIDS Conference largely because of its proximity to a vast region which has responded so dismally to the epidemic of HIV spreading among and from injecting drug users. The countries involved include Russia and many countries in Eastern Europe, and others in Central Asia. In Russia, 37% of people who inject drugs are HIV-positive, while injecting drug users account for about 80% of new HIV infections. Russia still refuses to provide opioid substitution therapy (such as methadone), opposes most effective means of controlling HIV among injecting drug users and has an appalling record of breaching the human rights of injecting drug users. Russia and many of its neighbours have intensified their support for massive

investment in drug prohibition at the very time in history when it has become clear that law enforcement efforts to control global drug supplies have failed comprehensively. As Michel Sidibé, the Executive Director of UNAIDS, said recently, ‘criminalisation does not work’.

There is also now a much greater appreciation of the significant unintended negative consequences of drug law enforcement. Massive investment in efforts to cut drug supply risks shifting problems from one country to a different country. Sometimes efforts to reduce drug availability shift the drug market from one drug to a different drug. In recent decades, the price of street drugs like heroin or cocaine has slumped by 80% while the purity of these drugs has increased. Illicit drug use has also been spreading recently to more countries. Punitive drug laws have made the already difficult task of reducing the spread of HIV among and from injecting drug users much more difficult. The international trade in illicit drugs is estimated by the United Nations Office on Drugs and Crime to have an annual turnover of US\$322 billion. The lucrative profits from this trade fuel crime, violence, instability, corruption and narco-terrorism. Distinguishing between governments and drug traffickers is often difficult in countries such as Colombia, Peru, Bolivia, Mexico, Pakistan, Burma and Afghanistan.

The recognition that zealous drug prohibition and HIV control among injecting drug users are mutually exclusive options is not confined to AIDS activists. UN Secretary-General Ban Ki-Moon said in May 2009 that ‘in addition to criminalising HIV transmission, many countries impose criminal sanctions for same-sex sex, commercial sex and drug injection. Such laws constitute major barriers to reaching key populations with HIV services. Those behaviours should be decriminalised, and people addicted to drugs should receive health services for the treatment of their addiction’.

In 2010 the UN Development Program (UNDP) and UNAIDS announced the formation of a new global commission to examine how legal environments affect HIV efforts. A joint press release noted that ‘laws can compromise the ability of high-risk populations to access HIV prevention and treatment services’. Global drug prohibition also makes it more difficult to raise the funding needed for effective HIV prevention services. Each year the world only spends US\$180 million on harm reduction in low and middle income countries while it is estimated that at least US\$2.13 billion is required. Consequently the world now provides an average of only two sterile needles and syringes per drug user per month. Only 8% of international heroin injectors are currently in methadone treatment.

After a long struggle, some countries are now starting harm reduction programs. Other countries are starting to rapidly expand programs with low coverage. But this has been difficult when the world has been preoccupied by a law enforcement dominated response to illicit drugs.

UN Secretary-General Ban Ki-Moon said on World AIDS Day, 1 December 2009, ‘I urge all countries to remove punitive laws, policies and practices that hamper the AIDS response ... In many countries, legal frameworks institutionalise discrimination against groups most at risk ... We must ensure that AIDS responses are based

on evidence, not ideology, and reach those most in need and most affected.’ On 13 September 2010, his first day as Executive Director of the UN Office on Drugs and Crime, Mr Yury Fedotov said ‘drug dependence is a health disorder and drug users need humane and effective treatment – not punishment.’

Navanethem Pillay, UN High Commissioner on Human Rights, reminded us recently that ‘individuals who use drugs do not forfeit their human rights. Too often drug users suffer discrimination, marginalised and often harmed by approaches which over emphasise criminalisation and punishment while under emphasising harm reduction and respect for human rights.’ In 2009, for the first time ever, the paramount UN drug policy making body, the Commission on Narcotic Drugs, and the paramount UN human rights organisation, the Human Rights Council, both considered the human rights of injecting drug users.

The Vienna Declaration is yet another sign that the system of global drug prohibition, which began 101 years ago, is slowly dying. Although it is not yet clear what will replace the old system, it is clear that a new system will one day abandon the ‘one size fits all’ approach and be based solidly on science and human rights.

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Support for prison NSP trial – but where?

By Sean Costello

Commonwealth, state and territory health ministers are on the record as agreeing that a needle and syringe program (NSP) should be trialled in an Australia prison. However, a question remains over which prison this will be.

The shared acceptance of the need for a trial is reflected in the recently released *Sixth National HIV Strategy*, which includes people in custodial settings as a priority population. The Strategy, endorsed by the Commonwealth, state and territory health ministers, states:

*'In view of the well documented return on investment and the effectiveness of Australian community-based NSPs, it is appropriate ... for state and territory governments to identify opportunities for trialling this approach in Australian custodial settings. This is also supported by the international evidence demonstrating the effectiveness of prison NSPs.'*¹

The other national health strategies covering blood-borne viruses, such as the *Third National Hepatitis C Strategy* and *Third National Aboriginal and Torres Strait Islander Blood Borne Viruses and STIs Strategy*, make similar statements.

Human rights in the ACT

Canberra's new Alexander Maconochie Centre (AMC), which opened in March 2009, is one prison often mooted as a possible site for trialling a prison NSP.

Named after a 19th century prison reformer renowned for his humane approach to detention, the Centre has already been highlighted for its attempts to prioritise human rights in its design and policies.

The ACT was the first jurisdiction in the country to enact human rights legislation, the *Human Rights Act 2004*. In 2007, with the impending design and construction of the AMC in mind, the ACT Human Rights and Discrimination Commissioner undertook a human rights audit of all existing correctional facilities in the ACT. One of the key recommendations of that review was the implementation of a pilot program for a needle and syringe exchange with provision for safe disposal of needles. The Audit also recommended the government consider establishing a safe injecting room. The report suggests:

'As the ACT has a community-based needle-syringe exchange program, the principle of equivalence would normally require a needle exchange within correctional facilities in order to minimise the harm of injecting drug use.'

