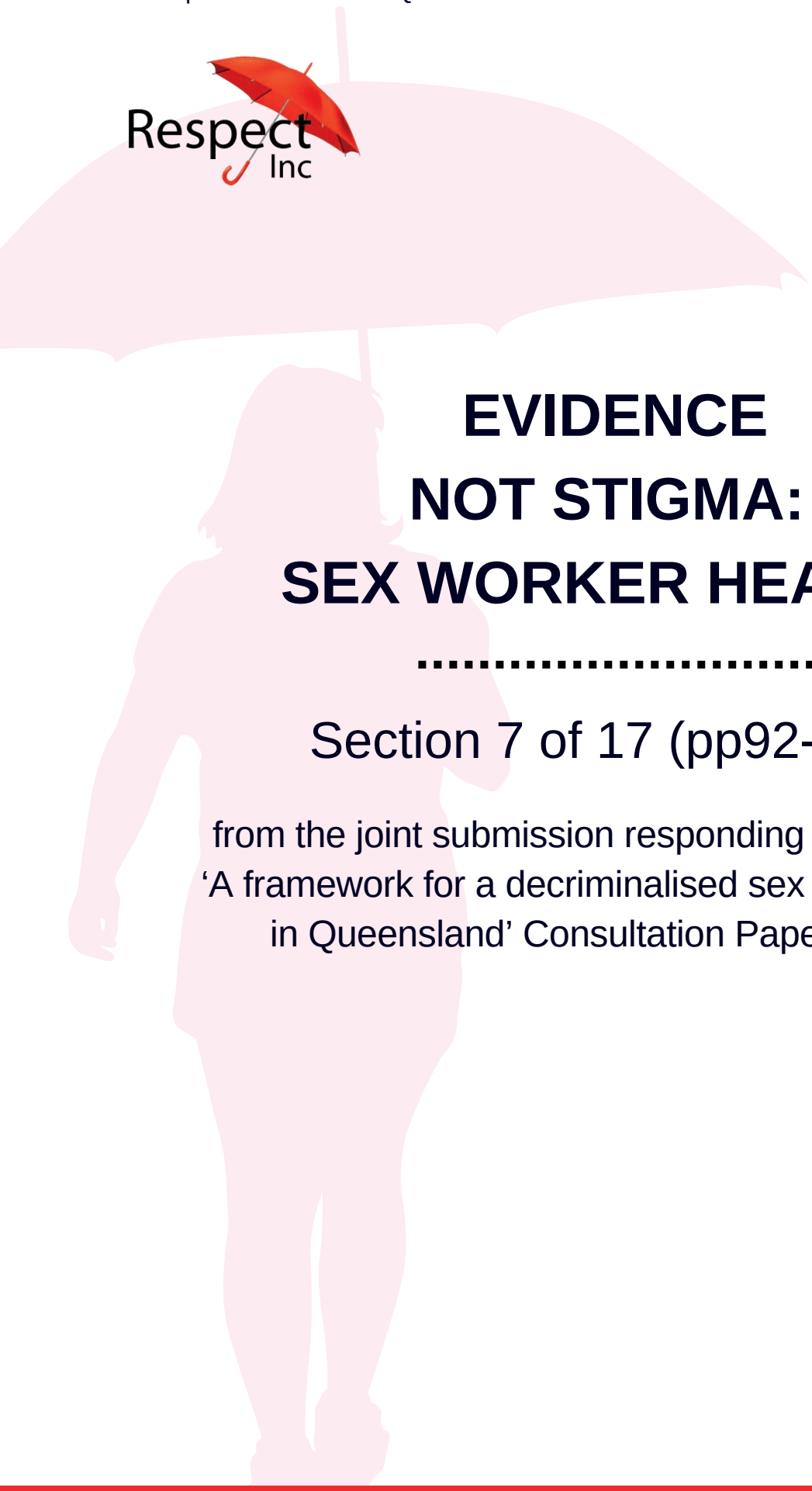

EVIDENCE NOT STIGMA: SEX WORKER HEALTH

Section 7 of 17 (pp92-106)

from the joint submission responding to the QLRC
'A framework for a decriminalised sex work industry
in Queensland' Consultation Paper WP 80'

CHAPTER 11: PUBLIC HEALTH AND THE HEALTH OF SEX WORKERS

Q23 Should laws or other measures be taken to promote public health and protect the health of sex workers and their clients about:

(a) the use of prophylactics;

(b) managing the risk of sexually transmitted infections;

(c) sexual health testing; or

(d) another matter?

Q24 If yes to Q23, what should those measures be and why?

Q. 23 Should there be laws to promote public health and protect the health of sex workers and clients?

No. The new decriminalisation framework should include the repeal of all current sex work-specific laws, including those relating to public health, and promote the globally recognised successful community development peer education approach to STI and HIV prevention instead.

