



**HUMAN RIGHTS &
DISCRIMINATION COMMISSIONER**

ACT Human Rights Commission

Legal Issues in Australian Public Health

A series of 7 papers on the impacts of discrimination and criminalisation on public health approaches to blood borne viruses and sexually transmissible infections

September 2013

These papers were developed by a group of public health and legal experts to draw together evidence and discussion on a range of impediments to a human rights approach to the prevention and management of blood borne viruses and sexually transmitted infections. They also provide recommendations regarding mechanisms for aligning relevant legislation and practices with public health approaches to preventing blood borne viruses and sexually transmitted infections, consistent with the National Strategies.

Report on Legal Issues in Public Health -

A series of 7 papers on the impacts of discrimination and criminalisation on public health approaches to blood borne viruses and sexually transmissible infections

‘People with HIV, STIs and viral hepatitis have a right to participate in the community without experience of stigma or discrimination, and have the same rights to comprehensive and appropriate healthcare as do other members of the community (including the right to the confidential and sensitive handling of their personal and medical information).’

(Australia’s National Strategies for Blood Borne Viruses and Sexually Transmissible Infections 2010-2013)

Global Context

UN Declaration on HIV/AIDS

In 2011, Australia co-facilitated the review on progress against the UN Declaration on HIV/AIDS, and the future course of the global AIDS response, at the 2011 UN General Assembly High Level Meeting on AIDS in New York. On 10 June 2011, the General Assembly adopted the new UN Declaration, which for the first time identifies those most at risk of infection and emphasizes the importance of human rights approaches and destigmatisation in addressing HIV.

Global Commission on HIV and the Law

The Global Commission on HIV and the Law was launched in June 2010 by the United Nations Development Programme (UNDP), with the support of the UNAIDS Secretariat. The Commission’s aim is to increase understanding of the impact of the legal environment on national HIV responses. Its aim is to focus on how laws and law enforcement can support, rather than block, effective HIV responses.

Australian Context – National Strategies on BBVs and STIs

Australia’s domestic response to blood borne viruses (BBVs) and sexually transmissible infections (STIs) is guided by the suite of five national strategies for BBVs and STIs. The current strategies were developed through a collaborative partnership between governments and civil society, and were endorsed by all Health Ministers in May 2010. Addressing barriers, including discrimination and stigma, to effective prevention and treatment is identified as a priority action area across a number of the National Strategies, and directly involve Federal, as well as State and Territory, jurisdictions.

List of attached individual papers:

- 1. Aligning criminal laws and law enforcement practices with the public health objectives of the National Strategies**
- 2. Addressing Discrimination against people living with blood borne diseases**
- 3. Addressing Discrimination in immigration law and policy**
- 4. Criminalisation of people living with HIV for non-disclosure, HIV exposure and HIV transmission**
- 5. Criminalisation of people who inject drugs**
- 6. Sex work regulation, human rights and alignment with evidence**
- 7. Removing legislative and policy barriers to NSP and injecting equipment access**

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- **Consolidated Recommendations of 7 Papers**

Paper 1: Aligning criminal laws and law enforcement practices with the public health objectives of the National Strategies (no recommendations)

Paper 2: Addressing Discrimination against people living with blood borne diseases

1. Review and amend discrimination law in each jurisdiction to improve coverage in terms of: the definition of discrimination; including drug addiction as a disability; removing the technical requirement of a comparator; and lessening the burden of proof on complainants. This and other Recommendations should be progressed by the Federal Attorney-General, as well as all jurisdictions through the Standing Council on Law and Justice (formerly the Standing Committee of Attorneys-General).
2. Improve coverage of discrimination law to include sexuality, gender diversity and occupation (as sex worker) as protected attributes on a national and local basis.
3. Expand coverage of vilification and harassment law to include broader grounds such as disability, sexuality and gender diversity on a national and local basis.
4. Improve accessibility of discrimination complaints mechanisms by decreasing delays and backlogs, and increasing timely investigations and early conciliations through additional funding and other measures.
5. Increase funding for advocacy by community groups and/or legal centres to support discrimination case representation, as well as mapping barriers in cases that do not proceed to finalisation by complaint agencies or Tribunals.
6. Consider indemnifying complainants in respect of respondents' legal costs, except in vexatious cases.
7. Increasing funding for community groups, legal centres and human rights agencies to engage in outreach, community education and rights awareness for priority populations.
8. Ensure monitoring of compliance with discrimination laws through comprehensive and coordinated de-identified data collection across human rights agencies, as well as communities.
9. Increase powers and funding for human rights agencies to conduct systemic work and on an own motion basis, ie without the need for a formal complaint.
10. Ensure regular measuring of public attitudes, through for example community surveys.