The principle of equivalence referred to in the report is relevant to two ACT laws. Section 19 of the *ACT Human Rights Act 2004* requires the ACT government to treat those deprived of liberty humanely, and section 9 of that

Act requires the government to protect the right to life of those in its care. More explicitly, section 53 of the *ACT Corrections Management Act 2007* states that the Chief Executive must ensure that:

'Detainees have a standard of health care equivalent to that available to other people in the ACT.'

The ACT Human Rights and Discrimination Commissioner, Dr Helen Watchirs, co-chairs the Legal Working Group of the Commonwealth Ministerial Advisory Committee on Blood Borne Viruses and Sexually Transmissible Infections. The ACT Government did not wholly endorse the Commissioner's recommendation that consideration be given to establishing prison NSPs, but did commit to a review of implementing such a trial 18 months after the AMC commenced operations.

Unfortunately, an NSP trial did not eventuate. Instead, under ACT Health's *Adult Corrections Health Services Plan 2008–2012* harm reduction for injecting drug users is limited to providing bleach:

*'Given the evidence that some individuals continue to inject drugs during incarceration, bleach should be readily available and accessible without repercussion as a harm minimisation tool against HIV.'*²

Deliberations continue ...

The AMC commenced admitting detainees in March 2009, so the ACT Government now has 18 months of data regarding detainees to consider. Media reports have suggested that 60 percent of males and 70 percent of the small female population have tested positive for hepatitis C antibodies.³ Katy Gallagher MLA, ACT Health Minister, recently noted that there was evidence a detainee had contracted hepatitis C whilst at the AMC.

'It appears that one detainee has evidence of the transmission of hepatitis C whilst at the AMC, so this is our first case where this is evidence to support transmission of hepatitis C whilst in custody,' Ms Gallagher said before an ACT Legislative Assembly budget estimates hearing.⁴ Ms Gallagher confirmed that the government has undertaken evaluation of current drug policies and services and their subsequent effect on prisoners and staff within the AMC. The review's key sources of information were ACT Corrective Services and ACT Health's internal data from 1 June 2009 to 31 May 2010, the 2010 ACT inmate health survey, published data and an external component implemented by the Burnet Institute, involving interviews, observations and analysis of all the data collected for consideration within the context of the final evaluation report.⁵

On 5 January, following the release of a draft report produced from the 18-month audit, Ms Gallagher made a definitive statement of support for an NSP program at the AMC, saying 'I'll put my neck out here; I would like to see a needle and syringe program at the jail ... Cabinet has to make that decision, but that's what I'll be arguing.'⁶

The ACT Chief Minister Jon Stanhope's opposition to trialling an NSP at AMC was assumed to be a major hurdle to any trial commencing. In 2007, he was reported as saying he had 'yet to be convinced' of the trial of such an exchange. However, in recent months he has changed this position.

In September 2010, Mr Stanhope suggested that as part of a review of the first 12 months of the AMC, the issue of an NSP could be reconsidered:

*'In regard to the continued availability and access of inmates at Alexander Maconochie to illicit drugs, I now am more inclined to believe that a needle exchange, as a minimum, is something that I would accept.'*⁷

The Minister also supported the recent public statements made by Katy Gallagher, stating:

*'The health issues are quite clear and stark ... So I join with Katy Gallagher in saying it is inevitable ... indeed the appropriate moral response for us to consider a needle exchange in the Alexander Maconochie Centre.'*⁸

Nonetheless, the introduction of an NSP is not yet ACT Government policy and the issue continues to be debated. The major union representing corrections officers, the Community and Public Sector Union (CPSU), is strongly opposed to such a program. ACT Regional Director Vince McDevitt has suggested his members are 'unanimously' opposed to any NSP trial.

'They do not want to be confronted in their workplace by a drug affected prisoner wielding a hypodermic', Mr McDevitt previously remarked in response to the Chief Minister's 2010 comments.

The potential double standard of an NSP was also an issue for corrections officers:

*'They [the officers] take their jobs seriously and part of that job is keeping illegal drugs out of the jail and if you provide needles because drugs are in there anyway, well that message doesn't sit very comfortably with them.'*⁹

Mr Stanhope has acknowledged the CPSU's concerns and that the government would have to consult with them closely prior to making a decision. The ACT Government recently engaged Knowledge Consulting to undertake a review of the first 12 months of the AMC operation, but

that review may not even consider the NSP issue.

Public Pressure on the issue is mounting. On 14 January, drug policy organisation Anex placed an advertisement in *The Canberra Times* calling for public support on the issue, with numerous prominent Australian figures backing the campaign, including Professor Emeritus Sir Gustav Nossal AC CBE and Nobel Prize (Medicine) Laureate Professor Peter Doherty.¹⁰ Whether this will bring the ACT any closer to being the first Australian jurisdiction to introduce a prison-based NSP remains to be seen.

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spanc

Study of the Prevention of Anal Cancer

Anal cancer is increasingly a problem in the gay community and the statistics are disturbing. Anal cancer in gay men is more common than cervical cancer was in women before the use of the Pap smear. Gay men are more than 20 times more likely than other men to develop anal cancer. The aim of the SPANC study is to find out whether regular testing programs should be introduced for gay men to prevent anal cancer.

We need Sydney men aged 35 years or above, from all walks of life, who have had sex with men, and who have not been previously diagnosed with anal cancer. If you would like to help with this research or would like to know more about it, please contact the SPANC team through the SPANC website.

'SPANC' stands for Study of the Prevention of Anal Cancer.

spanc.org.au
1800 4 SPANC

This study has been approved by St Vincent's Hospital Human Research Ethics Committee reference number: HREC/09/SVH/168. SPANC Recruitment Advertisement Ver 1.0 - 29/11/10. Image courtesy: Male Visions Studio, Tucson, Arizona, USA www.malevisions.com



Regional Feature: HIV and prison in Thailand – a double sentence

Does prison have to be an HIV/TB/hepatitis incubator? A group of people living with HIV/AIDS in Thailand say 'no'.

By Karyn Kaplan

There is ample evidence that HIV, TB and hepatitis C rates are higher inside prisons and other closed settings than in the general community, in many places across the globe. But does it have to be this way? What factors contribute to the public health crisis in prisons? Most importantly, what can community advocates do about it? This article takes a look at the specific situation of Thailand, where a unique community/government collaboration reveals a glimmer of hope in an otherwise dire situation.