Peer educator programs have been instrumental since the beginning of the HIV pandemic[60] in persuading brothel managers and workers to adopt safer sex practices. Condom use in brothels rose from under 11% of sexual encounters to over 90% between 1985 and 1989 and high rates of condom use have been consistently maintained by sex workers since, with the health of sex workers improving commensurately.[61] This major contribution to HIV and STI prevention by sex workers and sex worker community organisations is now recognised as an essential plank of HIV and STI prevention in Australia:

> Continued health promotion and prevention efforts of peer-based sex worker organisations have sustained the low prevalence of HIV among sex workers.[62]
>
> Strong and sustained health promotion programs among sex workers have led to rates of STI in this priority population among the lowest in the world.[63]

Respect Inc and DecrimQLD support sex workers' uptake of safe working practices and regular testing, which is best achieved through the community development approach of peer education, WHS guidelines and access to free, voluntary and anonymous testing. This was supported in our recent survey where 62.7% of sex worker participants selected peer education as the best approach to promoting the use of safer sex practices, 19.1% selected

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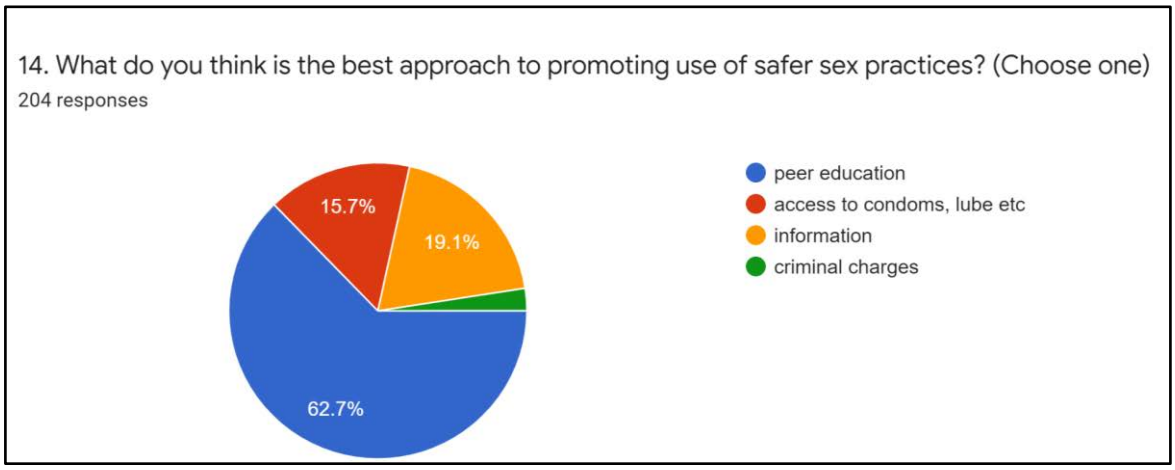
[60] Australian Broadcasting Corporation (ABC). (2007). *Rampant: How a city stopped a plague* (part 5). https://www.youtube.com/watch?v=-gqrcHFI0Rk&list=PLZ9KDADG-2mhngQci4JqJnSqbWWwPmqOw&index=5

[61] Donovan, B., et al. (2012). p. 11.

[62] Australian Government Department of Health Eighth National HIV Strategy 2018-2022 p. 14. https://www1.health.gov.au/internet/main/publishing.nsf/Content/ohp-bbvs-1/$File/HIV-Eight-Nat-Strategy-2018-22.pdf

[63] Australian Government, Health Department (2018) *Fourth national sexually transmissible infections strategy*, p. 14. https://www1.health.gov.au/internet/main/publishing.nsf/Content/ohp-bbvs-1/$File/STI-Fourth-Nat-Strategy-2018-22.pdf

information, 15.7% selected access to condoms, lube, etc. Only 2.5% chose criminal charges as helpful in promoting safer sex practices, as shown in the graph below:



Laws criminalising condom use, sex workers living with STIs and sexual health testing are harmful to public health and do not achieved positive health outcomes:

> The public health evidence clearly shows the harms associated with all forms of sex work criminalisation, including regulatory systems, which effectively leave the most marginalised, and typically the majority of, sex workers outside of the law. These legislative models deprioritise sex workers' safety, health, and rights and hinder access to due process of law.[64]

The idea that criminal laws and police enforcement are needed to protect the wider community and maintain good sexual health of sex workers reinforces harmful stigma.[65] It is also counterproductive to the desired health outcomes[66] and is recognised in state and national policy as creating barriers to accessing health services. For example:

National HIV Strategy 2018-2022

> Sex workers experience barriers to accessing health services including stigma and discrimination. They also face a range of regulatory and legal issues including criminalisation, licensing, registration and mandatory testing in some jurisdictions. These barriers create a complex system of impediments to evidence-based prevention, access to testing and healthcare services. They can result in increased risk of BBVs and STIs, loss of livelihood, and risk to personal and physical safety. Evidence that has emerged since the previous strategy definitively shows that decriminalisation of sex work is linked to the reduction of HIV risk and rates.[67]

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[64] Platt, L., Grenfell, P., Meiksin, R., Elmes, J., G. Sherman, S., Sanders, T., Mwangi, P., Crago, A-L. 2018 Associations between sex work laws and sex workers' health: A systematic review and meta-analysis of quantitative and qualitative studies | PLOS Medicine

[65] Stardust, Z. et al 2021.

[66] Jeffreys, E., Fawkes, J. & Stardust, Z. (2012). Mandatory Testing for HIV and Sexually Transmissible Infections among Sex Workers in Australia, *World Journal of AIDS*, vol 2, pp. 203-211.

