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Centre for Health Protection
NSW Department of Health
Locked Bag 961
North Sydney NSW 2059

**Re: Public Health Bill 2010 Consultation Draft - Section 76:
Persons with sexually transmitted diseases to inform sexual partners**

Dear Sir/Madam

The following submission is made by a coalition of twelve Australian agencies that are widely acknowledged as expert in the field of HIV care and control:

- Australian Federation of AIDS Organisations;
- National Association of People Living with HIV/AIDS;
- Australasian Society for HIV Medicine;
- National Centre in HIV Epidemiology and Clinical Research;
- National Centre in HIV Social Research;
- Australian Research Centre in Sex, Health and Society;
- Scarlet Alliance, Australian Sex Workers Association
- Albion Street Centre;
- ACON;
- Positive Life (NSW);
- HIV/AIDS Legal Centre; and
- Bobby Goldsmith Foundation

This coalition has come together specifically to communicate our objection to the legal requirement for HIV-positive people to disclose their HIV status prior to 'sexual intercourse' (under Section 76 of the draft Bill). Section 76 is antithetical to the accepted norms of Australian public health practice based on sophisticated scientific and epidemiological research, and is out of touch with scientific and service provider understanding of sexual behaviour. The proposed legislation would inevitably be applied inconsistently and inequitably, and decisions to pursue would be unacceptably arbitrary. This coalition submits Section 76 should be removed from the draft Public Health Bill.

Yours sincerely

Don Baxter
Executive Director
Australian Federation of AIDS Organisations

Joint submission of Twelve HIV Expert Agencies

on

The Public Health Bill 2010 Consultation Draft:

Section 76: Persons with sexually transmitted diseases to inform sexual partners

Australia's response to HIV is internationally esteemed. That response has been driven by strong leadership from government working in partnership with health care providers, academic researchers, community based agencies and affected communities. Based largely on public health management rationale, including the prioritising of health promotion and harm minimisation, Australia's particular HIV response has delivered impressive results in terms of minimising HIV transmission. Expert statistical modelling has demonstrated the response has saved many thousands of lives (and billions of dollars)¹. HIV prevalence in Australia remains one of the lowest in the world, at about 0.1%².

Each of Australia's five National HIV Strategies (and the impending sixth) has ensured that Australia's HIV response has been consistent with the requirements of the World Health Organisation's 'Ottawa Charter for Health Promotion'. The Charter recognises that HIV-related vulnerabilities can be multi-faceted, requiring a holistic approach addressing total life experience. That work is most effectively achieved in 'an enabling environment'.

Australia's enabling environment has been facilitated by a supportive legal environment, including HIV-specific privacy and anti-discrimination laws and, in most instances, the absence of specific laws targeting HIV as recommended by UNAIDS. In that context, we acknowledge the commendable decision of the NSW Parliament in its 2007 abolition of section 36 of the *Crimes Act 1900*, whereby the stand alone HIV-specific offence of causing a grievous bodily disease was removed and replaced by inclusion of infection with a grievous bodily disease under grievous bodily harm offences.

Government's commitment to legislation which supports HIV prevention and public health promotion is essential to Australia's approach to HIV/AIDS. That includes: eliminating legal barriers to prevention programs; encouraging people who engage in high risk behaviours to engage with services; and encouraging early diagnosis and treatment - without fear of breaches of human rights, discrimination or stigma.

*HIV Futures 6*³ notes that more than 25% of those surveyed have experienced discrimination in a health care setting. That data exists amidst growing discomfort and concern triggered by the

¹ See, for example, National Centre in HIV Epidemiology and Clinical Research, *Return on Investment 2: Evaluating the cost-effectiveness of Needle and Syringe Programs in Australia*, National Centre in HIV Epidemiology and Clinical Research and Commonwealth Department of Health and Ageing, Canberra, 2009.

² National Centre in HIV Epidemiology and Clinical Research, *HIV/AIDS, Viral Hepatitis & sexually Transmissible Infections in Australia Annual Surveillance Report*, National Centre in HIV Epidemiology and Clinical Research, Sydney, 2009.

³ Grierson J, Power J, Croy S, Clement T, Thorpe R, McDonald K, Pitts M. *HIV Futures 6: Making Positive Lives Count. The Living with HIV Program*. Melbourne: The Australian Research Centre in Sex, Health and Society, La Trobe University; 2006.

significant media attention that has accompanied criminal trials for HIV exposure and transmission during the last few years.

In the current climate, it is vital that health and public policy aim to reduce HIV-based stigma and discrimination, and effect strong engagement with the multiple systems in place to address HIV transmission and the consequences of living with HIV. Section 76, proposed in the Draft Public Health Bill, stands in stark contrast to that goal.

The following submission is made by a coalition of twelve Australian agencies that are widely acknowledged as expert in the field of HIV care and control:

- Australian Federation of AIDS Organisations;
- National Association of People Living with HIV/AIDS;
- Australasian Society for HIV Medicine;
- National Centre in HIV Epidemiology and Clinical Research;
- National Centre in HIV Social Research;
- Australian Research Centre in Sex, Health and Society;
- Scarlet Alliance, Australian Sex Workers Association
- Albion Street Centre;
- ACON;
- Positive Life (NSW);
- HIV/AIDS Legal Centre; and
- Bobby Goldsmith Foundation.

Though all the above agencies have a specific focus on HIV, their areas of expertise are diverse. In coalition, their experience covers the full range of HIV's impact in Australia, including epidemiology, research, prevention, primary care, community services, policy development and advocacy.

This coalition of HIV expert agencies has come together specifically to communicate to NSW Health our uniform belief that the legal requirement for HIV-positive people to disclose their HIV status prior to 'sexual intercourse' (as expressed in Section 76 of the draft Bill) is highly problematic. The coalition submits section 76 should be removed because its application is antithetical to the accepted norms of Australian public health practice based on sophisticated scientific and epidemiological research, and out of touch with the scientific and service provider understanding of sexual behaviour. Most importantly, the legislation would inevitably be applied inequitably or inconsistently, and decisions to pursue charges would be unacceptably arbitrary.

Submission 1:

- a. That section 76 (1) be removed from the draft Bill, **or**
- b. That section 76 (1) be replaced with a section that entrenches the public health message of mutual responsibility. Possible drafting is annexed at A.

NSW is one of only two Australian states specifically mandating disclosure of HIV status prior to sex (the other being Tasmania).

Section 76 (1) of the draft Bill states:

(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.