Paisan Suwannawong, founder of the Thai AIDS Treatment Action Group (TTAG) and founding chairman of the Thai Network of People Living with HIV/AIDS (TNP+), is '100% sure' that he contracted HIV and hepatitis C in prison in Chiang Mai, northern Thailand, more than 18 years ago. 'The conditions were terrible. I was a heroin addict, and heroin was available in the prison – but clean needles were not. It would not be an underestimation to say that sometimes 100 people would use the same needle.' Northern Thailand in the late 1980s was the epicenter of Thailand's raging HIV/AIDS epidemic, and injecting drug users (IDUs) were hit hard. For more than two decades, IDUs boasted the highest prevalence rates, of more than 50%.

Even while Thailand was receiving international accolades for its successful condom campaigns that dramatically reduced new infections by almost 80% and made it an international success story, this risk reduction approach was not expanded to include injectors, despite their obvious need. The 'harm reduction' approach to drug use, which

would include the provision of clean injecting equipment, substitution therapy and other low-threshold HIV prevention tools, continues to be a 'hot potato' issue in Thailand, with projects reaching only a fraction of those in need.

Patients or criminals?

'We (IDUs) are either in prison or in heaven,' says Paisan, half-jokingly. 'Despite a 2002 government policy that claims drug users are considered "patients" to be treated and not criminals, we are still illegal under the law. To consume drugs is a crime. The majority of people in prison are charged with drug-related offenses. Harm reduction is still not officially accepted! For years, people were forced to quit drugs before being eligible for HIV treatment, and we continue to be arrested every day by the police who can easily extort money because of this vulnerability.'

continued overleaf

It was in response to these injustices that Paisan founded TTAG, to focus on access to treatment and other human rights issues for some of society's most marginalised people, namely IDUs and people in or just leaving prison. TTAG's mission is to promote leadership and advocacy among people living with HIV and marginalised groups, to fight for their human rights. One of its most successful programs is just two years old, but already designated a 'technical model' by the Ministry of Public Health, which is also a key partner of the program. The project, the 'Prison Health Project', aims to help people both in prison and recently released from prison to realise their right to health through accessing HIV-related information, services, and treatment.

While the project targets people living with HIV as a priority, a lot of educational activities are conducted with prisoners in general, prison health staff, and prison guards. Bunniam Wongjaikham, another HIV-positive activist and TTAG staff member, who runs the prison health project out of TTAG's Chiang Mai office, says that he is still amazed at the way government officials have 'green lighted' his team's work. 'I think we were allowed to work in the closed setting because there are so few health staff in prisons and therefore they recognised that we can lighten their load and help

them accomplish their responsibilities effectively, and now they see the value of this work and its impact on the prisoners and even themselves.'

Drug use and harm reduction

There are more than 200,000 people in prison in Thailand, almost twice its official capacity, and nearly 25% of prison inmates are pre-trial detainees.¹ HIV rates are higher in Thai prisons than among the general population, and six studies have found that a history of imprisonment is 'significantly associated with acquiring HIV'² and that 'there is an increased HIV risk through sharing needles with multiple partners while in holding cells before incarceration'³. The majority of people in prison are sentenced for drug-related offences. Undocumented citizens, ethnic minorities, and migrants from Burma are other disproportionately incarcerated populations, at higher risk of HIV but with fewer rights to access treatment.

Heroin is still the drug of choice for many injectors in Thailand, although its high price and low availability has made it difficult to access. IDUs now inject a range of substances apart from heroin, including methamphetamine (from pill form), midazolam (a sedative), liquid methadone, etc., often in combination. The majority of people who use drugs in Thailand today,

however, use the very cheap, easily accessible methamphetamine pills (and also crystal ice), and drug use in general has sky-rocketed due to widespread availability of these drugs in Thailand. Most people in prison on drug charges are incarcerated on methamphetamine-related charges.

In December 2010, Thailand's first national harm reduction policy was approved both by the National AIDS Committee and the Office of Narcotic Control Board. The policy still requires cabinet approval but if passed, would allow for a package of harm reduction services to be provided legally to people who use drugs. Whether this will apply in prison remains to be seen. Thailand's Constitution provides for equal access to healthcare, however, for many marginalised groups this lofty goal seems still far-off. In Thai prisons high-risk behaviors, including unprotected consensual and non-consensual sex, tattooing with unsterilised equipment, 'penile modification' and injecting drug use are all commonplace. Despite this, authorities still fail to provide appropriate HIV and other blood-borne virus prevention services and prison health services generally fall far short of international standards.

As Dr Sanchai Chasombat, former head of Thailand's ARV treatment program, reminded the audience at Thailand's first multisectoral 'prison health summit'⁴ at the end of 2009, organised by TTAG, the prison structure is designed to put a prisoner into custody and 'correct' him or her, and there are a meager number of health personnel inside prisons. Referral to hospitals outside is crucial, but numerous barriers, including the low prison/guard ratio and low HIV awareness among prison staff, as well as a 10-baht-per-prisoner-per-year health budget for HIV care, make it nearly impossible for expeditious or quality care to be provided. It is essential that organisations such as TTAG are able to access people in prison to provide them with all the necessary information

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about HIV – how it is transmitted, testing and treatment information, and also information about human rights – and what Thailand’s universal health care scheme can potentially provide. In my work as TTAG’s Director of Policy and Development, I frequently join TTAG’s team in northern Thailand at prison trainings and advocacy meetings. It is important for us to learn about the various constraints of all the different players, from their own perspective. To this end we place high value on developing strong, trusting relationships, not only with prisoners but also with officials, guards and health personnel. Everyone has a role to play to make improved health care and HIV treatment access work.