[67] Australian Government Department of Health *Eighth National HIV Strategy 2018-2022*, p. 22. https://www1.health.gov.au/internet/main/publishing.nsf/Content/ohp-bbvs-1/$File/HIV-Eight-Nat-Strategy-2018-22.pdf

National Sexually Transmissible Infections Strategy 2018-2022

> Sex workers experience specific barriers to accessing health services, including stigma and discrimination and regulatory and legal issues—criminalisation, licensing, registration and mandatory testing in some jurisdictions. These can impede access to evidence-based prevention, testing, treatment and support services and can result in increased risk of STI, loss of livelihood, and risk to personal and physical safety.[68]

Queensland HIV Action Plan 2019–2022

> …address the legal, regulatory, system and policy barriers which affect priority populations and influence their health-seeking behaviour and access to testing and healthcare services and calls to 'address barriers to evidence-based prevention, treatment and care' and 'support improved awareness of HIV and associated legal issues'… [69]

Queensland Sexually Transmissible Infections (STI) Action Plan 2019–2022

> Monitor and address the legislative, regulatory and policy environment which impact on access to testing, treatment and management.[70]

Queensland Sexual Health Framework objectives:

> Ongoing activity to address stigma and discrimination and promote culturally responsive practice, with policy support for priority populations.
>
> Cross-agency acknowledgement of social determinants of sexual health and including these in system responses.[71]

Research demonstrates that criminal frameworks and licensing of sex work (such as we have in Queensland) produce worse health outcomes than decriminalisation.[72] Platt et al argue that:

> ...criminalisation and repressive public health approaches to sex work (e.g., mandatory registration and HIV/sexually transmitted infection [STI] testing) have been shown to hinder the prevention of HIV. Conversely, mathematical modelling has estimated that decriminalisation of sex work could halve the incidence of HIV among sex workers and their clients over a 10-year period, and evidence from New Zealand indicates that sex workers in decriminalised settings report improved workplace safety, health and social care access, and emotional health.[73]

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[68] Australian Government Department of Health *Fourth National Sexually Transmissible Infections Strategy 2018-2022*, p. 22. https://www1.health.gov.au/internet/main/publishing.nsf/Content/ohp-bbvs-1/$File/STI-Fourth-Nat-Strategy-2018-22.pdf

[69] Queensland HIV Action Plan 2019-2022 4.5, 4.6

[70] Queensland Sexually Transmissible Infections (STI) Action Plan 2019-2022 4.4

[71] Queensland Sexual Health Framework

[72] Harcourt et al. (2010). The decriminalisation of prostitution is associated with better coverage of health promotion programs for sex workers

[73] Platt, L., et al (2018).

Repeal of criminal laws and charges attached to use of prophylactics (condoms, dams), mandatory testing and working while infective with an STI or HIV will retire QPS from their current role as 'safe sex police', a job for which they were never qualified.

Sex workers in Australia have better sexual health than the general community

The research consistently shows that Australian sex workers have good sexual health with low rates of blood-borne viruses (BBVs) and sexually transmitted infections (STIs) that are equal to, or lower than, the general population. Sex workers have high rates of sexual health testing and high rates of prophylactic use compared with the general population. Australia's National STI Management Guidelines state: 'there is no evidence that sex workers in Australia have higher rates of sexually transmitted infections (STIs) than the general population'.[74] The Lancet (2014) found the decriminalisation of sex work was associated with lower HIV transmission.[75]

Q. 23 (a) Mandatory condom use laws

Queensland's Work Health and Safety Regulation 2011[76] already requires provision of and use of PPE by the worker and the client as well as requiring information and training on use and correct storage:

> 44 (2)The person conducting a business or undertaking who directs the carrying out of work must provide the personal protective equipment to workers at the workplace, unless the personal protective equipment has been provided by another person conducting a business or undertaking.
>
> 44 (3)The person conducting the business or undertaking who directs the carrying out of work must ensure that personal protective equipment provided under subsection (2) is—...ensuring that the equipment is…(c)used or worn by the worker, so far as is reasonably practicable.
>
> 44 (4)The person conducting a business or undertaking who directs the carrying out of work must provide the worker with information, training and instruction in the—
> (a)proper use and wearing of personal protective equipment; and
> (b)the storage and maintenance of personal protective equipment.
>
> 45 The person conducting a business or undertaking who directs the carrying out of work must ensure, so far as is reasonably practicable, that—
> (a) personal protective equipment to be used or worn by any person other than a worker at the workplace is capable of minimising risk to the person's health and safety; and (b) the person uses or wears the equipment.

[74] Australian Government, Health Department. (2018). *Fourth national sexually transmissible infections strategy*. https://www1.health.gov.au/internet/main/publishing.nsf/Content/ohp-bbvs-1/$File/STI-Fourth-Nat-Strategy-2018-22.pdf

[75] The Lancet HIV and sex workers series, July 23, 2014. HIV and sex workers; Platt, L., et al. (2018).

[76] Queensland Work Health and Safety Regulation 2011 Chapter 3 Part 5 Section 44, 45, 46, 47.

These WHS regulations are appropriate and ample to ensure PPE usage in sex industry workplaces within a decriminalisation framework. Maintaining Prostitution Act s.77A or replacing it with another sex industry-specific law is an unnecessary duplication of what are universal WHS requirements and laws. As sex workers actually have higher rates of prophylactic use than the general public, s. 77 acts to discriminate on the basis of 'lawful sexual activity' and as such would likely be found incompatible with the ADA (Qld). Additionally, any inclusion within the new framework of provisions for not using prophylactics, similar to the current offence in s77A, would likely conflict with sections 17 and 25 of the HRA, which provides for protection from torture and cruel, inhuman or degrading treatment and the right to privacy. Police entrapment of sex workers would not stand up to the HRA, creates barriers to sex workers accessing health and justice services and has no basis in public health discourse. To be explicit: prophylactic laws in Queensland are enforced by police posing as clients who pressure, harass and offer inducement in order to arrest sex workers who agree to provide services without condoms.