'Sexual intercourse' is defined as:

- (a) sexual connection by the introduction into the vagina, anus or mouth of a person of any part of the penis of another person, or
- (b) cunnilingus.

Section 76 (1) is identical in purpose to s.13 in the current Act, however, it differs from current section 13 (1) in two ways:

- Use of 'defendant' (at (a)) to replace 'person with whom intercourse is proposed': 'defendant' being more succinct but carrying the same meaning.
- Use of 'sexually transmitted disease' to replace 'sexually transmissible medical condition'. 'Sexually transmitted disease' is currently undefined. The draft Bill proposes a definition of 'sexually transmissible medical condition' as a 'scheduled medical condition that is transmissible by means of sexual intercourse'. That definition is broad, and therefore problematic⁴, but is not the focus of this submission as the section clearly relates to HIV.

Unfortunately, the Draft Bill includes a significant increase to the maximum penalty attached to offences under section 76: an issue which is addressed below under Submission 3.

This submission focuses on the specific impact of section 76 on HIV.

History of Proceedings under Section 76 (1) -

It is proposed that section 76 (1) replace section 13 (1) under the current *Public Health Act 1991*. This submission notes that section 13 (1) has only ever been applied on two occasions (see table below).

Finalised Charges under section 13 (1), *Public Health Act 1991 – 1991 to 2009.*

⁴ For example, it is broadly accepted that Hepatitis C cannot be sexually transmitted except under very unusual circumstances but it is not clear whether Hepatitis C is covered by the definition.

Year	Plea	Result	Factors
2005 ⁵	Not guilty	Dismissed	No evidence
2009 ⁶	Guilty	Discharged without conviction	Mitigating factors: <ul style="list-style-type: none"> • Use of condoms • Accused disclosed at the time, following risk episode • Accused made follow up phone call to advise partner of the availability of PEP

In the first instance, the case seemingly failed because the presiding magistrate was not satisfied that the police evidence proved the charge. In the second instance, the magistrate accepted a guilty plea, but decided a conviction (or penalty) was inappropriate given the accused's behaviour. That is, the accused had committed the offence but the accused's actions did not warrant a penalty or, indeed, the impact a conviction may have had on his life.

1. HIV Public Health Response

The public health system includes manifold laws, policies, processes, and education and service delivery mechanisms for addressing HIV. During the last few years, significant efforts have been made to ensure the effectiveness of the HIV response, in terms of both prevention and support.

The stated objectives of the draft Bill are:

- (a) to promote, protect and improve public health,
- (b) to control the risks to public health,
- (c) to promote the control of infectious diseases,
- (d) to prevent the spread of infectious diseases,
- (e) to recognise the role of local government in protecting public health.

This coalition of expert agencies submits that Section 76 fails to embody those objectives, and is generally antithetical to public health efforts as it:

1.1 Undermines the 'enabling environment'

This submission argues that while it is likely many people would want to know a partner's HIV positive status, that obligation should not be legally defined – because it is counter-productive to HIV prevention efforts. Indeed, our combined experience suggests the greatest likelihood of HIV-positive people disclosing their HIV status is in an 'enabling environment': an environment where HIV transmission risk is clearly understood and HIV stigma is minimised.

- *That while section 76 appears to support many HIV-negative persons' desire to know the HIV status of their sexual partners, the likelihood of HIV disclosure is greatest in an enabling environment: an environment which is undermined by section 76.*

⁵ Data obtained from the NSW Bureau of Crime Statistics and Research.

⁶ Data supplied by the HIV/AIDS Legal Service (not yet in NSW Bureau of Crime Statistics and Research database).

1.2 Undermines the message of mutual responsibility

As noted above, many working on HIV policy, support and primary health care have noted a breakdown of the key public health message of 'mutual responsibility' fundamental to HIV prevention efforts. Those observations have been backed up by behavioural research.

Notably, the Victorian *Public Health and Wellbeing Act* specifically names the responsibilities of all people in minimising opportunities for infection, by including in its principles (at section 111, (b)):

a person at risk of contracting an infectious disease should take all reasonable precautions to avoid contracting the infectious disease

Notably, the *Public Health and Wellbeing Act* has also removed the requirement for disclosure prescribed by the previous *Public Health Act*, and also any penalty for failure to disclose. The Act also addresses obligations to the tested (at section 111c):

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

That principle enshrines the obligation of those who believe they may have come into contact with an infectious disease, to be tested. Despite a lack of behavioural research on this specific issue, anecdotal evidence suggests legal culpability based on a definitive diagnosis (i.e. that defined by section 76 (1)) may militate against people testing for HIV: a possibility with dire consequences for HIV prevention.

South Australia's *Public Health Bill 2009* also includes a specific principle in relation to individuals' responsibility to avoid contracting a controlled notifiable condition (at section 14):

(4) A person must not, insofar as is reasonably practicable, act in a manner that will place himself or herself at risk of contracting a controlled notifiable condition that is capable of being transmitted.

A similar assertion is included in NSW's Policy Directive "HIV - Management of People with HIV Infection Who Risk Infecting Others", which states (at 1.)

every individual has a responsibility to prevent themselves and others from becoming infected and preventing further transmission of the virus [i.e. HIV]

- *Section 76 (1) undermines HIV prevention efforts by placing all responsibility for HIV prevention on people living with HIV. That notion appears to have increasing prevalence in affected communities: a situation that must be countered - not endorsed.*

1.3 Is inconsistent with National and State guidelines on people who put others at risk of HIV transmission

NSW Policy Directive 'HIV - Management of People with HIV Infection Who Risk Infecting Others' includes reference to section 13 - the obligation for people to disclose their HIV-status prior to sex, then proceeds to describe four levels of management (three of which are formally numbered as management levels) which operate without regard to the disclosure requirement. That is, none of the prescribed levels of support/management are required when an individual fulfils their legal obligation under section 76 (1).

The ensuing management process is then described as a series of interventions which clearly prioritise support, as indeed does the work of the NSW Assessment Panel. Notably, despite its work with people with HIV who have engaged in unprotected sex without disclosing their status, the NSW Assessment Panel has not referred matters for prosecution under section 13. That is likely because such a referral is contrary to the rationale of the Panel in supporting individuals and thereby managing risk to public health.

- *Section 76 (1) undermines HIV prevention efforts because it is incompatible with the practice of the NSW Assessment Panel, and indeed NSW Health.*

1.4 Operates outside HIV management systems

There is no mechanism in place for NSW Health to track the laying of charges under section 76 (1), and indeed NSW Health appears to have been unaware of the prosecution of the above mentioned Sydney man in 2009 until alerted by a community organisation some time after charges had been laid. NSW Health appears also to lack a system for identifying whether the charge has previously been laid. This systemic failing indicates that section 76 (1) is conceptually and practically incompatible with HIV surveillance and public health management systems (in NSW and nationally).