Since TTAG began working in prisons in the North several years ago, numerous unique projects have been implemented, apart from trainings, support groups and advocacy meetings. TTAG, with the Research Team from the Health Service Monitoring and Development Project for Female Inmates in Chiang Mai Women’s Correctional Institute, developed a peer-driven research project called ‘Ensuring Health and HIV Services for Doubly-Marginalized HIV-positive Women in Chiang Mai Women’s Correctional Institute’, where former prisoners and people living with HIV were trained in ethics, research skills, and data collection. These women then helped develop the research protocol and data collection tool and in conducting interviews with HIV-positive women prisoners, about their experiences accessing HIV-related health care. The findings were disseminated publicly and recommendations have been addressed directly by the prison. Also, TTAG responded to an obvious need after starting to work in prisons: helping people recently released from prison who are HIV-positive continue to access their HIV treatment, care and services seamlessly. This is not a simple endeavor given the stigma,

discrimination, shame, joblessness, poverty and other challenges many of this population already face. ‘Prisons must be seen as just another part of the community, not separate, not invisible. But most people want to forget about prisons or that in fact, people are constantly cycling in and out,’ said Paisan. ‘Thailand will never resolve its HIV epidemic if it can’t even control prevention and treatment successfully in its prisons.’

Vienna Declaration

The Reference Group to the United Nations on HIV and Injecting Drug Use issued a *Consensus Statement on World AIDS Day 2010*, which included a call for the ‘end to the imprisonment of people who have committed no crime other than drug use or possession for personal use’. Punitive approaches to health-related issues such as drug dependence are not evidence-based, nor humane. Ending the imprisonment of people who use drugs would not only reduce the HIV-related harms unnecessarily perpetuated in prisons in Thailand and around the world, but would also bring us a step closer to realising universal access to prevention and treatment goals, and improve community health in general. Until that recommendation becomes a reality, Thai prisons will continue to swell with poor, marginalised people

living with or at high risk of HIV, and insufficient resources or political commitment to manage it. TTAG’s model is a small one, addressing only a small fraction of the problem. With positive government support, however, what started as a small project driven by the HIV-positive community could become a national model for replication. ‘Thailand has a policy of universal access to free HIV treatment and care, which we (people living with HIV) fought hard for. I will not stop fighting until every person, in prison or not, has equal access to this right,’ insists Paisan.

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Ending the imprisonment of people who use drugs would not only reduce the HIV-related harms unnecessarily perpetuated in prisons in Thailand and around the world, but would also bring us a step closer to realising universal access to prevention and treatment goals, and improve community health in general.

Reviewed by Sally Cameron

It would seem that at some point during the last three years, the prosecution of individuals for HIV exposure and transmission developed from an 'emerging issue' to an issue of some substance. Increased research and monitoring revealed that internationally, the number of people being prosecuted appears to be increasing. It also found that in some jurisdictions, such prosecutions had occurred for many years but had largely fallen under the radar of HIV agencies – failing, in turn, to trigger a strong policy response despite some of those cases reflecting quite appalling miscarriage of justice. The implications of prosecutions for HIV exposure or transmission are now so established that the area has been given a handy (although not completely accurate) abbreviation: 'criminalisation'. Researchers and analysts are publishing, agencies are aware and responding, and affected communities are becoming increasingly informed.

One person who has played a significant role in the scale up of the policy response is Edwin Bernard, who rang me some years ago because he was seeking out others working on this issue. Such calls are, after all, how networks become established. During that call, Edwin said he was considering creating a blog where he would list the criminalisation related media he was using in his research. No other such centralised resource existed. It still doesn't. Edwin created the blog (criminalhivtransmission.blogspot.com) which is now accessed by many, including those from HIV agencies large and small. In 2007, Edwin also wrote a book, *Criminal HIV Transmission*, for NAM, a UK non-government agency which produces evidence-based resources covering both medical and social aspects of HIV.

Recently, Edwin has produced another book, *HIV & the criminal law*, which is twice as long as the first: reflecting



growing interest in criminalisation and the availability of relevant research. *HIV & the criminal law* manages to centralise all recent research and analysis, including recent works by the Australian Federation of AIDS Organisations, the Australasian Society of HIV Medicine, HIV/AIDS Legal Centre and the National Association of People Living With HIV/AIDS. More importantly, it organises that information in a logical, accessible format, moving through:

- **Fundamentals:** data on the pandemic, the role of evidence informing prevention, the challenge of HIV-related stigma, and human rights.
- **Law:** applicable kinds of laws, the rise of prosecutions in high income countries, and legislation contagion in Africa.
- **Harm:** the impact of HIV on physical and emotional wellbeing, harm in the popular imagination, legal constructions of harm
- **Responsibility:** law, ethics, disclosure, sexual risk taking, prevention
- **Risk:** how HIV is transmitted, differing levels of risk for different sexual acts, the effect of post-exposure prophylaxis, legal definitions of risk.

- **Proof:** gathering evidence, deciding to prosecute, state of mind, intention, and cause and effect.
- **Impact:** impact on public health systems, impact on human rights, impact on women

The book also includes a summary of HIV transmission-related law in many countries around the world.

HIV & the criminal law includes current information and analysis to explain why prosecutions for HIV exposure and transmission are problematic, the data to back up those assertions, and recommended approaches by key agencies and analysts. For example, the Risk chapter, provides clear summaries of key scientific and behavioural research on transmission risk demarcated by sex, sexual act, viral load and condom use. That information is counter posed against examples of prosecutions for acts that involved little or no risk, because 'criminal statutes are often written and criminal cases are often decided without full consideration of the latest relevant scientific research'. Similarly, the Proof chapter outlines numerous examples of evidentiary weakness, and explains in simple terms many of the limits of immunological and virological data, including phylogenetic analysis.

Being pragmatic, I would have preferred larger font but have already encountered many who admire the book's 'notebook' size (think somewhere between an iPhone and an iPad, or what we used to call 'A5'). *HIV & the criminal law* is also available (in digestible chunks) online at <http://www.aidsmap.com/law> It is a great resource: clear and comprehensive but written in plain English. It makes a valuable contribution to current thinking in this area.