There is no evidence to suggest that the criminalisation of condom or prophylactic use has a public health benefit. Research demonstrates that there are high rates of condom use amongst sex workers—including migrant sex workers—in jurisdictions that do not legally mandate sex workers to use condoms. *The sex industry in NSW: A report to the Ministry of Health* (2012) study found that sex workers were approaching 100% condom use in Sydney brothels with no differences for migrant sex workers.[77]

There is little evidence that prophylactic laws support sex workers having autonomy around safer sex. Peer education on sex work methods to assume control of the booking and talk to clients about condom use are lifelong skills then shared among co-workers[78], and do not expose sex workers to discriminatory policies or harmful police entrapment. Sex workers have been at the forefront of safer sex mobilisation since the 1980s and perform an often unacknowledged role in educating their clients about sexual health issues.

Any new law specific to the sex industry that makes the use of prophylactics mandatory will ensure the continuation of police entrapment and all of the harmful consequences that this entails. It is likely that if such laws were included in the new framework it would result in *more* police entrapment because, we assume, police would have fewer other bases on which to pursue criminal charges against sex workers.

Respect Inc and DecrimQLD would also like to point out that the cost of this type of policing is exorbitant compared with the cost of peer education. If the human rights and public health arguments are not enough to convince Queensland policy makers that entrapment of sex workers via verbal enticement about condom use should discontinue, we hope that the economic argument might. Sex workers in Queensland have yet to hear a single logical argument in favour of these police powers.

[77] Donovan, B., et al. (2012).

[78] Donovan B. & Harcourt, C. (1996). 'The female sex industry in Australia: A health promotion model', *Venereology*, vol 9, no 1, pp. 63-67.

Q. 23 (b) Criminalisation of sex workers working with an STI

As with mandatory prophylactic laws, criminalisation is not an effective public health strategy for sex workers with STIs. Community development and peer education demonstrates better and longer-lasting results. We argue that criminalisation of sex workers based on their 'health status' denies an individual equality before the law, undermines public health outcomes and perpetuates stigma. National policy in Australia recognises that criminalisation may impede access to evidence-based prevention, testing, treatment and support services and may result in increased risks of STI and BBV, loss of livelihood and risk to the personal and physical safety of sex workers.[79]

A 2008 case in the Australian Capital Territory where a sex worker living with HIV was jailed is a stark example of how criminalisation of sex workers with STI can seriously impact health seeking behaviour. Despite no evidence of transmission of HIV or unsafe sex practice, the person was prosecuted for providing a sexual service whilst knowingly HIV-positive, and they were outed in the media across Australia, New Zealand, Germany, Vietnam, Belgium and Hong Kong.[80] As a result of this case, 'many sex workers became fearful of testing for HIV', leading to a dramatic drop in sex worker attendance at outreach medical services. They report: 'In the four-week period following the court case, the numbers attending the service dropped from an average of 40 per night to three'.[81]

Given the advancement of biomedical intervention and current epidemiology of HIV in Australia, including that people living with HIV on now widely available treatment do not risk transmission of HIV, provisions that criminalise sex workers living with HIV are no longer justified. Queensland Positive People explains:

> Criminal law and popular understandings have not kept up with the scientific consensus regarding HIV transmission and clinical advances. Criminal laws perpetuate stigma, discrimination, and mis-education around HIV.[82]

There is already a comprehensive process in Queensland to manage the very small number of cases where a person living with HIV places another person at risk.[83] The Public Health Act 2005 allows for the management of HIV-related risks, such as when a person living with HIV places others at risk, for example through unprotected sex. The process outlines a staged approach for the management and supervision of counselling, education and support for those persons living with HIV who place others at risk and have not responded to initial interventions at the local level, or are unwilling or unable to change their risk behaviours. Each Australian state and territory has implemented management processes that align with the *National Guidelines for the Management of People with HIV Who Place Others at Risk*.

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[79] Australian Government Department of Health (2018- 2022) *Eight National HIV Strategy*, p. 22.

[80] Daniel, A. (2010). The sexual health of sex workers: No bad whores, just bad laws, *Social Research Briefs*, NSW Health, no 19, p. 1.

[81] Jeffreys, E., Matthews, K. & Thomas, A. (2010) 'HIV criminalisation and sex work in Australia', *Reproductive Health Matters*, vol 18, no 35, pp. 129-136.

[82] Queensland Positive People. (2020). *Issues and options paper: Sexual conduct involving HIV and the criminal law in Queensland Exposure Draft*.

[83] Queensland Department of Health (2014) Guideline for the management of people living with HIV who place others at risk of HIV. https://www.health.qld.gov.au/__data/assets/pdf_file/0022/147640/qh-gdl-367.pdf

The Public Health Act (s143) also contains penalties for people who 'recklessly spread controlled notifiable conditions'.

The responsibilities and powers provided to the Chief Health Officer and the Department of Health contained within the *Public Health Act 2005* to manage people living with HIV who put others at risk should, and do, apply to everyone irrespective of the setting where the sexual activity occurs. Additional laws are not necessary. Given these offences are already provided for within current legislation, it would be a duplication to include other provisions on working with an STI. Duplication for sex worker-only penalties or regulation would likely conflict with sections 17 and 25 of the HRA, which provide for protection from torture and cruel, inhuman or degrading treatment and right to privacy. Any ongoing criminalision or discrimination against sex workers on the basis of health status would be arguably incompatible with the ADA (Qld).