11. Provide funding to relevant government, expert and community stakeholders to conduct sustained anti-discrimination education programs in relation to blood borne viruses.
12. Work with professional bodies and fund human rights agencies to incorporate training modules on discrimination obligations and laws for health care workers.

Paper 3: Addressing Discrimination in Immigration Law and Policy

1. The exemption of the *Migration Act 1958* from the *Disability Discrimination Act 1992* should be repealed.
2. The health requirement in the Migration Act and Regulations should be amended to ensure that people with disabilities are not subjected to unjustifiable discrimination in migration decisions.
3. Mandatory testing for HIV should be replaced with voluntary testing of applicants, with appropriate counseling and support provided to all applicants who undertake HIV testing for migration purposes.

Paper 4: Criminalisation of people living with HIV for non-disclosure, HIV exposure and HIV transmission:

1. It is recommended that the Commonwealth Government in cooperation with the States and Territories Governments develop **National Guidelines on Prosecutions and Policing** for HIV exposure and transmission. Issues to address include:
 - (a) a consistent approach to criteria for initiating prosecutions, to ensure prosecutions are restricted to exceptional cases, eg principles to inform prosecutions, or a set of 'model' guidelines for State and Territory adoption;
 - (b) explanation of issues relating to transmission risk and harm;
 - (c) promotion of the development of formal mechanisms for cooperation and coordination between health and criminal justice authorities (departmental staff, police and prosecutors) and clarification of the relationship between agencies involved in public health management under public health legislation and agencies involved in prosecutions under criminal legislation. National guidelines can support development of protocols for cooperation in management of cases or referral both from health to police, and police to health;
 - (d) consideration of the role of mental health laws and services;
 - (e) the need for governments to systematically monitor and analyse prosecutions and to research their social and public health impacts, to inform the national response.

2. It is recommended that the Commonwealth Government in cooperation with the States and Territories, and civil society partners develop **National Guidelines on Restricting the Role of Criminal Laws** to address exposure and transmission. This would include:
 - (a) consideration of the need for a nationally consistent approach to the definition of offences, to address the prevailing confusion among clinicians and communities that results from the patchwork of current offences;
 - (b) national agreement on what constitutes exceptional cases that warrant criminal punishment, or the criteria that should inform criminality (ie clarifying the nature of intent or malice that in principle should be required by law to warrant a criminal penalty); and
 - (c) a shared understanding of the potential public health harm caused by enactment of HIV-specific offences.

Implementation of these recommendations will require a cooperative approach between Departments of Health and Attorneys-General. A partnership approach between DOHA and the Standing Council on Law and Justice (formerly the Standing Committee of Attorneys-General) is required to ensure a whole of government approach. For example, this may require cross-agency working parties at Commonwealth and State/Territory levels, involving the Departments of Health, Attorneys-General, Police, Directors of Public Prosecution and key HIV services.

Paper 5: Criminalisation of people who inject drugs

1. It is recommended that the Commonwealth Government in cooperation with the States and Territories and civil society partners expedite efforts to roll out drug use related public health commitments as agreed under the National HIV Strategy and National Hepatitis C Strategy. This would include:
 - (a) harmonising drug control laws to ensure they align with evidence-based, cost-effective public health policies and outcomes;
 - (b) implementing methods to further enshrine human rights protections in public health practice, particularly in relation to people who inject drugs;
 - (c) reviewing and reforming anti-discrimination laws to ensure people with a history of injecting drug use access to discrimination complaints mechanisms; and
 - (d) scaling up of corrections based BBV prevention initiatives (including access to new injecting equipment, bleach and disinfectants, evidence-based drug treatment, peer education and

harm reduction information, and development of appropriate infection control standards).

2. It is recommended that the Commonwealth Government in cooperation with the States and Territories and civil society partners develop human rights informed drug policy with the potential to increase beneficial public health outcomes including:
 - (a) a commitment to trialing innovative interventions (with strong evaluation mechanisms), particularly where those interventions have demonstrated success in other jurisdictions and/or countries;
 - (b) funding an independent audit of the net benefits and harms resulting from current drug control laws, policies and criminal justice system practices and approaches; and
 - (c) commissioning research to provide the evidence-base for staged legislative and regulatory reform to address the issues outlined in this paper.

Paper 6: Sex work regulation, human rights and alignment with evidence

1. That the Commonwealth Government recognise decriminalisation as the evidence based model of sex industry regulation that supports effective health promotion, public health outcomes and the human rights of sex workers.
2. That a working party is formed between Commonwealth, State and Territory Governments and civil society to address legislative barriers to human rights for sex workers and effective implementation of health promotion. This would include but not be limited to:
 - a. Recognise voluntary testing as the optimum approach to HIV and STI testing and work with jurisdictions to address mandatory testing where it is in place.
 - b. Recommend the removal of registration of individual sex workers on the grounds of human rights and the barriers it creates to health promotion implementation.
 - c. Review laws that criminalise sex workers with HIV and/or STIs, and work with jurisdictions to recognise sex workers as a community affected by HIV, and to effectively manage any individual who places people at risk in line with National Guidelines.