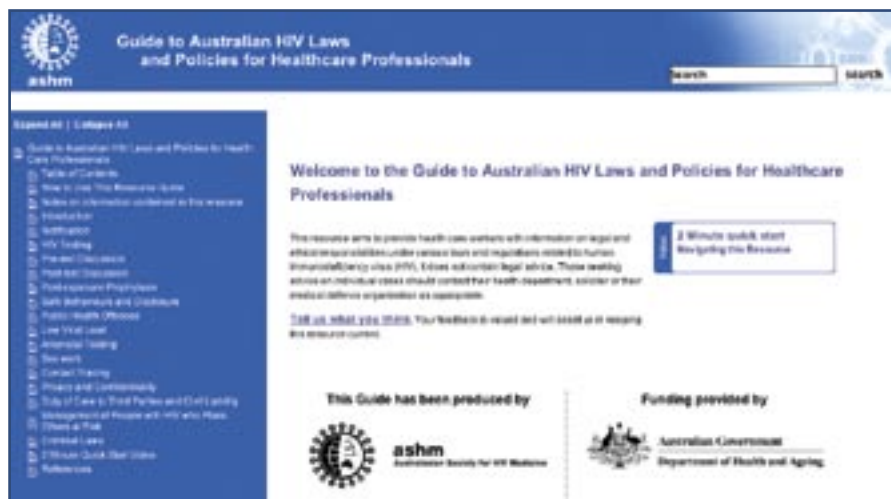
Sally Cameron is a consultant and former policy analyst at AFAO. She is currently undertaking a project on criminalisation for AFAO.

Prosecutions for HIV exposure and transmission have attracted substantial media coverage: a point not lost on those working in HIV-related health care. In late 2008, the Australasian Society for HIV Medicine (ASHM) recognised GPs' growing concerns about a possible increase in such prosecutions. Mindful of the broad ranging legal and regulatory responses affecting healthcare professionals, ASHM commissioned an online resource to address legal regulation across HIV clinical practice. The resulting *Guide to Australian HIV Laws and Policies for Healthcare Professionals* ('the Guide') provides a summary of key legislation and policy guidelines, as well as links to the actual legislation and policy through AustLII and other primary resources.

The resource is primarily a text-based website and is refreshingly free of bells and whistles such as flash-based animations, which tend to hinder accessibility and limit functionality across different platforms. The left hand menu of the Guide presents a range of 'chapters' that can be read in sequence, or users can jump straight to their specific area of inquiry or interest. The main menu also provides a detailed reference section for further research, and a 'quick start video guide'.

Subject areas covered by the Guide include:

- Notification of HIV test results
- HIV Testing
- Pre- and Post-test Discussion
- Post-exposure Prophylaxis
- Safe Behaviours and Disclosure
- Public Health Offences
- Low Viral Load
- Antenatal Testing
- Sex work
- Contact Tracing
- Discrimination
- Privacy and Confidentiality
- Duty of Care to Third Parties and Civil Liability
- Management of People with HIV who Place Others at Risk, and
- Criminal Laws.



The resource also includes useful social research and epidemiological data to provide context for legal and policy provisions. On selecting a topic, the requested information is displayed on the right half of the screen, with quick link menus to sub-sections in the chosen topic area, as well as options to print or download chapters for later reference.

Importantly, the Guide also provides state-based information related to many topics, such as state-specific notification statistics, information on public health offences, contact tracing, privacy and confidentiality, and criminal laws, which is also displayed in the quick link sub-menus of each section.

Although the website is targeted at healthcare professionals, its potential reach is far greater, as it is an accessible resource for researchers, HIV service providers and community members, whether wanting to understand laws in their state or to compare laws across jurisdictions. The Guide is also a useful tool for policy and law reform.

This resource helps put HIV and the law clearly back on the agenda, after an apparent lack of activity in the HIV/law nexus since the mid 1990s. The last 18 months has seen significant pieces of work in Australia by the Australian Federation of AIDS Organisations, the National Association of People Living With HIV/AIDS, the Australian Injecting & Illicit Drug Users League, HIV/

AIDS Legal Centre, Scarlet Alliance, and the NSW Sex Workers Outreach Project, as well as the establishment of a Legal Working Group to inform the work of the Ministerial Advisory Committee on Blood Borne Viruses and Sexually Transmissible Infections. At the international level, the increase in prosecutions for HIV exposure and transmission and the spread of highly problematic laws through Africa has pushed numerous international HIV agencies to publish on the impact of law on HIV, moved 'law' onto the agenda at the 2010 international HIV conference, and resulted in the establishment of no less than a Global Commission on HIV and the Law.

The Guide is also a welcome successor to *The 1993 Australian HIV/AIDS Legal Guide*, which provided an invaluable resource for many years, but now lacks currency due to numerous changes in laws and the introduction of new policy frameworks since its publication. The Guide has gone some way to this gap in legal resources developed for the Australian context.

Clearly, the Guide cannot replicate legal advice and it provides only minor comment on the administration of listed laws and policy, however the basics are there. As the only available Australian resource centralising Australian law and policy, the Guide exceeds the ASHM's mandate and makes a valuable contribution to current HIV-based texts.

it has over 60 percent of the global population of people living with HIV.

To the credit of our government, a proposal to place HIV and law reform on the agenda of the meeting of Commonwealth Law Ministers, which is to occur in Sydney in July 2011, was advanced by the Attorney-General Robert McClelland at a meeting in October 2010. It does not bode well that there was resistance to this proposal from other countries. Further in-country consultations are to be held on the agenda for the meeting.

As a member of the Commonwealth HIV and AIDS Action Group, AFAO has been working behind the scenes to advocate for these issues to be placed on Commonwealth agendas. Australia is well positioned to play a pivotal role in 2011, but it will take leadership from more than one country, and probably more than one CHOGM, before we start to see solid progress on law reform across the 53 member states of the Commonwealth.

In the lead up to CHOGM, the Commonwealth HIV and AIDS Action Group and the International HIV/AIDS Alliance published a report *Enabling Legal Environments for Effective HIV Responses*, with recommendations for an agenda for action for Commonwealth states. The report calls for HIV-related law reform, improved police and

prosecution practices and a more prominent role in addressing these issues for Commonwealth bodies including the Commonwealth Secretariat, Commonwealth Foundation, Commonwealth Lawyers Association and Commonwealth Medical Association.

The report is available at: <http://www.aidsalliance.org/includes/Publication/Enabling-legal-environments-for-effective-HIV-responses.pdf>

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Australia is well positioned to play a pivotal role in 2011, but it will take leadership from more than one country, and probably more than one CHOGM, before we start to see solid progress on law reform across the 53 member states of the Commonwealth.