- *Section 76 (1) is incompatible with HIV surveillance and public health management systems.*

2. Fair and Consistent Application

Section 13 has been applied only twice during the 19 years that HIV disclosure prior to sex has been a legal requirement in NSW. That understanding is problematic as it suggests that section 76 (1):

2.1 Cannot be appropriately policed

The *Report on the Review of the Public Health Act 1991* supports ACON's argument that 'section 13 is virtually impossible to police and enforce', and states that, in conjunction with other factors, poor enforceability weighs against section 13's utility. Yet, the report argues for the continued inclusion of section 13 as a public health offence.

Indeed, section 13 is self-evidently difficult to police, given its rare application amidst the likely many thousands of instances of the offence having been committed, including the many instances of 'sexual intercourse' involving no or remote risk of HIV transmission. The notion of charges rarely being laid in the context of frequent offences being committed means that the possible laying of charges is unacceptably arbitrary. Moreover, in two instances charges have arguably been laid

inappropriately. In the first case, charges were dismissed due to lack of evidence. In the second, the person charged had not only practised safe sex with his heterosexual sexual partner, but when he identified a risk incident had occurred, he notified his partner of his HIV-positive status, and phoned her the following day to ensure she was aware of the availability of post-exposure prophylaxis (PEP). The presiding magistrate held that despite his guilty plea, a conviction was inappropriate. The application of section 13 makes it difficult for communities and individuals to understand what, in practice, the offence might mean.

- *Section 76 (1) makes many sexual encounters unlawful but it is not enforced. In fact, the public health review found it cannot be effectively enforced.*

2.2 Is applied to HIV only

As noted above, section 76 applies to any 'sexually transmitted disease', which is defined as a 'scheduled medical condition that is transmissible by means of sexual intercourse'. That broad definition fails to clearly exclude those conditions with very low transmission risk during sexual intercourse, but assuming usual judicial practice in the application of the *Acts Interpretation Act 1987*, would likely include Chlamydia, syphilis and various hepatitises.

Although this submission relates to the application of section 76 to HIV only, it is by comparing HIV to other undefined 'sexually transmitted diseases' that the likely bias of section 76 becomes apparent. Charges under section 13 have not been laid in relation to any sexually transmitted disease other than HIV. In fact, it is questionable whether the Health Department or the general community would really countenance such a charge being laid. Moreover, section 76 is a summary charge, meaning charges are laid by police prosecutors without referral to the Director of Public Prosecutions or the Health Department. This submission argues that it is difficult to envisage significant police interest in a person making a complaint about sex with a person who has an STI such as syphilis or Chlamydia, and although having theoretical application to other sexually transmitted diseases, section 76 (1) effectively targets HIV.

- *Section 76 (1) is written to have general application but is biased towards application to HIV only.*

2.3 Confuses individual desires with a legal system supporting HIV prevention

There has been no Australian case specifically testing public health (or other) laws in relation to whether the use of condoms without disclosure satisfies legal requirements for a person with HIV to prevent exposure or transmission to another person. That issue, however, was tested in a New Zealand Court in October 2005. The accused, Dalley, was charged in relation to heterosexual oral sex without a condom, and vaginal intercourse during which a condom was used. The judge, found Mr Dalley not guilty (of criminal nuisance) in relation to both charges. The oral sex charge was dismissed on the basis of the negligible, if any, transmission risk. The charge relating to unprotected vaginal sex was dismissed on the basis of the use of condoms, and scientific evidence on the reliability of condom use in HIV prevention: the charge requiring the accused to use 'reasonable' precautions and care, rather than 'failsafe' precautions.

Notably, Judge Thomas also defined the difference between a legal and a moral duty:

It seems to me that most people would want to be told that a potential sexual partner was HIV positive. There may well be a moral duty to disclose that information. There is however a difference between a moral duty and a legal duty, the legal duty in this case being to take reasonable precautions against and use reasonable care to avoid transmitting the HIV virus.

Similarly, this submission argues that while it is likely many people would want to know a partner's HIV positive status, that obligation should not be legally defined – because it is counter-productive to HIV prevention efforts. Indeed, our combined experience suggests the greatest likelihood of HIV-positive people disclosing their HIV status is in an 'enabling environment': an environment where HIV transmission risk is clearly understood and HIV stigma is minimised.

- *Section 76 (1) appears to support many HIV-negative persons' desire to know the HIV status of their sexual partners, however, the likelihood of HIV disclosure is greatest in an enabling environment: an environment which is undermined by section 76 (1).*

3. Scientific evidence on risk

When section 13 was drafted in 1991, only seven years after identification of HIV, little was known of the basics of HIV science, and less of HIV epidemiology. Since then, significant Australian and international research has aimed to better understand HIV and its transmission, generating sophisticated scientific and epidemiological data which forms the basis of Australia's HIV response. That research, and its expert analysis, is at odds with section 76 (1) in relation to:

3.1 Transmission risk: unprotected sex

Longitudinal cohort studies have determined that the per-contact rate of HIV transmission is approximately 0.001 (1 in a thousand) per episode of penile-vaginal sex and 1 in 200/300 per episode of anal sex. Those estimates, representing averages, have been accepted by numerous Australian courts. As far back as 1995, Victorian courts⁷ found that the higher estimated rate (one chance of transmission in 200) did not constitute an 'appreciable risk' for the purposes of Victorian criminal law. The risk of transmission through oral sex while biologically possible, is considered so low it is impossible to calculate as a 'risk'.

While the use of Anti-retroviral treatment (ART) to prevent the transmission of HIV was suggested as early as 2002⁸, its potential use in HIV prevention continues to be debated and researched. Scientific debate is particularly focussed on key knowledge gaps, including the indirect correlation between viral load in blood (the basis for HIV testing) and semen (the host for most HIV transmitted through sexual means). A number of studies (in development or underway), will further inform understanding of transmission risk.

- *Section 76 (1) applies to all instances of vaginal, anal and oral sex without prior disclosure. This submission argues that disclosure is an onerous and inappropriate*

⁷ *R v B*, followed by *R v D*, and *Mutumeri v Cheesman*

⁸ Hosseinipour M, Cohen MS, Vernazza PL, Kashuba AD. Can antiretroviral therapy be used to prevent sexual transmission of human immunodeficiency virus type 1? *Clin Infect Dis* 2002 May;34(10):1391-5.

mandate given the low probability of transmission during a single unprotected sexual encounter: a probability which ranges from an average of 1/200 or 300 to a risk that is so low as to be unable to be calculated.