Q. 23 (c) Mandatory testing

> Hansard 1 October, **1886** REPEAL OF THE CONTAGIOUS DISEASES ACT.
> Mr. JORDAN, in moving- "That this House disapproves of the compulsory examination of women under the Contagious Diseases Act." [84]

It should be concerning to public health policy makers that more than 100 years following the repeal of the Contagious Diseases Act 1886, Queensland politicians re-enacted another mandatory sexual health testing regime for sex workers. Queensland's sex industry laws, s89 and s90 of the Prostitution Act 1999 and s 14 and s 26 of the Prostitution Regulation, combine to result in what is commonly called 'mandatory testing' of sex workers who work in licensed brothels. It is a defence for a sex worker (s89) and for a brothel owner (s90) to avoid a charge if a 'certificate of attendance' is obtained by the sex worker at the time of undertaking a sexual health screening for sexually transmissible infections (s26) and at least 3 monthly (s14). The Prostitution Licensing Authority requires the certificates to be collected and kept for a period of time and licensed brothels prevent sex workers from beginning work or continuing to work (after 3 months) unless a certificate proving that a screening has been undertaken is provided. The overall impact of this set of laws is a system of mandatory testing.

Within the sexual health sector it is widely recognised that the system is a farce and has no value to public health and in fact creates barriers to accessing services and is a waste of sexual health resources. This is because, unlike the stated intention in the law that the sex worker 'had been medically examined or tested at intervals prescribed under a regulation to ascertain whether the prostitute was infective with a sexually transmissible disease' (s90,3,a), the certificate only indicates that the person attended the clinic and had screenings by participating in the mandatory testing regime: it does not indicate whether the person has a STI or is 'infective'. Regular voluntary testing is considered best practice, as is the implementation of safer sex practices. Mandatory testing systems are not effective and are discriminatory.

Australia's National HIV Strategy and the National Sexually Transmissible Infections

[84] Hansard 1 October, 1886. accessed 26 May, 2022. https://documents.parliament.qld.gov.au/events/han/1886/1886_10_01_A.pdf

Strategy[85] recognise **voluntary testing** not mandatory testing as best practice and explicitly identified mandatory testing of sex workers as a key barrier to evidence-based prevention, access to testing and healthcare services.[86] This is partly because mandatory testing 'endorses a false sense of security in the form of a "certificate", which, due to window periods, doesn't actually confirm a sex worker's sexual health status but instead just indicates that the sex worker has complied with the state's mandatory testing regime.

Australian research on the cost benefit of mandatory testing in Australia found that testing should not be 'locked by legislation'.[87] The cost of over-testing is high—screening sex workers for HIV every 12 weeks costs $4mil for every one HIV infection averted.[88] Mandatory testing places an unnecessary burden on sexual health clinics, which are already beyond capacity. Access to sexual health clinics for sex workers is often impacted by excessive wait times and sex workers who are experiencing symptoms of an STI, who are in need of quick access, are regularly asked to wait. Mandatory testing acts as a barrier to sex workers' realisation of good sexual health.[89]

Mandatory testing of sex workers is also incompatible with the HRA by impacting the right not to be subject to medical treatment without full, free and informed consent. Mandatory testing would likely conflict with aspects of sections 15, 17, 25 and 37 of the HRA, which provides for equality before the law, protection from torture and cruel, inhuman or degrading treatment, right to privacy as well as the right to health services. Laws can limit human rights but only when it is 'necessary, justifiable and proportionate', which is not the case here. Mandatory testing of sex workers is considered a violation by a number of international human rights organisations, such as the United Nations Human Rights Office of the High Commission for Human Rights and UNAIDS.

Mandatory testing framework under the Queensland Health Communicable Diseases Unit

The Queensland Health Communicable Diseases Unit does not consider that sex workers are a high priority public health risk as evidenced by the declining focus on sex workers in their clinical guidelines. Following the implementation of mandatory testing and up until 2012, Queensland Health maintained a bulky clinical guidelines document for sexual health testing that included a five-page section specifically about sex workers. This document, the *Queensland Sexual Health Clinical Management Guidelines 2010* along with the *Sexual Health Certificate of Attendance* covered the legal sexual health requirements for sex workers from a medicolegal perspective. The guidelines also contained detailed rules about the exclusion periods for various STIs (i.e. the time periods for treatment, determining whether, and for how long, the previously issued sexual health certificate of attendance was invalidated).

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[85] Australian Government, Health Department (2018) *Eighth national HIV strategy*. https://www1.health.gov.au/internet/main/publishing.nsf/Content/ohp-bbvs-1/$File/HIV-Eight-Nat-Strategy-2018-22.pdf

[86] Ibid. p. 22 HIV Strategy, Ibid, p. 22 STI Strategy.

[87] Wilson, D. P., Heymer, K. J., Anderson, J., O'Connor, J., Harcourt, C., & Donovan, B. (2010) 'Sex workers can be screened too often: A cost-effectiveness analysis in Victoria, Australia', *Sexually Transmitted Infections*, vol 86, no 2.

[88] Ibid.

[89] Jeffreys, E. et al (2012).

Sometime after 2012 the guidelines were edited and the sections that referred to specific populations such as sex workers were removed. This document was ultimately replaced by a link to the ASHRA and AHSM *Australian STI Management Guidelines (ASMG)*[90], which is an online resource for primary care health professionals to support the prevention, testing, diagnosis, management and treatment of STIs in adults and adolescents.