- d. Address policing approaches including evidentiary use of condoms as adverse to health promotion.
3. Review anti-discrimination protection coverage for sex workers and create nationally consistent coverage that supports the reduction of stigma and discrimination.

Paper 7: Removing Legislative and Policy Barriers to Needle and Syringe Programs ('NSP') and Injecting Equipment Access

1. Review and repeal specific legislation in each jurisdiction prohibiting peer distribution of injecting equipment.
2. Review of unintended negative impacts of associated legislation including self-administration, and aiding and abetting legislation on peer distribution of injecting equipment.
3. All jurisdictions to implement NSP in prisons in line with available evidence and as part of a comprehensive approach to BBV prevention among prisoners.
4. Review relevant legislation and policy to improve the regulatory processes in relation to NSP service planning and approval at the local level; and
5. Strengthen partnerships between local councils, police and neighbourhood drug action teams to support greater understanding and support for NSP services.
6. Review and repeal policy and legislative inconsistencies in relation to safe disposal in all jurisdictions, and ensure IDU are properly informed of any changes.
7. All NSP staff to be provided with training on risk-benefit analysis in relation to mandatory reporting requirements, BBV prevention and building and maintaining positive client/staff rapport with a highly marginalised clientele; and
8. Review and address the potential for mandatory reporting requirements to directly and indirectly impact on access to NSP and injecting equipment.

Legal and Discrimination Working Group Paper 1
Lack of alignment of criminal laws and law enforcement practices
with the public health objectives of the National Strategies

Background and context

The purpose of this briefing paper is to provide an introductory overview of the need for action to align criminal laws and law enforcement practices with the public health objectives of the National Strategies relating to STIs, HIV and viral hepatitis. More detailed briefing papers relating to specific issues affecting people living with HIV, sex workers and people who use drugs are included in this Report.

Criminalisation of people living with HIV, sex workers and people who use illicit drugs is a barrier to a human rights-based approach to prevention and management of BBVs and STIs. The Commonwealth provided leadership in highlighting these issues in the early 1990s; the 1992 Report of the Legal Working Party of the Inter-Governmental Committee on AIDS (LWP IGCA) represented a milestone in this regard. The 1992 Report recommended that sex work and illicit drug use (self-administration) be decriminalised and that prosecutions for HIV transmission only occur as a last resort and with approval of health authorities. There has been little progress in implementing a nationally consistent approach to these three issues, and in some jurisdictions the situation has deteriorated rather than improved in recent years. Priority should be given to ensuring legislation, and police and prosecution practices support health promotion strategies.

Criminalisation of people living with HIV for non-disclosure, HIV exposure and HIV transmission

There have been 16 prosecutions of people living with HIV in Australia in the last five years relating to sexual transmission, exposure or non-disclosure of HIV status to sexual partners. In total there have been 32 prosecutions over the last two decades. The damaging public health impacts of these prosecutions are beginning to become apparent. Some occurred in circumstances where far less punitive support interventions would have been more appropriate to apply.

The increasing occurrence of criminal prosecutions of people with HIV creates an environment of fear and uncertainty. Criminal sanctions can be a disincentive to HIV testing and disclosure, and contribute to stigma especially as offence enforcement disproportionately affects vulnerable populations, including sex workers, gay men and recent migrants. Contrary to the HIV prevention rationale of such laws, they may actually increase rather than decrease HIV transmission. Notably, *HIV Futures 6* found that 42.4% of those surveyed reported being worried about disclosing their

HIV status to sexual partners 'because of the current legal situation'.¹

The BBVSS *National Guidelines for the Management of People with HIV who Place Others at Risk* (2008) were intended to avoid inappropriate use of criminal sanctions. To ensure that the Guidelines are having their intended effect, action needs to occur to reinforce the priority of the public health approach to HIV and to promote the *National Guidelines* in supporting a response that focuses on behaviour and that is in proportion to actual risk.

There is a narrow category of circumstances in which prosecutions may be warranted, involving deliberate and malicious conduct, where a person with knowledge of their HIV status engages in deceptive conduct that leads to HIV being transmitted to a sexual partner. Different laws apply in each jurisdiction with varying requirements in relation to issues such as disclosure of status to sexual partners. The extent to which public health authorities are aware of or involved in prosecutions is highly variable.