- *Section 76 (1) allows no defence (i.e. presentation of scientific evidence) on the nature of relative risk that is context dependent, and thus, the accused's efforts to reduce risk: an area of scientific knowledge which has developed considerably since 1991, and which will continue to develop during the next decade.*

3.2 Transmission risk: Condom use

The correct use of condoms is highly effective in preventing HIV transmission. NCHECR's *Mathematical models to investigate recent trends in HIV notifications among men who have sex with men in Australia* found lack of condom use combined with the presence of STIs (other than HIV) now appears to be the main driver of the increase in new HIV notifications⁹. Condom use is likely the primary component of HIV prevention and the most widely used strategy for risk reduction, yet it is deemed irrelevant under the draft Public Health Bill, which states a person may be convicted for not disclosing his or her HIV status regardless of whether condoms (or other risk-reduction strategies) were used. Such a conviction was recorded in 2009, following the charging of a Sydney man under section 13 of the current *Public Health Act 1991* after he had protected sex (i.e. used a condom) with a female partner without first disclosing his HIV positive status. While no conviction was recorded by the Magistrate in that instance, arguably no charge should have been laid as the person had not engaged in behaviour likely to result in a risk to public health.

- *Section 76 (1) runs counter to scientific and epidemiological evidence on the effectiveness of condom use in preventing HIV infection.*

4. Behavioural Evidence

Despite having been in place for almost 20 years, there is no evidence to suggest that NSW's disclosure law has had any direct beneficial impact on HIV prevention efforts.

4.1 Disclosure laws do not increase disclosure rates

The little international empirical evidence regarding the efficacy of disclosure laws indicates a lack of connection between the existence of such laws and belief structures/sexual risk behaviours. For example, recent US research compared attitudes, beliefs and behaviours among almost 500 people at elevated risk of HIV infection, approximately half of whom lived in a state that mandated HIV disclosure prior to sex (Illinois), and half of whom lived in a state without disclosure laws (New York). The study found no connection between the existence or lack of laws, and belief structures, disclosure practice and other sexual risk reduction behaviours¹⁰.

⁹ David Wilson, Alexander Hoare, David Regan, Handan Wand, Matthew Law February 2008, p.33.

¹⁰ Burris SC, Beletsky L, Burleson JA, Case P, Lazzarini Z. Do criminal laws influence HIV risk behavior? An empirical trial. *Arizona State Law Journal* 2007. Temple University Legal Studies Research Paper No. 2007-03.

Recently, the National Centre in HIV Social Research recruited more than 1200 men who have sex with men (MSM) for a study on HIV-related stigma. That national survey found no differences between disclosure rates of HIV positive men from New South Wales compared to other Australian jurisdictions.¹¹ Also, there were no differences between *all* men (both HIV positive and HIV negative) from different jurisdictions in terms of disclosing their HIV status to any sexual partners. So, while adherence to the principle of disclosure by a positive partner may prevent transmission, there is no evidence that disclosure laws trigger disclosure.

- *Section 76 (1) would not increase the likelihood of HIV positive (and HIV negative) persons disclosing their HIV status.*

4.2 Some people cannot disclose their HIV status

NCHECR's scientific modelling estimates that 30% of new HIV infections occur as a result of transmission from the estimated 9% of MSM who are unaware that they are HIV positive¹². People who are unaware they have acquired HIV cannot disclose their HIV positive status and may incorrectly advise sexual partners that they are HIV negative. The high rate of transmission may be the result of a range of factors including people's elevated risk of transmitting HIV (due to high viral load) during the brief period following HIV infection, and people's willingness to forgo condom use if they believe both partners to be HIV negative. Indeed, recent findings from the National Centre in HIV Social Research's E-male study demonstrated that using a condom with casual sexual partners is *less* likely following disclosure¹³.

- *Section 76 (1) undermines HIV prevention efforts and safe sex messages by ignoring the significant risk of HIV transmission by persons who are HIV positive but believe themselves to be HIV negative.*

4.3 Some people erroneously believe they have disclosed their HIV status: serosorting

Serosorting describes a process whereby gay men engage in unprotected anal intercourse and other sexual acts only with men they believe to be of the same HIV-status as themselves. Many gay men will (occasionally, sometimes or frequently) practice forms of non-verbal HIV-status disclosure which can lead to misunderstandings regarding HIV status. Education campaigns, such as the joint AFAO/NAPWA 'Think Again' campaign and ACON's 'You Just Don't Know' campaign, directly address the practice of serosorting, including mistaken expectations, assumptions and misunderstandings. Service providers' concerns about the breadth and fallibility of serosorting is backed up by Zablotska et al.'s 2009 research into serosorting, which identifies instances of

¹¹ de Wit J and Murphy D. Personal communication.

¹² Wilson D, Hoare A, Regan D, Wand H, Law M. Mathematical models to investigate recent trends in HIV notifications among men who have sex with men in Australia. Sydney: National Centre in HIV Epidemiology and Clinical Research; 2008.

¹³ Rawstorne P, Holt M, Kippax S, Worth H, Wilkinson J, Bittman M. E-male survey 2008: key findings from a national online survey of men who have sex with men in Australia. (Monograph 3/2009). Sydney: National Centre in HIV Social Research; 2009.

miscommunication, including instances when an HIV-positive person believes an HIV-negative person has communicated their HIV-positive status - and vice-versa¹⁴.

- *Section 76 (1) undermines HIV prevention efforts targeting serosorting practices, whereby, in some instances gay men may erroneously believe they have communicated their HIV status prior to 'sexual intercourse'.*

4.4 Some people do not disclose their HIV status

Not all people will disclose their HIV-positive status before every sexual interaction with a new partner during the course of their lives. The recent study by the National Centre in HIV Social research found that most HIV-positive men (76.2%) had disclosed their serostatus to their regular partner(s), and fewer than half of the HIV-positive men in the study (38.3%) had disclosed their serostatus to their casual sex partners. People may fail to disclose their HIV status for a range of reasons including:

- Use of risk reduction strategies

The decision not to disclose (which may be considered or spontaneous) may be informed by understanding of risk reduction behaviours: for example, using safer sexual practices (including condoms) or the belief that having a low viral load equates to low risk of transmission⁷¹⁵¹⁶¹⁷¹⁸.