The ASMG includes small separate sections for priority populations, which set out best-practice testing and advice. The overview for sex workers states:

> Currently, there is no evidence that sex workers in Australia have higher rates of sexually transmitted infections (STIs) than the general population. Sustaining low STI rates remains a priority.[91]

In the section on *Clinical Indicators for Testing* it is noted that some sex workers in some jurisdictions require periodic mandatory testing and these jurisdictions are Victoria and Queensland. Now that mandatory testing has ben repealed in Victoria, this will leave Queensland as the only jurisdiction requiring mandatory testing for sex workers.

The *Follow Up* section includes a link to the online Scarlet Alliance *Red Book*[92], which is a sexual health resource by sex workers for sex workers. The *Red Book* is available in Chinese, Korean, Thai and English and includes comprehensive and detailed information on sexual health in a sex work context that is understood by, and available to, sex workers within our own networks.

Now, and for the last 10 years apart from a Queensland Health infosheet[93] with a brief section on sex work and a link to the Certificate of Attendance[94], references to sex work and sex workers are almost invisible as a priority population for sexual health on the Queensland Health website. This evidences the low priority, as a wider public health concern, that is placed on the mandatory testing of sex workers and sex worker sexual health by the communicable diseases experts at Queensland Health. There is no appetite for mandatory testing of sex workers among the sexual health sector in Queensland; advocates of this archaic practice are outliers and out of touch with the evidence.

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[90] Australasian Sexual and Reproductive Health Alliance (ASHRA) and Australasian Society for HIV, Viral Hepatitis and Sexual Health Medicine (ASHM). *Australian STI management guidelines for use in primary care*. Online resource. https://sti.guidelines.org.au/

[91] Australasian Sexual and Reproductive Health Alliance (ASHRA) and Australasian Society for HIV, Viral Hepatitis and Sexual Health Medicine (ASHM) Australian STI Management Guidelines for use in Primary Care. Online resource. https://sti.guidelines.org.au/populations-and-situations/sex-workers/

[92] Scarlet Alliance Red Book: STI & BBV resources for sex workers by sex workers. Online resource. https://redbook.scarletalliance.org.au/

[93] Queensland Government and ASHM. STI/BBV testing tool for asymptomatic people. Online resource. https://www.health.qld.gov.au/__data/assets/pdf_file/0025/726523/sti-bbv-testing-tool.pdf

[94] Queensland Health. Sexual health certificate of attendance. https://www.health.qld.gov.au/__data/assets/pdf_file/0021/444351/sexual-health-check-certificate.pdf

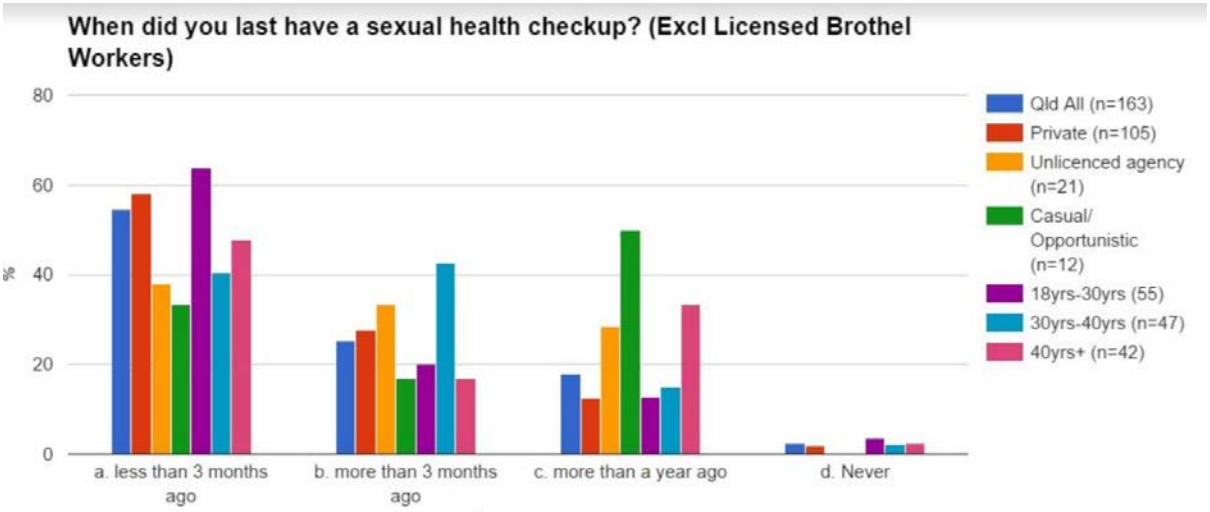
Sex workers in Queensland have high rates of voluntary sexual health testing.[95]

Male sex workers, transgender women sex workers

In a 2018 study of male and transgender sex workers in Queensland (TaMS study) it was found that the majority had attended for sexual health checks either at a sexual health clinic (66.7%) or GP (32.8%) less than three months earlier, despite not being required to test or provide attendance certificates to work.[96] Similar results were found for male sex workers in the 2015 *Hook-up* study[97] wherein despite many participants indicating that they did sex work sporadically, almost two-thirds of the participants tested every three months. Most of the participants of the TaMS study knew about PrEP (pre-exposure prophylaxis for HIV) and several were using it (as part of the contemporaneous QPrEPD trial); however, they had some concerns. These were: potential side effects, that it did not give them protection for other STIs and that it could become mandatory under future legislation.[98]

Sex workers outside of the licensed brothel sector

Enhanced data collection by Respect Inc 1 August 2015-April 2016 for Queensland Health asked 208 sex workers who did not work in licensed brothels about the time period since their last STI checkup:



Respect Inc reported the above results to Queensland Health 1 June 2016:

> The results indicate that more than approximately half of sex workers have regular sexual health check ups of three month intervals or less, by their own choice without mandatory testing. Those who test at longer intervals are still having regular checkups with very low numbers reporting that they have never had a sexual health check. Also indicated are that younger sex workers tend to test more frequently than mature sex

[95] It should be noted that the data presented here provides an indication of high levels of regular testing in the context of a largely criminalised workforce where barriers to accessing testing are recognised and there is no legal requirement for this demographic to undergo testing.