Further work is required by those with expertise in sexual health promotion and in criminal law to consider the limited circumstances in which criminal offences should apply and to define the measures that need to be put in place to ensure that prosecutions are a last resort option and that public health management options have been considered in each case.

This is an area where Australia should be applying lessons learned from Canada, the United Kingdom and New Zealand, for example in relation to prosecution guidelines and case law eg to establish a defence for condom use, and to require courts to take into account factors such as viral load. It is an area that requires active monitoring at the national level, stronger engagement by public health officials and research to assess health promotion impacts. This area has also been made more complex by Australia's first case of civil liability for sexual transmission of HIV in Sydney in 2010. More civil and criminal cases are anticipated.

Criminalisation of people who use illicit drugs

Punitive drug control laws create barriers to effective prevention, treatment and care for BBVs including hepatitis C and HIV. Laws and law enforcement approaches need to be harmonised with public health priorities. Punitive drug control laws add to stigma, drive people away from services and are a barrier to peer education and

¹ Grierson J, Power J, Croy S, Clement T, Thorpe R, McDonald K, Pitts M. *HIV Futures 6: Making Positive Lives Count*. (2006) The Living with HIV Program. Melbourne: The Australian Research Centre in Sex, Health and Society, La Trobe University.

more extensive distribution of sterile injecting equipment. The current ‘war on drugs’ approach to global drug control has led to large-scale health and human rights violations.²

A significant and increasing proportion of people in Australian prisons have been incarcerated for offences relating to illicit drugs. This is despite the fact that prisons are one of the main ‘drivers’ of the hepatitis C epidemic among people who inject drugs, with ‘having ever been in prison’ identified as an independent risk factor for hepatitis C infection.³

The 1992 LWP IGCA report recommended that self-administration offences be repealed. Some progress has occurred in introducing cautions for minor drug offences and diversionary programs that enable police and courts to refer drug offenders away from the criminal justice system into drug treatment. However, the overall approach to drug control in Australia remains highly punitive.

Possession of a used needle and syringe can be used by police to gain admissions of drug use and as evidence of self-administration offences. Fear of contact with police and being charged with drug-related offences creates barriers to NSP access and reduces the likelihood of people calling an ambulance in the case of drug-related overdoses. Drug use offences also mean that in all but one jurisdiction it is illegal for an individual to provide others with access to new injecting equipment unless that person is authorised to dispense equipment through a needle and syringe program (see the separate Legal Working Group paper on *Barriers to NSP and Injecting Equipment Access*).

Decriminalisation of possession, use and trafficking of small quantities of illicit drugs (as has recently been called for by the NSW DPP),⁴ would significantly reduce law enforcement costs, encourage the community to view the use of illicit drugs as primarily a health and social issue, and provide an enabling environment for health promotion and peer education. This approach is supported by the recent evaluation of the decriminalisation of small-scale illicit drug use in Portugal which found decreases in heroin use, increases in drug treatment uptake, and associated decreases in drug related deaths and levels of HIV and hepatitis C infections following decriminalisation.⁵

² Open Society Institute, ‘At What Cost? HIV and Human Rights Consequences of the Global “War on Drugs”’, New York, United States (2009).

³ Maher, L., et al. Risk behaviours and antibody hepatitis B and C prevalence among injecting drug users in South-Western Sydney, Australia. *Journal of Gastroenterology and Hepatology*: Volume 19(10) October 2004, p.1114-1120.

⁴ Merritt C, ‘Wars on drugs failing: DPP’ *The Australian*, 9 November 2010.

⁵ Reference: Hughes, C. and Stevens, A. The effects of decriminalization of drug use in Portugal, *Briefing Paper 14*, Beckley Foundation. United Kingdom (2007).

Similarly positive outcomes have been associated with opiate substitution programs, such as methadone. There is now a strong international evidence base to show that such programs lead to improvements in social functioning and psychological and physical health, and reductions in criminality and incarceration.⁶ However, Australia lacks an expanded range of programs, specifically heroin prescription programs, for which there is similar positive evidence.⁷

Taken together the issues and evidence outlined above strongly suggest the need for a review of the impact of criminalisation and current drug control laws on the health and human rights of people who use illicit drugs in Australia. Such a process would be consistent with approaches already underway in numerous other countries and is supported by current knowledge and evidence relating to best practice BBV prevention, treatment and care strategies. Australia's own track-record in relation to HIV prevention among people who inject drugs highlights the essential role of pragmatic law reform in developing effective responses to public health issues among this group in our community.

Criminalisation of sex work

Policing practices in relation to sex work undermine public health objectives in jurisdictions that criminalise the sex industry. Street-based sex workers are particularly vulnerable. Police use of condoms as evidence of offences is in direct opposition to health promotion messages. Sex workers have increased control over their working conditions in a decriminalised and deregulated legislative framework.