Understanding of transmission risk continues to develop and many in HIV affected communities endeavour to understand risk reduction. The January 2008 release of 'The Swiss Consensus Statement'¹⁹ drew international attention. It noted agreed scientific evidence that transmission risk is affected by viral load and the presence of other sexually transmissible infections (STI's), but went a step further by asserting a person with HIV is not sexually infectious and cannot transmit the virus through heterosexual intercourse if the person:

- consistently adheres to anti-retroviral therapy (ART), with regular evaluation by an expert treating physician;
- has had a viral load below the limits of detection (blood plasma level <40 copies/ml) for at least six months; and
- has no additional sexually transmissible infections present.

- Fear of loss of privacy

¹⁴ Zablotska I, Imrie J, Prestage G, Crawford J, Rawstorne P, Grulich A, Fengy J, Kippax S. Gay men's current practice of HIV seroconcordant unprotected anal intercourse: serosorting or seroguessing? *AIDS Care*, 21, 2009.

¹⁵ Prestage G, Mao L, Kippax S, et al. Use of viral load to negotiate condom use among gay men in Sydney, Australia. *AIDS and Behaviour*, (In press).

¹⁶ Van De Ven P, Kippax S, Crawford J, Rawstorne P, Prestage G, Grulich A, Murphy D. In a minority of gay men, sexual risk practice indicates strategic positioning for perceived risk reduction rather than unbridled sex. *AIDS Care*, 14, 2002, p. 471–480.

¹⁷ Van de Ven P, Murphy D, Hull P, Prestage G, Batrouney C, Kippax S. Risk management and harm reduction among gay men in Sydney. *Critical Public Health*, 14, 2004, p. 361–376.

¹⁸ Van de Ven P, Mao L, Fogarty A, Rawstorne P, Crawford J, Prestage G., Grulich, A., Kaldor, J., Kippax, S. Undetectable viral load is associated with sexual risk taking in HIV serodiscordant gay couples in Sydney. *AIDS*, 19: 2005, p. 179–184.

¹⁹ Vernazza P, Hirschel B, Bernasconi E, Flepp M. (2008) Les personnes séropositives ne souffrant d'aucune autre MST et suivant un traitement antirétroviral efficace ne transmettent pas le VIH par voie sexuelle. *Bulletin des médecins suisses*. 89(5).

Some people are unwilling to disclose their HIV status, as once disclosed that information can and does travel. Notably, the Australian Research Centre in Sex, Health and Society's *HIV Futures 6* reports that 51% of HIV-positive respondents (from all Australian states and territories) have had their HIV status disclosed without their permission. Fear of disclosure may be particularly relevant to persons who have not disclosed to family and friends and who are not generally out about being HIV positive²⁰, however, it may apply to anyone because the consequences can be significant, including rejection by family, friends and others, or more formal forms of discrimination. Despite discrimination on the basis of HIV-status being unlawful across Australia, *HIV Futures 6* reports continuing instances of discrimination in relation to health services (26.4%), insurance (17.3%), workplace (16.3%), and accommodation (7.9%).

In fact, the primacy of ensuring confidentiality around an individual's HIV status is enshrined in a range of formal privacy mechanisms, many of which are mandated by the NSW *Public Health Act* (e.g. the collection of coded notification data), in recognition of the fact that the implications of HIV-disclosure can be dire.

Further, confidence in privacy protection is key to creating an enabling environment in which HIV positive people and those at risk will engage with others (particularly service providers) and feel confident to disclose HIV status. There is no effective privacy protection for the disclosure required under section 76. The still nascent tort of breach of confidence remains untested in this context but offers limited protection or remedy.

- Fear of rejection/discrimination

Some people do not disclose their HIV-positive status fearing rejection. The Project Maleout study²¹ found 62% of HIV-positive participants avoided having sex with people they believed were HIV positive. Van de Ven et al.²² found some 80% of HIV-negative men said they always or sometimes avoided sex with people they think are HIV positive. Unpublished data from the Positive Health study²³ shows that as many as 27% of HIV-positive men surveyed have been sexually rejected due to their HIV status. Those findings are concerning given two decades of evidence showing the effectiveness of safe sex practices.

The results from a recent survey by the National Centre in HIV Social Research strongly suggest that reliance on disclosure of HIV status to reduce the risk of transmission of HIV increases stigma and discrimination. HIV-negative men who relied on HIV status disclosure were more likely to stigmatise people living with HIV.²⁴ Consequently, section 76 (1) may be understood as antithetical to national and state strategies that seek to reduce HIV-related stigma/discrimination.

²⁰ Grierson J, Power J, Croy S, Clement T, Thorpe R, McDonald K, Pitts M. *HIV Futures 6: Making Positive Lives Count. The Living with HIV Program*. Melbourne: The Australian Research Centre in Sex, Health and Society, La Trobe University; 2006.

²¹ Van De Ven P, Rawstone P, Crawford J, Kippax S, 'Facts and Figures 2000 Male Out Survey', National Centre in HIV Social Research, 2001.

²² Van De Ven P, Kippax S, Crawford J, Rawstone P, Prestage G, Grulich A, Murphy D. In a minority of gay men, sexual risk practice indicates strategic positioning for perceived risk reduction rather than unbridled sex. *AIDS Care*, 14, 2002, p. 471–480.

²³ By the National Centre in HIV Social Research.

²⁴ de Wit J, Murphy D, Donohoe S, and Adam P. (July, 2010) Vicious circle of self-protection: reliance on serostatus disclosure to reduce risk of HIV is associated with greater stigma among HIV negative MSM in Australia. Poster accepted to XVIII International AIDS Conference, Vienna (Abstract number 11886).

- *Section 76 (1) undermines HIV prevention efforts which address the fact that, for a variety of reasons, some people do not disclose their HIV status prior to sex.*
- *Section 76 (1), by encouraging disclosure of HIV status, may increase levels of HIV stigma.*

4.5 Fear of legal repercussions from disclosing HIV status

During the last few years there has been considerable media reporting of criminal prosecutions of people for exposing others to HIV or infecting others with HIV. Although few in number (but possibly increasing in frequency), criminal prosecutions relating to HIV have triggered fear and uncertainty among affected communities, with probable consequences for public health management.