[96] Jones, J., Dean, J., Brookfield, S., Forrest, C., Fitzgerald, L. (2018). Factors influencing transgender and male sex worker access to sexual health care, HIV testing and support study (TaMS) report, p. 21.

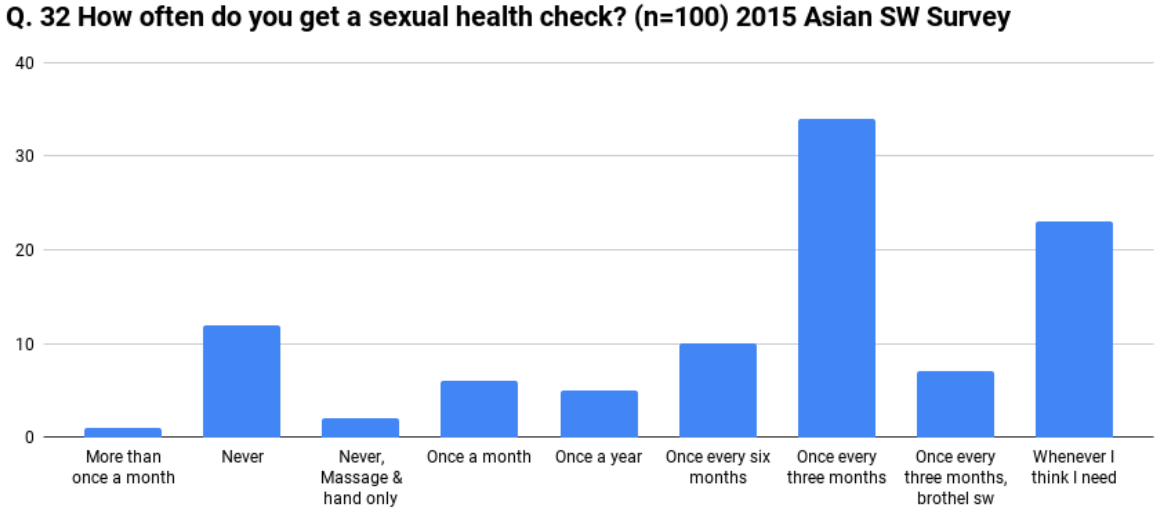
[97] Prestage, G., Bradley, J., Hammoud, M., Cox, C., Tattersal, K. & Kolstee, J. (2014). *Hook-up: A study of male sex work in NSW and Queensland*, The Kirby Institute, The University of New South Wales, Sydney Australia., p. 19.

[98] Jones, J., et al. (2018), p. 44-47.

workers. Unlicensed agency workers appear from these results to test less frequently than the average, however, included in this subset are massage workers who offer hand relief only without oral or insertive sex, so they may feel there is less need for sexual health checks.

Migrant sex workers of Asian-language background

A Respect Inc 2015 needs assessment of 100 migrant sex workers of Asian-language background found almost half were obtaining a sexual health check every three months or more often, even those not working in licensed brothels. Another 23% said that they would get a check whenever they thought they needed one. It was also reported that since massage parlour-based sex workers tend to only do hand relief they choose less frequency with their sexual health checks.[99]

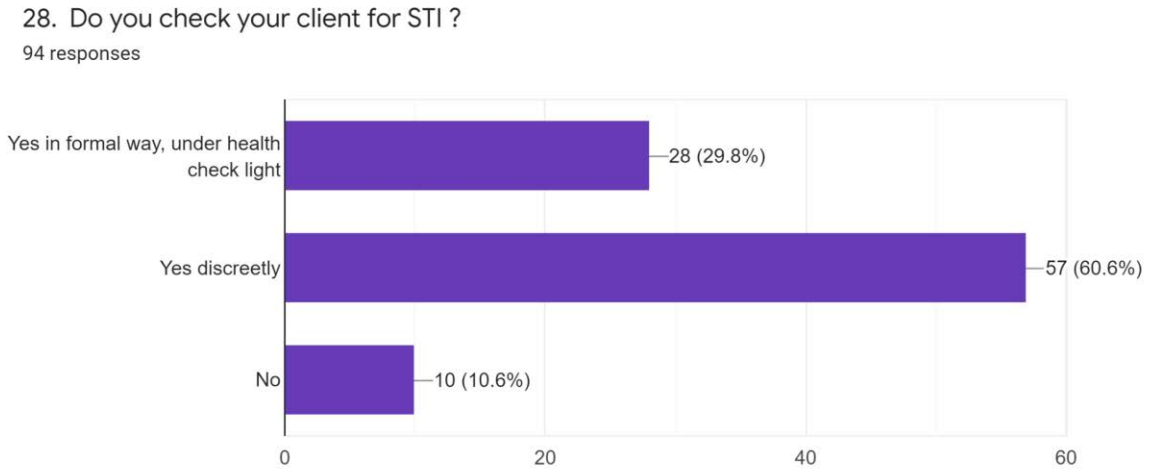


Sexual health checking of clients

Visual checking of clients by sex workers to ascertain whether they may have visible evidence of an STI is a long-standing traditional practice of sex workers who do full service sex work, which has been incorporated into standard WHS strategies for sex work.[100] In the Queensland licensed brothel guidelines the practice is described in a very clinical manner using a lamp, which suits some sex workers, but many sex workers prefer more informal methods of checking and these are shared and explained through peer education. Sex workers are informed through peer education and WHS that STIs can have no symptoms and that an absence of visible symptoms does not necessarily indicate an absence of STIs.