Decriminalisation, as has occurred in NSW, is associated with better coverage of health promotion programs for sex workers.⁸

Sex work laws have become more punitive in recent years, with onerous requirements and heavy-handed approaches used in enforcement of regulatory schemes. Mandatory screening is required in jurisdictions that regulate the sex industry through licensing (Victoria and Queensland), rather than adopting a model of full decriminalisation. Some jurisdictions also criminalise working with an STI,

⁶ Hall, W., J. Ward, et al. (1998). The effectiveness of methadone maintenance treatment 1: Heroin use and crime. *Methadone maintenance treatment and other opioid replacement therapies*. J. Ward, R. P. Mattick and W. Hall, Amsterdam, Harwood Academic Publishers: 17-57.

⁷ Lintzeris, N. Strang, J. Metrebian, N. Byford, S. Hallam, C. Lee, S. and Zador, D. (2009) 'Methodology for the Randomised Injecting Opioid Treatment Trial (RIOTT): Evaluating injectable methadone and injectable heroin treatment versus optimised oral methadone treatment in the UK'. RIOTT Group, London.

⁸ C. Harcourt, J. O'Connor, S. Egger, et al. 'The decriminalisation of prostitution is associated with better coverage of health promotion programs for sex workers' (2010) *Australian and New Zealand Journal of Public Health* (34)5, p.482-486.

including HIV (following a widely reported prosecution in 2008 of a gay male sex worker in the ACT).

Data indicates that sex workers can achieve similar or better health outcomes in decriminalised contexts without the expense and invasiveness of excessive regulation and mandatory screening. The priority is to ensure legislation and police practices that support health promotion. There is an increasing body of evidence from Australia and New Zealand supporting full decriminalisation on public health grounds.⁹

Health and safety standards are applied sporadically to sex work where it is an illegal activity. In decriminalised contexts, occupational health and safety standards can contribute to a reduction in STI transmission and improvements in overall working conditions. Standards can require the provision of condoms, proper lighting, sanitation and measures to ensure the personal security of sex workers. Rather than arresting sex workers and closing down unlicensed premises, the most effective approach to preventing HIV and STIs is to treat sex workers as partners in prevention, and support them to engage in sexual health promotion as peer educators and advocates and as the safe sex educators of their clients. Involving sex workers directly in prevention and health promotion programs has contributed to a strong culture of condom use and voluntary testing.

⁹ Abel, G., Fitzgerald, L., Healy, C. and Taylor, A. (eds) 'Taking the crime out of sex work: New Zealand sex workers' fight for decriminalisation', (2010) Bristol: Policy Press; Harcourt, C., Egger, S., Donovan, B. (2005), 'Sex work and the law', *Sexual Health* 2(3): 121–8; Donovan, B., Harcourt, C., Egger, S., Fairley, C. 'Improving the health of sex workers in NSW: maintaining success' (2010) *NSW Public Health Bulletin* 21(3-4): 74–7; Jeffreys, E., Matthews, K. and Thomas, A. 'HIV criminalisation and sex work in Australia', (2010) *Reproductive Health Matters* 18(35): 129–36.

Legal and Discrimination Working Group Paper 2: Addressing Discrimination Against People Living with Blood Borne Viruses

A. Introduction

In order to know and enforce their rights, people living with blood borne viruses need legal protection against discrimination, as well as support through advocacy, human rights services and education. Discriminatory or unfair treatment increases the negative impact of their health status and can reduce access to care, eg discrimination and stigma have been correlated with poor access to health care and risk behaviour.¹⁰ Social burdens are exacerbated when people with blood borne viruses lose jobs, need to find alternate health care, move house, or must seek new services when they have been denied elsewhere.¹¹

Discrimination is a very significant human rights abuse that needs to be proactively prevented, systemically monitored, and practically redressed through accessible complaints mechanisms. Lack of human rights protection creates or further deepens vulnerability of people living with blood borne viruses, as the impact of infection becomes disproportionate in stigmatising and isolating people in the community, and making them less able to protect themselves by seeking information, support, testing, treatment and care.¹²

People from affected communities require protection from multiple forms of discrimination,¹³ not only because they may be thought to be living with a blood borne virus, but also because of the primary stigma they may suffer because of their vulnerable status, such as men who have sex with men, people who inject drugs, prisoners and sex workers.¹⁴ The UN General Assembly's 2011 *Political Declaration on HIV/AIDS: Intensifying our Efforts to Eliminate HIV/AIDS* for first time identifies

¹⁰ Sayles et al, 'The Association of Stigma with self-reported access to medical care and Antiretroviral Therapy Adherence in Persons Living with HIV/AIDS' *J Gen Intern Med* (2009) 24(10); 1101-8. Discrimination has also been associated with an increase in HIV related risk behaviour in some groups of persons affected with HIV AIDS: Peretti-Watel et al, (2007), 'Discrimination against HIV Infected People and the Spread of HIV: Some Evidence from France', *PLoS ONE* 2(5), e41; Ahern, J., J. Stuber, et al. "Stigma, discrimination and the health of illicit drug users," *Drug and Alcohol Dependence* (2007), 88: 188-196.