*HIV Futures 6*²⁵ reveals that 42.4% of those surveyed reported being worried about disclosing their HIV status to sexual partners 'because of the current legal situation'. That finding is a direct result of both public health and criminal laws impacting HIV disclosure but counter to the intention behind these laws. Additionally, 28.4% of those surveyed expressed some concern about the legal implications of disclosure of sexual practices to service providers: a finding with serious implication for the capacity of services to develop strong relationships with their clients, and hence provide support and facilitate HIV prevention strategies.

- *Section 76 (1) undermines HIV prevention efforts by contributing to HIV-positive people's fear of disclosure to sexual partners, and fear of discussion of risk behaviours to service providers.*

4.6 Expectation that positive people will disclose

Many analysts assert a marked reduction in the extent to which affected communities galvanise around HIV prevention. The 'Think Again' campaign is based on the premise that while in the 1980's the 'default position' of gay men was, 'Assume everyone is HIV-positive. Don't ask, don't tell. Practice safe sex always'. Now many gay men think, 'If he is positive he should tell – otherwise assume he is HIV-negative'.

The 2000 Project Maleout study²⁶ found 79.3% of HIV-negative respondents expected an HIV-positive man to reveal his HIV-status before having sex (in the context of 81% of HIV-negative men saying they would avoid having sex if they thought the person had HIV). As noted above, not all HIV-positive gay men will disclose their HIV-status prior to each new sexual partner and some efforts at non-verbal communication will be misinterpreted.

²⁵ Grierson J, Power J, Croy S, Clement T, Thorpe R, McDonald K, Pitts M. *HIV Futures 6: Making Positive Lives Count. The Living with HIV Program. Melbourne: The Australian Research Centre in Sex, Health and Society, La Trobe University; 2006.*

²⁶ Van De Ven P, Rawstone P, Crawford J, Kippax S, 'Facts and Figures 2000 Male Out Survey', National Centre in HIV Social Research, 2001.

- *Section 76 (1) undermines HIV prevention efforts by supporting the mistaken assumption of HIV-negative people that HIV-positive people will disclose 'because it's the law', and by inference, because it is 'right'.*

5. Collection and Analysis of Data

It has long been argued that the success of Australia's HIV response is the result of insistence on a sound evidence base. Indeed the current *National HIV/AIDS Strategy* states 'research plays a critical role in providing much of the evidence base for policies and programs at all levels', and the term 'evidence based' is again liberally scattered through the draft 6th National HIV Strategy.

The development of epidemiological, behavioural and social research essential to the development of that evidence base involves the compilation of both quantitative and qualitative research. Given modes of HIV transmission, such research frequently includes consideration of subjects' sexual and drug using behaviours, requiring particular methodologies conducive to the sensitive nature of such data collection. Unfortunately, in some instances research is also stymied by the legal frameworks in various Australian states and territories. Research ethics requires that researchers develop means to minimise any possible harm to study participants, and it would be highly preferable if public health laws relating to consenting sexual practices were repealed.

- *Section 76 (1) undermines capacity to undertake scientific research to inform the HIV response.*

Summary – Submission 1:

The coalition of above agencies seeks the removal of section 76 (1) from NSW's *Draft Public Health Bill*. That is not to argue that HIV-positive persons should not disclose their HIV status prior to engaging in risk behaviours, but that disclosure is ill-conceived as the core of HIV prevention policy. Instead, risk minimisation and safe sexual practice must form the basis of HIV prevention efforts. Further, disclosure is most likely in an enabling environment where HIV-related stigma is minimised: an environment facilitated by understanding of HIV and messages of mutual responsibility.

- a. That section 76 (1) be removed from the draft Bill, **or**
- b. That section 76 (1) be replaced with a section that entrenches the public health message of mutual responsibility. Possible drafting is annexed at A.

Submission 2:

That section 76 (2) be removed from the draft Bill.

Section 76 (2), which is identical to current section 13, states:

(2) An owner or occupier of a building or place who knowingly permits another person to:

- (a) have sexual intercourse at the building or place for the purpose of prostitution, and
- (b) in doing so, commit an offence under subsection (1), is guilty of an offence.

Section 76 (2) is proposed to replace section 13 (2) under the current *Public Health Act 1991*. The NSW Bureau of Crime Statistics and Research reports no case has ever proceeded under section 13 (2) of the *Public Health Act 1991*.

The public health implications of sex work regulation have long been recognised. Given that sex work frequently involves penetrative sex²⁷, the potential for HIV transmission is high. That potential has been borne out in many countries where transmission through sex work has been a major factor in domestic HIV epidemics.²⁸ Australia, however, is among the few countries where the incidence of HIV among sex workers is very low. Despite sophisticated HIV surveillance mechanisms, only a handful of suspected cases of HIV transmission in a sex work setting have ever been identified in Australia. That is extraordinary, given more than 28,000 diagnoses of HIV infection have been recorded in Australia since 1983²⁹, and best estimates of some 20,000 persons engaging in (legal and illegal) sex work in Australia in any one year. New South Wales is estimated to have the largest population of people working in the commercial sex industry, at approximately 10,000 persons in any year.³⁰

As noted in the *UNAIDS Guidance Notes on HIV and Sex Work*, 'evidence-informed measures to address sex work are an integral component of an effective, comprehensive response to HIV'.³¹ HIV prevention efforts will only be effective if responsive to the realities of the commercial sex industry. That requires engagement with the broad context in which the commercial sex industry operates.

6. Sex work in a decriminalised environment

New South Wales is the only Australian state to have decriminalised sex industry regulation³². That decision has been broadly applauded by public health experts as having increased accessibility of sex workers to health care and support, and health care workers' access to sex workers, with resulting positive public health outcomes. Research into implementation over some 15 years has failed to reveal any negative consequences arising from decriminalisation, with

²⁷ Frequently but not always. See, for example C Harcourt, B Donovan (2005) 'The many faces of sex work' *Sexually Transmitted Infections*, 81 (which lists types of sex work that do not include penetrative sex), and C Harcourt, B Donovan, B Sullivan (2009) 'Law and Sexual Health Project' 'International Society for STD Research, London, June/July 2009 (which estimates that of those surveyed some 20% did not engage in penetrative sex during sex work).

²⁸ This includes the understanding that HIV epidemics have been affected through transmission in sex work settings but also transmission to/by sex workers and clients during personal relationships.

²⁹ National Centre in HIV Epidemiology and Clinical Research, *HIV/AIDS, Viral Hepatitis & sexually Transmissible Infections in Australia Annual Surveillance Report*, National Centre in HIV Epidemiology and Clinical Research, Sydney, 2009

³⁰ Estimate by Sex Workers Outreach Project (SWOP), cited in Sex Services Premises Planning Advisory Panel. *Sex services premises: Planning guidelines*. Sydney: NSW Department of Planning, 2004.