The 2015 Respect Inc survey of Asian-language background sex workers found most did an STI visual check on clients prior to the booking (n=94):

[99] Respect Inc. (2015). *Needs assessment for Asian sex workers in Queensland: March 2015-September 2015*, p. 11.
[100] Scarlet Alliance Red Book—How to check for visible signs of STIs. Online resource. https://redbook.scarletalliance.org.au/checking-clients/



Victoria repealed public health offences—Queensland should follow

Victoria's Sex Work Decriminalisation Act 2022 repealed public health offences[101] similar to those in Queensland on the basis that the policies created barriers for sex workers and were stigmatising. An explanation of the public health reasoning can be found on the Victorian Department of Health website.[102] The decriminalisation of sex work in Queensland should also result in the repeal of these laws and instead provide more resourcing for peer support of sex workers—especially new sex workers and CALD sex workers—and the provision of translated materials, outreach and support for sexual health services to provide free, anonymous, voluntary testing for all sex workers.

In summary, there should be no laws to mandate prophylactic use, working while infective or sexual health testing. All of these sexual health issues will be well covered and better served by comprehensive sex work WHS guidelines and peer education. Instead of criminal laws there should instead be a renewed focus on peer education, improved access to free and anonymous testing and the implementation of sex worker-led WHS guidelines to enable sex workers (and sex work business operators) to make informed decisions about best-practice safer work practices and testing.

Q.23 (d) Other matters

We defer to QPP, HALC & NAPWHA regarding their advice on Section 317 (b) of the Criminal Code (Qld) 1899: '*Any person who, with intent to do some grievous bodily harm or transmit a serious disease to any person; is guilty of a crime, and is liable to imprisonment for life'.* And we support their call for an urgent review of section 317 of the Criminal Code to remove the reference to 'transmit serious disease'. This provision was created before the significant advances in treatment, which have resulted in undetectable equalling untransmittable in relation to risk of transmission of HIV. The 'serious disease' provisions of Section 317 are no longer justified. Stigma makes leaving a law like this in the Criminal Code dangerous. It is the most marginalised people living with HIV (sex workers who are trans, migrant and/or people of colour) that are likely to be impacted by this law.

[101] VIXEN 2022. Decrim Info Hub. https://vixen.org.au/vixen-victoria/info-workers/#sexual-health

[102] Victoria Department of Health. Key issues—Stage one health reforms. https://www.health.vic.gov.au/preventive-health/key-issues-stage-one-health-reforms

There should be no criminal laws to mandate sexual health testing, use of condoms or working with an STI. This is because it is against sex workers' human rights, is exceptional law to which no other profession is subject, sex workers have low rates of STIs, high rates of condom use, high rates of sexual health testing, and peer education and health promotion is a more effective way to ensure all of this instead of criminal laws.[103] Currently the police engage in entrapment, posing as clients to try to get sex workers to agree to providing services without condoms.The cost of this policing and excessive testing are exorbitant compared with the cost of peer education.

A better system is for criminal laws to be removed and the focus shifted to peer education, improving access to testing and enabling sex workers to make informed decisions about best-practice safe work practices and testing.

Recommendation 25: Decriminalisation of sex work must include repeal of sex industry-specific public health laws as part of the repeal of the Prostitution Act and Regulations.

Recommendation 26: Queensland's decriminalisation framework should not include laws relating to the use of prophylactics, sexual health testing or sex workers with an STI.

Recommendation 27: The risk of sexually transmissible infections is mitigated by existing laws and regulations:

- WHS Act requirements on provision and use of PPE and training on use and storage.
- peer education that supports sex worker uptake of safer sex practices
- access to free, anonymous and voluntary testing (regardless of Medicare card)
- Queensland's system of managing people who put others at risk.

Recommendation 28: The implementation of decriminalisation should include a re-focus on improved access to peer education and community development for sex workers and free, anonymous and voluntary testing.

Recommendation 29: Sex Industry WHS guidelines should incorporate references to existing requirements under the WHS Act on provision and use of PPE and training on use and storage.

Recommendation 30: Review of section 317 of the Criminal Code (Qld) 1899 to remove reference to 'transmit serious disease' to reflect current science and negligible transmission risk.

Recommendation 31: Mandatory testing is likely to be incompatible with human rights protections under sections 15 (recognition and equality under the law), 17 (protection from torture and cruel, inhumane or degrading treatment), 25 (privacy and reputation) and 37 (right to health services) of the HRA and breach the ADA under the attribute of 'lawful sexual activity'.

Recommendation 32: Criminal restrictions on sex workers living with STIs is likely to be incompatible with human rights protections under sections 17 (protection from torture and

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cruel, inhumane or degrading treatment) and 25 (privacy and reputation) and is incompatible with AD Act under the attribute of 'disability'.

Recommendation 33: Prophylactic laws for sex workers are likely to incompatible with sections 15 (recognition and equality under the law), 17 (protection from torture and cruel, inhumane or degrading treatment) and 25 (privacy and reputation) of the HRA and is incompatible with the AD Act under the attribute of 'lawful sexual activity'.