¹¹ UNAIDS & ICRW, *HIV-related Stigma and Discrimination: A Summary of Recent Literature* (2009).

¹² UNAIDS, *Getting to Zero: 2011-2015 Strategy*, p.19 – 'Stigma and discrimination, homophobia, gender inequality, violence against women and girls and other HIV-related abuses of human rights remain widespread. These injustices discourage people from seeking the information and services that will protect them from HIV infection, from adopting safe behaviour and from accessing HIV treatment and care. Where HIV-related stigma, discrimination, inequality and violence persist, the global response will forever fall short of the transformations required to reach our shared vision.'

¹³ A. Malcolm et al, 'HIV-Related Stigmatization and Discrimination: its Forms and Contexts (1998) 8 *Critical Public Health* 347.

¹⁴ P. Aggelton and R. Parker, 'HIV and AIDS-related stigma, discrimination and human rights', *Health and Human Rights* (2002) vol 6, 1-18, and 'HIV and AIDS-related discrimination: a conceptual framework and implications for action, *Social Science and Medicine* (2003) vol 57, 13-24.

populations that epidemiological evidence demonstrates are at higher risk,¹⁵ and states in Article 80 that countries:

‘Commit to national HIV and AIDS strategies that promote and protect human rights, including programmes aimed at eliminating stigma and discrimination against people living with and affected by HIV, including their families, including through sensitizing the police and judges, training health-care workers in non-discrimination, confidentiality and informed consent, supporting national human rights learning campaigns, legal literacy and legal services, as well as monitoring the impact of the legal environment on HIV prevention, treatment, care and support.’

Ban Ki-Moon, Secretary –General of the United Nations has stated that:

[D]iscrimination remains a fact of daily life for people living with HIV...Stigma remains the single most important barrier to public action. It is the main reason too many people are afraid to see a doctor to determine whether they have the disease, or to seek treatment if so. It helps make AIDS the silent killer, because people fear the social disgrace of speaking about it, or taking easily available precautions. Stigma is a chief reason the AIDS epidemic continues to devastate societies around the world. We can fight stigma. Enlightened laws and policies are key.¹⁶

The Global Commission on HIV and the Law will make specific, evidence-informed, human rights based and actionable recommendations in a Report due to be launched in 2012.¹⁷ It is expected that the Report will have examples and lessons applicable to other blood borne viruses.

In the field of Hepatitis C, discrimination has been an identified issue for further action for almost two decades.¹⁸ The seminal report by the NSW Anti-Discrimination Board into Hepatitis C related discrimination noted the serious, ongoing impact of discrimination on the lives of many, and the very close association of Hepatitis C with injecting drug use.¹⁹ Since then, research from Australia and international settings

¹⁵ Adopted on 10 June 2011 – article 29.

¹⁶ Ban Ki-Moon: ‘The Stigma Factor’ Op Ed, *The Washington Times*, 6 August 2008.

¹⁷ http://www.hivlawcommission.org/index.php?option=com_content&view=article&id=88&Itemid=80&lang=en

¹⁸ Krug, G. "Hepatitis C: Discursive domains and epistemic chasms," (1995) *Journal of Contemporary Ethnography* 24(3): 299-322; Crofts, N., R. Louie, et al. "The next plague: Stigmatization and discrimination related to hepatitis C virus infection in Australia," (1997) *Health and Human Rights* 2: 87-96; Orr, N. and S. Leeder "The public health challenge of hepatitis C," *Australian and New Zealand Journal of Public Health* (1998) 22(2): 191-195.

¹⁹ Anti-Discrimination Board of New South Wales *C-Change: Report of the enquiry into Hepatitis C related discrimination*. Sydney (2001).

has characterised the experience of living with Hepatitis C by the experience of discrimination.²⁰

B. National Blood Borne Viruses Strategies

A Guiding Principle of the five National Strategies is that:

‘People with HIV, STIs and viral hepatitis have a right to participate in the community without experience of stigma or discrimination, and have the same rights to comprehensive and appropriate healthcare as do other members of the community (including the right to the confidential and sensitive handling of their personal and medical information).’²¹

The *Sixth National HIV Strategy 2010-13* highlights the priority actions of promoting programs to challenge stigma and discrimination including education, compliance and measurement (eg survey attitudes), support for advocacy, and improved access to effective complaints systems.