³¹ UNAIDS, *UNAIDS Guidance Notes on HIV and Sex Work*, UNAIDS, Geneva, 2009.

³² Noting a limited number of offences remain in the *Summary Offences Act 1988*

anecdotal evidence from sex work and other health and law based agencies suggesting decriminalisation has delivered positive benefits.

The UNAIDS 2002 *Sex Work and HIV: Technical Update* states that ‘in the face of oppressive laws, sex work is likely to become increasingly clandestine, making HIV/AIDS and STI prevention and care activities nearly impossible to implement³³. This submission argues that section 76 (2) is likely to push the activities of sex workers living with HIV underground, i.e. away from support of HIV and sex work support agencies.

6.1 Importance of an Enabling Environment

This expert coalition recognises that some Australian sex workers are HIV positive³⁴. Matthew's 2008 survey of sex workers living with HIV found:

The rise in criminal prosecutions for the transmission of HIV and the increased discourse around criminal transmission has led to an overall sense of being burdened with responsibility. For sex workers with HIV, this is felt in addition to the dual stigma already faced. Participants reported resentment and fear around this issue.

HIV-related stigma compounded by stigma related to sex work, represents a significant barrier to HIV positive sex workers' accessing medical and psychosocial care and support services. An effective HIV response is facilitated by an environment that enables sex workers living with HIV to be open about their sex work so that options around safe sex practice can be fully explored and understood. The impact of section 76 (2) runs counter to that goal.

- *Section 76 (2) contributes to the marginalisation and social exclusion of sex workers living with HIV, which is contrary to HIV prevention goals.*

6.2 Regulation and Support in Place

The *WorkCover NSW Health and Safety Guidelines for Brothels* provide brothel proprietors with minimum standards for maintenance of a safe and healthy environment for sex workers, other employees, clients and visitors. Those Guidelines state:

- The employer must provide an adequate supply of Personal Protective Equipment (PPE) and ensure it is adequately maintained, where appropriate. This includes condoms, dams, gloves, water-based lubricants and other personal protective equipment such as towels and linen free of charge to workers. Where a person is employed as a subcontractor and is registered as a proprietary limited company they should provide their own work equipment and PPE. ... Employers must also ensure that the PPE provided is used correctly and not used beyond their expiry date.
- Brothels should make provision for regular staff health monitoring, with employees consulted on choice of doctors. The employer should pay for the medical check and for

³³ UNAIDS, *Sex work and HIV/AIDS: Technical Update*, UNAIDS, June 2002.

³⁴ In 2008, Scarlet Alliance undertook a national needs assessment of sex workers living with HIV. AFAO endorses all recommendations made within the needs assessment report. Matthews K & Scarlet Alliance (2008) *National Needs Assessment of Sex workers who live with HIV*, Scarlet Alliance.

the employee's time while undergoing medical examination. Sex workers should attend a sexual health service or private doctor for sexual health assessment, counselling and education appropriate to individual needs. Frequency of assessment is a matter for determination by the individual sex worker in consultation with his/her clinician. Evidence of attendance for sexual health tests should not be used as an alternative to safe sex practices. Sexual health certificates do not imply freedom from STIs nor should sexual health certificates be shown to clients.

The *WorkCover NSW Health and Safety Guidelines for Brothels* provides a framework for safe sex practice within the commercial sex industry. Additional regulation is not required.

- *Section 76 (2) is at odds with decriminalisation of the NSW sex industry. It is heavy handed in an environment where legal enforcement is not required.*

7. Safe Sex Practice

7.1 High Rates of Condom Use

Australian research indicates that the commercial sex industry has demonstrated excellent uptake of safe sex practice as an occupational health and safety issue, with condom use considered standard in brothel and privately based sex work. The recent 'Law and Sexual Health' study reported consistent (100%) condom use of 95% to 100% among some 600 sex workers in randomly selected brothels in Sydney, Melbourne and Perth³⁵. Lee et. al. also reported 100% condom use among 40 sex workers visiting the Melbourne Sexual Health Centre, with three reported incidents of condom breakage or slippage at work³⁶. Scott et. al.'s NSW regional research found all of the 18 female sex workers interviewed reported using condoms with clients for intercourse and oral sex³⁷. Woodward et. al.'s study found that between 40% and 50% of female sex workers working privately or in legal brothels reported clients sometimes offering extra money for sex without a condom. More than 99% of those sex workers responded that following such an offer they would refuse to see the client, talk them into using a condom, or provide an alternative service³⁸.

- *Section 76 (2) undermines the importance of safe sexual practice in commercial sex settings, and holds a person liable for an 'offence' in instances where there is no HIV exposure or transmission risk.*

7.2 Low STI Rates Support Safe Sex Practice

³⁵ Donovan B, O'Connor JL, Harcourt C, Wand H, Egger S, Schneider K, Fairley CK, Chen MY, Kaldor JM, Marshall L, Bates JL, 'Law and Sexual Health (LASH) Project poster from the International Society for STD Research in London, June/July 2009, National Centre in HIV Epidemiology and Clinical Research, University of New South Wales, University of Melbourne, Fremantle Sexual Health Centre, Melbourne Sexual Health Centre, Sydney Sexual Health Centre, Urban Realists Planning and Health Consultants, Australia, 2009.

³⁶ Lee DM, Binger A, Hocking J, Fairley CK, 'The incidence of sexually transmitted infections among frequently screened sex workers in a decriminalised and regulated system in Melbourne' *Sexually Transmissible Infections*, 2005

³⁷ Scott J, Hunter J, Hunter V, Ragusa A, 'Sex work and health in a rural context: results of qualitative study undertaken in New South Wales', 2008.

³⁸ Woodward C, Fischer J, Najman J, Dunne MP. *Selling Sex in Queensland*, 2003.

There are no recorded cases of HIV transmission in a sex work setting and only a handful of suspected cases, supporting research findings that the incidence of condom use in commercial sex settings is very high. While sexually transmissible infections (STIs) may be transmitted in instances when HIV cannot, recorded incidence of STIs is an accepted indicator (only) of safe sex practices.