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laws. Still, as Meena Saraswathi Sesu (General Secretary of Sangram in India) has pointed out, international agencies and some national governments with large influence, frequently attempt to utilise the treaties and laws on trafficking to suppress *every* form of adult, voluntary, consenting sex work outside marriage. To the extent that this is done or attempted, it constitutes an over-reach in the operation of international treaty and local law⁴. As a matter of law, public policy, HIV containment and respect for individual human rights, it is essential to insist on confining these treaty and local laws against human trafficking to their proper sphere.

That sphere rests upon protection against unconsensual and under-age involvement in the sex industry. It does not, as such, demand total suppression or elimination of that industry, contrary to the informed choices exercised by adult sex workers, their clients and others. ... Those who want to turn anti-trafficking laws and treaties into a moral or religious crusade must be bluntly told that this is not sustained by the language of the treaties, international and national law, universal human rights and, most importantly, the strategies essential to contain the HIV epidemic.

6. Re-visiting international law:

Sometimes the vagueness and ambiguity of law can be a cause of difficulties for those who are subject to it. That is because of the different religions, cultures and traditions that exist in the world. Ambiguity is even more common in international than in national law. To secure common agreement over the language of a treaty, it is often necessary to resort to vague and ambiguous language. Whilst this sometimes secures a step forward in the achievement of understandings of universal human rights, it can also lead to the use of international law for unintended purposes. ...

Putting it bluntly, law has quite frequently been invoked to suppress adult, private, consenting sexual activity in the fields of:

- Commercial sex work
- Homosexual adult activity
- Trans-sexual identity, and
- Access to erotic materials. ...

In international law, the *International Covenant on Civil and Political Rights* (ICCPR)⁵ provides many restrictions on involuntary slavery, servitude or unlawful imprisonment⁶. Nevertheless, it insists that 'everyone shall have the right to recognition everywhere as a person before the law'⁷. And that requirement, self-evidently, extends to sex workers. ...

Attempts to divert international treaty law into a total suppression of commercial sex work (prostitution) would not only amount to a distortion of the language and true purpose of such treaties. It would constitute a particularly damaging development for the effectiveness of the global HIV response.

7. Speaking frankly with religion:

As this conference has shown, people, including sex workers and their friends, feel sensitive and protective of their own religious traditions. The world's religions contribute in many ways to understandings of public morality as such understandings exist in most countries. ...

Sometimes, in practical terms, religions claim the 'high moral ground'. They oppose legal and other reforms, even when these are designed to support the HIV response. Those engaged in the HIV response must open a dialogue with religious leaders. The right to life and to access to essential health care is normally an avenue that can be deployed to promote religious tolerance and the acceptance of diverse views in society, including over sexual matters. ...

In Australia, despite the formal positions of the Roman Catholic Church on sexual morality, great practical leadership has been provided by particular religious orders in supporting the treatment of people living with HIV; in outreach to CSWs (commercial sex workers); and in establishing and maintaining programs for the protection of injecting drug users (IDUs). The seventh commandment requires an outreach to, and dialogue with, religion.

8. Utilising courts and parliaments:

Whilst most of the important measures relevant to proscribed sexual conduct will derive from elected legislatures, courts and judges also have important parts to play in upholding sensible laws and invalidating laws and policies that exceed their proper bounds and restrict effective AIDS strategies.

Thus, in India, the *Naz Foundation Case*⁸ limited the operation of the anti-homosexual provisions of s377 of the *Indian Penal Code* 1860 so that it would apply only to minors. In Bangladesh, the Supreme Court, in the absence of any prohibitory legislation, held that its duty was to protect the rights of sex workers, as citizens, to maintain their livelihood and their right to work without being unreasonably harassed by the local administration⁹. ...

Sometimes, where local politics or institutional religious pressures make it difficult or impossible for legislators to agree on enactments deemed necessary for an effective HIV response, courts may properly be able to afford wise decisions. The main importance of the *Naz Foundation Case* in India may well lie in the 41 countries of the 54 member organisation of the Commonwealth of Nations which still criminalise consenting adult private homosexual acts. Because of the commonality of the constitutional protections invoked in *Naz* by the

continued overleaf

Delhi High Court, its reasoning may well be applicable in many other lands where legislative steps to repeal such laws have so far failed to achieve success. We should be alert to these possibilities.

9. Vigilance against new oppressions:

Throughout this conference, attention has been drawn to risky new actions that may, however well intentioned, serve only to oppress adult sex workers and their clients. Amongst the laws mentioned in debates have been:

- The introduction of mandatory testing regimes, without proper guarantees of follow-up and access to essential therapies and without the consenting participation of those who are tested;
- The introduction and enforcement of new criminal and regulatory laws against those who indirectly benefit from sex work, such as landlords or related businesses; and
- The revived efforts in some countries to suppress erotic material. ... Whilst particular forms and contents of such erotica may warrant special attention and regulation, the access of adults to adult images appears a fairly universal, and generally harmless desire. ... Attempts to suppress consenting adult private sexual conduct are rarely effective, certainly according to the letter of the law. And this fact gives rise to potential corruption, oppression and impediments to an effective response to HIV.

10. Universal rights for sex

workers: This brings me to the last commandment. Universal human rights extend to all people. Sex workers are not exempted or excluded. They enjoy all the rights guaranteed to human beings by international law. Those rights include the 'right to work' which is defined¹⁰ to include 'the right of everyone to the opportunity to gain his living by work which he freely chooses or accepts'. See also *Universal Declaration of Human Rights*, Art.23.1.

Likewise, workers are guaranteed by international treaty law, the 'enjoyment of just and favourable conditions of work'. These include 'safe and healthy working conditions'¹¹. It is the duty of the law in every nation to support the achievement of these global attributes belonging to every human being everywhere. And this includes sex workers¹².

When we leave Pattaya to return to our homes and families, and are far away, we will remember the international experts who came together to examine the issues of HIV and sex work. We will recall the learned papers, the powerpoint presentations, the brave statements and the scientific analysis.

But above all, we will remember the energy of the sex workers in their 'concert with attitude'. Their insistence on their own dignity and rights. And the importance of upholding that insistence so as to provide them with respect and also to help contain the HIV epidemic amongst them, their families and clients.