Similarly the *Third National Hepatitis C Strategy* emphasises the need for public education campaigns to dispel myths and misconceptions, and reduce discriminatory attitudes and behaviour in the general community and specifically healthcare settings. It also focuses on the need to include information on complaints mechanisms for reporting discrimination in resources for people living with Hepatitis C, and addressing it in healthcare worker training.

The *Second National Sexually Transmissible Infections Strategy* also stresses that health promotion interventions feature support for safe sex work practices and cultural change to reduce stigma and discrimination. It also states that access to non-discriminatory health services by sex workers is vital.

Priority populations identified in the five National Strategies are diverse. As stated above they may face primary discrimination founded on their vulnerable status, as well as secondary discrimination based on assumptions about having blood borne viruses. They include:

- men who have sex with men;
- people who inject drugs;

²⁰ Hopwood, M. and C. Treloar *The 3D Project: Diagnosis, Disclosure, Discrimination and Living with Hepatitis C*, (2003) Sydney, National Centre in HIV Social Research; Treloar, C. and T. Rhodes "The lived experience of hepatitis C and its treatment among injecting drug users: Qualitative synthesis," (2009) *Qualitative Health Research* 19(9): 1321-1334.

²¹ *Sixth National HIV Strategy 2010-13, Third National Hepatitis C 2010-13, Third National Aboriginal and Torres Strait Islander Blood Borne Viruses and Sexually Transmissible Infections Strategy 2010-13, Second National Sexually Transmissible Infections Strategy 2010-13, First National Hepatitis B Strategy 2010-13.*

- indigenous peoples;
- sex workers;
- people in detention;
- young people; and
- people from Culturally & Linguistically Diverse Communities (CALD).

Implementing the National Strategies requires robust discrimination legislation and adequately resourced human rights agencies, advocacy services and community based organisations which have the skills to focus on priority populations.

C. Discrimination Legislation

Discrimination against people with blood borne viruses can be challenged as unlawful discrimination on the ground of disability, but may also appear as other types of discrimination against priority groups (such as discrimination on the ground of sexuality), which are not unlawful across all jurisdictions, and have differing coverage (eg 'sexual orientation' and 'homosexuality'). Legislative reforms are necessary to make the process of bringing a case more user-friendly and easier for complainants to access, and to cover multiple manifestations of discrimination.²²

Disability discrimination

Discrimination on the basis of disease status is already unlawful in all Australian jurisdictions, subject to some broad exceptions (such as religion) and exemptions.²³ The coverage of legislation is very wide, usually covering association with a person with a disability, presumed disability, past, present and future disability. It also provides protection in wide areas of public (not personal) life, including the public and private sector in employment, housing, access to premises, education, sport, clubs, unions, and goods and services, such as health care etc. Some jurisdictions have explicitly excluded illegal drug addiction as a disability, but legally prescribed methadone would not usually be caught in definitions of 'prohibited drugs'.²⁴

²² See NSW Anti-Discrimination Board, *C-Change: Report of the Enquiry into Hepatitis C-Related Discrimination* (2001) and *Discrimination – The Other Epidemic* (1992).

²³ HIV/AIDS status, has been found to fall within the definition of disability (or impairment) despite differences in wording in each jurisdiction, regardless of whether a person has developed AIDS or has any physical symptoms: see *NC v Queensland Corrective Services Commission* [1997] QADT 22, and *Hoddy v Executive Director, Department of Corrective Services* (1992) EOC ¶192-397. Hepatitis C status has also been accepted as a disability: *Hay v Dubbeld* [2005] VCAT 642.

²⁴ In *Marsden v Coffs Harbour and District Ex-Servicemen's Club* (2000) FAC 1619 the Court found that opioid dependency could amount to a disability under the Federal *Disability Discrimination Act 1992*. The NSW *Anti-Discrimination Act* was amended to exclude discrimination in employment in relation to an addiction to a prohibited drug: s.49A. In *Carr v Botany Bay Council* (2003) NSW ADT 2009 the Tribunal found that this did not apply to legally prescribed methadone.

There needs to be more consistent and comprehensive coverage of discrimination. Currently there is a national general harmonisation of State and Territory legislation process being considered by the Standing Council on Law and Justice (formerly the Standing Committee of Attorney-Generals). Also the new Federal Human Rights Framework commits to developing consolidated and harmonised Federal anti-discrimination legislation, which is now contained in separate legislation, including the *Disability Discrimination Act 1992 and Australian Human Rights Commission Act 1986*.²⁵

An important issue is the definition of discrimination itself and current concepts of direct and indirect discrimination, as well as the requirement of a comparator (a hypothetical person without the protected the attribute of the complainant, eg disability).²⁶ These provisions need to be simplified, modernised and strengthened. There is inconsistency in the higher burdens of proof in discrimination legislation compared to analogous laws, such as s.351 of the *Fair Work Act 2009* which requires the complainant to only show adverse action in a case (that is unfavourable treatment because of a protected attribute),²⁷ with the respondent then needing to show that discrimination did not occur.