In 2009, Donovan et. al. found STI prevalence among 600 brothel based sex workers was as low as STI prevalence in the general population. STI prevalence was similarly low across all three jurisdictions considered, only one of which has legislated STI testing³⁹. Lee et al⁴⁰ undertook a clinical audit of more than 500 female sex workers working in decriminalised or regulated environments attending the Melbourne Sexual Health Clinic. The study found that the incidence of STIs was low among decriminalised sex workers in Melbourne (with most infections acquired outside work). Notably, Scott et. al.'s research reported that rural female sex workers in NSW believed they would benefit from greater access to health services like those available to sex workers in urban settings, reiterating the argument that sex workers have a vested interest in their own sexual health.

- *Section 76 (2) is antithetical to evidence of HIV risk, as STI prevalence supports other evidence of the commercial sex industry's commitment to safe sex practice.*

Samaranayake et al⁴¹ reviewed records of patients at Melbourne Sexual Health Centre between 2005 and 2008, and found the incidence of STIs detected per 100 hours of consultation time was four fold higher for men who have sex with men than for female sex workers.

- *Section 76 (2) is antithetical to the HIV response because it inappropriately targets a low risk population group, i.e. people engaged in commercial sex work.*

8. Counter to scientific evidence on risk practices

This coalition argues that including an HIV/sex work related law on disclosure is counter-productive and unnecessary when safe sex practice forms the cornerstone of Australia's success in ensuring the sex industry has not become a primary location of HIV transmission.

- *Section 76 (2) targets disclosure only while ignoring safe sex practice.*

Summary – Submission 2:

³⁹ See Donovan B, O'Connor JL, Harcourt C, Wand H, Egger S, Schneider K, Fairley CK, Chen MY, Kaldor JM, Marshall L, Bates JL, 'Law and Sexual Health (LASH) Project poster from the International Society for STD Research in London, June/July 2009, National Centre in HIV Epidemiology and Clinical Research, University of New South Wales, University of Melbourne, Fremantle Sexual Health Centre, Melbourne Sexual Health Centre, Sydney Sexual Health Centre, Urban Realists Planning and Health Consultants, Australia, 2009.

⁴⁰ Lee DM, Binger A, Hocking J, Fairley CK, 'The incidence of sexually transmitted infections among frequently screened sex workers in a decriminalised and regulated system in Melbourne' *Sexually Transmissible Infections*, 2003.

⁴¹ Samaranayake A, Chen M, Hocking JS, Bradshaw C, Cummings R, Fairley CK, 'Legislation requiring monthly testing of sex workers with low rates of sexually transmitted infections restricts access to services for higher risk individuals' *Sexually Transmissible Infections*, 2009.

The coalition of above agencies seeks the removal of section 76 (2) from NSW's *Draft Public Health Bill*. That is not to argue that HIV-positive persons who engage in sex work should not disclose their HIV status prior to engaging in risk behaviours, but that disclosure is ill-conceived as the core of HIV prevention policy. Instead, risk minimisation and safe sexual practice must form the basis of HIV prevention efforts.

People living with HIV who engage in sex work risk social marginalisation as a result of the dual stigma associated with HIV and sex work. Legislating to force owners and occupiers of buildings used for commercial sex to refuse to employ people living with HIV is counter-productive to HIV prevention efforts, particularly given current provisions health and safety provisions.

Submission 2: That section 76 (2) be removed from the draft Bill.

Submission 3:

- That failure to disclose HIV status attract no penalty, **or**
- That should offences under Section 76 remain, penalties remain as mandated under the current *Public Health Act 1991*.

As noted above, the *Public Health Bill 2010 Consultation Draft* includes provision to dramatically increase penalties for offences committed under both sections 76(1) and 76 (2):

- Section 76 (1) increases the maximum penalty (under current section 13 (1)) from 50 penalty units to 100 penalty units or imprisonment for 6 months, or both.
- Section 76 (2) also increases the maximum penalty (under current section 13 (2)) from 50 penalty units to 100 penalty units or imprisonment for 6 months, or both.

A penalty unit is currently set at \$110.00, so effectively the maximum penalty for either offence increases from \$5,500 to \$11,000 plus six months jail. No reason for the increase has been provided.

The proposed increase in penalties is unexpected given the risk of HIV transmission associated with a single act of unprotected sex is now better understood than when the current section was first drafted: that is, there is less risk than was previously assumed.

Further the increase is surprising given section 76 (1) has never been successfully charged. It has only ever been applied twice: the first charge failing to find a guilty verdict, and the second failing to attract a conviction – let alone application of penalty. Section 76 (2) has never been prosecuted.

The coalition of above agencies argues that failure to disclose HIV status should not attract a penalty under the *Draft Public Health Bill*, per the recently drafted Victorian *Public Health Act 2008*, which repealed disclosure provisions under the previous Act and introduced a set of principles

without associated penalty. Alternatively, should a revised offence under section 76 remain, the penalty should remain the same as that prescribed in the current Act.

Submission 3:

- That failure to disclose HIV status attract no penalty, **or**
- That should offences under Section 76 remain, penalties remain as mandated under the current *Public Health Act 1991*.

Annexure A

The coalition submits two possible drafting options for section 76 (1):

Option 1: Application of Principles (no penalty)

The following is based on the concept of principles recently introduced into the Victorian *Public Health and Wellbeing Act 2008*.

Possible text:

The following principles apply to the management and control of sexually transmissible medical conditions:

- (a) the spread of a sexually transmissible medical condition should be prevented or minimised with the minimum restriction on the rights of any person;
- (b) a person at risk of contracting a sexually transmissible medical condition should take all reasonable precautions to avoid contracting the sexually transmissible medical condition;
- (c) a person who has, or suspects that they may have, a sexually transmissible medical condition should:
 - (i) ascertain whether he or she has a sexually transmissible medical condition and what precautions he or she should take to prevent any other person from contracting the sexually transmissible medical condition and
 - (ii) take all reasonable steps to eliminate or reduce the risk of any other person contracting the sexually transmissible medical condition;
- (d) a person who is at risk of contracting, has or suspects he or she may have, a sexually transmissible medical condition is entitled:
 - (i) to receive information about the sexually transmissible medical condition and any appropriate available treatment

Option: Specific Offence (maximum penalty to remain as under current Act)

The following is based on accepted priority principles of HIV prevention.

Possible text:

- (1) All persons who engage in sexual activity must take all reasonable steps to minimise the risk of acquiring or transmitting a sexually transmissible condition.
- (2) A person who is and is aware of being infected with sexually transmissible medical condition must not knowingly or recklessly place another person at risk of becoming infected with that condition unless that other person knew the risk of infection and voluntarily accepted the risk of being infected.
- (3) A person who contravenes subsection (2) is guilty of an offence.

Penalty: Fine not exceeding 50 penalty units.