To the cries from this conference 'who will speak for the voiceless?', the answer comes back. We will. We will convey their message from Pattaya. We will insist on human rights for all, including for sex workers. Nothing else is acceptable as a matter of a true public morality. Nothing else is sensible from the standpoint of responding to the urgent, ongoing global challenge of HIV and AIDS.

References

- 1 [2009] 4 *Law Reports of the Commonwealth* 838 (Shah CJ and Muralidhar J).
- 2 *Convention to Suppress the Slave Trade and Slavery* (1926 Slavery Convention) (1927) 212 UNTS 17; the *Supplementary Convention on the Abolition of Slavery, the Slave Trade and Institutions and Practices akin to Slavery* (the 1956 Supplementary Convention) (1958) 226 UNTS 3; *Protocol to Prevent, Suppress and Punish Trafficking in Persons, Especially Women and Children*, supplementing the *United Nations Convention Against Trans-national Organised Crime* (Palerma Protocol, 2000), Arts.3(a), (b), (c), 5.1. The *Palerma*

Protocol was adopted in 2000 at Palermo, Italy. It entered into force on 25 December 2003. By October 2009, it had been signed by 117 countries and there were 133 parties. The United Nations Office on Drugs & Crime (UNODC) is responsible for implementing the Protocol. Signature commits ratifying states to prevent and combat trafficking in persons and that expression is defined by reference to forms of "coercion" and "sexual exploitation". It renders "the consent of a victim of trafficking in persons to the intended exploitation ... irrelevant where any of the [forbidden] means ... have been used". But it is not, in terms, an international prohibition against all forms of sex work (prostitution).

- 3 See e.g. *Criminal Code Amendment (Slavery and Sexual Servitude) Act* 1999 (Aust); *Crimes Act* 1961 (NZ), s98(1).
- 4 See e.g. *The Queen v Wei Tang* (2008) 237 *Commonwealth Law Reports* 1 at 28–29 [66]–[70]. See also Sandhya Rao and Catu Sluggett, *Who Stole the Tarts? Sex Work and Human Rights*, Center for Advocacy on Stigma and Marginalisation (CASAM), September 1, 2009.
- 5 *International Covenant on Economic, Cultural and Social Rights*; 993 UNTS 14531 (1976), Art 6.
- 6 ICCPR, Arts.8, 11.
- 7 ICCPR, Art.16.
- 8 [2009] 4 *Law Reports of the Commonwealth* 838.
- 9 *BSEHR v Bangladesh* (2001) 53 *Dhaka Law Reports* 1 (Karim J).
- 10 *International Covenant on Economic Social and Cultural Rights*, ICESCR, Art.6.1.
- 11 *International Covenant on Economic, Cultural and Social Rights*; 993 UNTS 14531 (1976), Art. 7
- 12 Maguire, E. (2010, September). Body Politic – Scarlet Alliance (Australian Sex Workers Association), *The Monthly* (Australia), 36.

Michael Kirby AC CMG retired from the High Court of Australia on 2 February 2009 as Australia's longest serving judge. Since judicial retirement, his current achievements include being a member of the Eminent Persons Group which is investigating the future of the Commonwealth of Nations, and appointment to the UNDP Global Commission of HIV and the Law.

The full version of this speech is reproduced in *HIV Australia* online, available at www.afaoo.org.au

Updates to US HIV treatment guidelines

The United States Department of Health and Human Services released a number of updates to its HIV treatment guidelines for adults on 10 January 2011.

These include:

- A refinement of recommendations on when to start antiretroviral treatment in people diagnosed with tuberculosis. In people with CD4 counts below 200 cells/mm³ antiretroviral treatment should begin no more than two to four weeks after starting TB treatment. In people with CD4 counts between 200 and 500, antiretroviral treatment should be delayed no more than two to eight weeks after starting TB treatment. A majority of the guidelines panel also recommend that HIV treatment should be commenced within eight weeks of starting TB treatment in people with CD4 counts above 500 cells/mm³.
- CD4 cell counts in people on suppressive antiretroviral therapy should only be monitored every 6 to 12 months, unless there is a concomitant clinical condition or the patient is receiving immunosuppressive drugs.
- Virological failure should be defined as a viral load above 200 copies/ml, in order to rule out isolated blips or assay variations.
- Maraviroc/AZT/3TC is added to the list of acceptable regimens for first-line treatment. Combining maraviroc with either Truvada (Tenofovir/FTC) or Epzicom (abacavir/3TC, marketed as Kivexa outside North America) is described as 'may be acceptable but more data needed'.
- Saquinavir-based treatment is downgraded from 'Alternative' to

'Acceptable, but use with caution' as a result of a recent warning regarding abnormalities in cardiac rhythm in healthy volunteers who received the drug.

- Genotypic resistance testing for integrase inhibitor (INI) resistance should be considered at the time of failure of INI-containing treatment, in order to guide any future use of INIs. At present there is only one integrase inhibitor, raltegravir, available for prescription. Subsequent viral suppression after failure of raltegravir treatment may make it difficult to determine the INI resistance profile, should a patient require a new INI in the future. The panel also encourages physicians to think about the possibility of transmitted INI resistance in patients new to treatment – and in particular to consider whether the patient's source of infection was receiving an INI, since INI resistance is not currently a part of the standard panel of genotypic resistance tests that ought to be carried out for any patient starting treatment.

Reference

US Department of Health and Human Services. (2011). *Guidelines for the use of antiretroviral agents in HIV-1 infected adults and adolescents*, January 10.

— Keith Alcorn, *Aidsmap*
Published: 11 January 2011

Please note that the Australasian Society of HIV Medicine (ASHM) ARV Guidelines group are meeting in February to discuss the changes to the guidelines and that the Australian commentary to the guidelines may be amended after this meeting.

Atorvastatin and rosuvastatin have most favourable impact on lipids of patients with HIV

Atorvastatin and rosuvastatin have the biggest impact on lipid levels in HIV-positive patients, a US study published in the 1 February 2011 edition of *Clinical Infectious Diseases* shows.

Investigators compared the impact of atorvastatin, pravastatin and rosuvastatin on the lipid profiles of 700 HIV-positive adults. More favourable results were seen in patients treated with atorvastatin and rosuvastatin. The safety of the three drugs was comparable, and the rates of serious side-effects and treatment discontinuation because of toxicity were low.

'HIV-infected patients in clinical care who received rosuvastatin or atorvastatin had greater declines in total cholesterol, LDL-C, triglycerides, and non-HDL C values than those patients who received pravastatin', comment the investigators, who also note 'the greatest improvements in dyslipidemia was observed among those who received rosuvastatin'.

Increased blood lipids are common in HIV-positive patients and can increase the long-term risk of serious illnesses such as cardiovascular disease. Guidelines recommend the use of statins to treat high lipids in patients with HIV. However, there is currently little information about the comparable safety and effectiveness of individual statins when used in this population.

Investigators from the University of Alabama and the University of Washington, Seattle, therefore performed a retrospective study including HIV-positive adults who were treated with statins between

continued overleaf

2000 and 2008. The impact of the most commonly used statins on lipid profiles was compared. The safety of the drugs was also analysed.

Most of the patients (86%) were men, and the mean age when statin therapy was started was 43 years. The three most commonly prescribed statins were atorvastatin (43%), pravastatin (40%) and rosuvastatin (14%). Treatment with the statins improved the patients' lipid profiles.

After twelve months, mean total cholesterol had fallen by 15%, LDL-cholesterol by 13%, triglycerides by 20% and non-HDL-cholesterol by 17%. However, outcomes were better for those taking atorvastatin and rosuvastatin than for patients treated with pravastatin. Total cholesterol was significantly lower in patients taking these drugs, as was LDL-cholesterol, and non-HDL cholesterol.

After twelve months of therapy, 71% of patients had met national US guidelines for cholesterol control. But once again, outcomes differed according to the statin patients were taking.

Those treated with rosuvastatin ($p=0.03$) and atorvastatin ($p=0.001$) were significantly more likely than those taking pravastatin to reach the target for LDL-cholesterol reduction.

In addition, those treated with rosuvastatin were more likely than individuals taking pravastatin ($p=0.045$) to reach the non-HDL-cholesterol reduction target.

Treatment was generally safe and well tolerated. Overall 6% of patients

stopped statin therapy because of side-effects, and the rates of discontinuation did not differ significantly between the three drugs.

Traditionally, pravastatin has been the preferred statin for use in HIV-positive patients. This is because of its low risk of interactions with antiretrovirals. 'However,' write the investigators, 'our findings suggest that the lipid-lowering effectiveness of pravastatin was significantly less than that of rosuvastatin or atorvastatin.'

The investigators conclude, 'our findings are consistent with the recent British guidelines that include a recommendation to use rosuvastatin.'

Reference

Singh, S., et al. (2011). Comparative effectiveness and toxicity of statins among HIV-infected patients. *Clin Infect Dis* 52: 387–95. Available at: <http://cid.oxfordjournals.org/content/52/3/387.abstract> (accessed 13 January 2011).

— Michael Carter, *Aidsmap*
Published: 11 January 2011

Tenofovir with 3TC or FTC associated with lower lipid increases than other NRTI pairs

The combination of tenofovir and 3TC (or FTC) is associated with smaller increases in lipid levels than other pairs of nucleoside reverse transcriptase inhibitors (NRTIs) in patients starting HIV treatment for the first time, US researchers report in the online edition of AIDS.

Although tenofovir (Viread) with 3TC (lamivudine, Epivir) or FTC (emtricitabine, Emtriva) was associated

with better total cholesterol, low-density lipoprotein (LDL) cholesterol and triglyceride levels, it did not have a beneficial effect on high-density lipoprotein (HDL) cholesterol.

'Findings from this study demonstrate that comparisons of dyslipidemia and cardiovascular disease risk factors associated with antiretroviral medications should focus on individual agents rather than on class effect,' comment the investigators.

Cardiovascular disease is now an important cause of death in patients with HIV. The exact causes are unclear, but increases in lipid levels have been seen in patients after they start antiretroviral therapy.

Most of the research investigating the association between antiretrovirals and abnormal lipid levels has focused on the impact of the drug classes. Little attention has been paid to the effect of individual agents.

The investigators conclude that the study 'provides additional evidence that the metabolic impact of most antiretroviral agents, particularly those used more commonly in initial regimens in the current ART era, are relatively modest.'

Reference

Crane, H., et al. (2010). Impact of NRTIs on lipid levels among a large cohort initiating antiretroviral therapy in clinical care. *AIDS* 25, online edition. DOI: 10.1097/QAD.0b013e328341f925.

— Michael Carter, *Aidsmap*
Published: 14 December 2010



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February 2011

8–9

2011 Australian Health Care Reform Alliance (AHCRA) Summit

Canberra, Australia
<http://www.healthreform.org.au>

27–2 March

18th Conference on Retroviruses and Opportunistic Infections (CROI 2011)

Boston, US
<http://retroconference.org/2011>

March

16–18

HIV Capacity Building Partners Summit

Nairobi, Kenya
<http://www.hivcapacityforum.org>

20–25

Keystone Symposia: HIV Evolution, Genomics, and Pathogenesis; and Protection from HIV: Targeted Intervention Strategies

Whistler, British Columbia, Canada
<http://www.keystonesymposia.org/11X7>
<http://www.keystonesymposia.org/11X8>

23–25

9th European Workshop on HIV & Hepatitis – Treatment Strategies and Antiviral Drug Resistance

Paphos, Cyprus
<http://www.virology-education.com>

30–3 April

Australasian Society for Infectious Diseases (ASID) Annual Scientific Meeting 2011

Lorne, Australia
<http://www.asid.net.au/meetings/index.asp>

April

4–6

Communicable Disease Control Conference 2011

Canberra, Australia
<http://conferences.ozaccom.com.au/2011/pcd11/index.aspx>

10–13

Australian Health Promotion Association (AHPA) 20th National Conference

Cairns, Australia
<http://www.conferenceco.com.au/AHPA/>

13–15

12th International Workshop on Clinical Pharmacology of HIV Therapy

Miami, USA
<http://www.virology-education.com>

June

11–13

1st International HIV Social Science & Humanities Conference

Durban, South Africa
<http://www.iaohss.org/>

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