Recommendation

1. *Review and amend discrimination law in each jurisdiction to improve coverage in terms of: the definition of discrimination; including drug addiction as a disability; removing the technical requirement of a comparator; and lessening the burden of proof on complainants. This and other Recommendations should be progressed by the Federal Attorney-General, as well as all jurisdictions through the Standing Council on Law and Justice (formerly the Standing Committee of Attorneys-General)*

Other discrimination

Discrimination on the grounds of sexuality and gender identity is not fully covered at the Federal level. To highlight this problem, the Australian Human Rights

²⁵ Australia's Human Rights Framework commits to "combining federal anti-discrimination laws into a single Act to remove unnecessary regulatory overlap and make the system more user-friendly," Attorney-General Robert McLelland, 'Australia's Human Rights Framework', Media Release, 21 April 2010. Other Federal discrimination legislation includes the *Racial Discrimination Act 1975, the Sex Discrimination Act 1984, and the Age Discrimination Act 2004*.

²⁶ See eg. Goldberg S, 'Discrimination by Comparison', (2011) 120 *Yale Law Journal* 728.

²⁷ See s.342.

Commission published a Consultation Paper in 2011 on *Addressing Sexual Orientation and Sex and/or Gender Identity Discrimination*, and in 2010 issued a Discussion Paper on *Protection from Discrimination on the Basis of Sexual Orientation & Sex &/or Gender Identity*.

State and Territory laws on sexuality and gender identity discrimination vary in relation to terminology and exceptions – in some laws only ‘transgender’ people are covered.

Some jurisdictions protect sex workers from discrimination using protected attributes such as ‘occupation’ in the ACT, and ‘lawful sexual activity’ in Queensland and Tasmania, although the latter only has limited coverage of workers in legal brothels, which does not cover the diverse aspects of the sex work industry, such as street and other forms of work.

Vilification (inciting hatred, serious contempt or severe ridicule) on the ground of disability, sexuality and gender identity is not covered in all jurisdictions. Tasmania comprehensively covers vilification on the ground of any protected attribute, including disability & sexuality. Federal law only covers racial vilification/hatred, and sexual harassment, ie not vilification generally, or disability/sexuality vilification.

Recommendations

2. *Improve coverage of discrimination law to include sexuality, gender diversity and occupation (as sex worker) as protected attributes on a national and local basis.*
3. *Expand coverage of vilification and harassment law to include broader grounds such as disability, sexuality and gender diversity on a national and local basis.*

D. Access to complaints mechanisms and advocacy

The accessibility of human rights agencies handling discrimination complaints to affected and priority populations is crucial.²⁸ Barriers to access include affected persons not being aware of their rights and of procedures used by human rights agencies, delays in handling cases, expense of legal representation, and lack of assistance for complainants in responding to legal processes (eg gathering probative evidence, such as witness statements). Although there are legislative confidentiality protections, individuals may not want to risk revealing their identity, health status or

²⁸ See ‘Promoting the human rights of People Living with HIV and providing redress for violations of their human rights’ in UNAIDS Best Practice Collection, *HIV-Related Stigma, Discrimination and Human Rights Violations* (2005). Also L. Wiseberg (editor), UNAIDS and Human Rights Internet, *Human Rights and HIV/AIDS: Effective Community Responses* (1998).

other personal information by making a complaint. It would be extremely useful if agencies, advocates and community-based-organisations could map barriers to clients not proceeding with cases to finalisation.

There is an increasing trend in human rights agencies to increase their effectiveness by conciliating cases early, and/or using alternative dispute resolution processes, such as Victoria. A useful model in the ACT that could be extended to other jurisdictions is the registering of conciliated agreements with relevant Tribunals, which gives them the legal force of a Tribunal order without the delay and expense of a formally contested hearing.

As noted by UNAIDS in its *2011-2015 Strategy*:

‘Many of the victories in the HIV response have been human rights victories, achieved through advocacy, activism and litigation...Support for governments in realizing and protecting rights must be accompanied by efforts to enable civil society to claim these rights. Programmes that empower civil society to know and demand their rights need to be expanded significantly’.²⁹

Community groups need support for advocacy work, and priority populations must be informed of their legal rights to equality, and practical avenues for enforcing them. Funding for community groups and/or legal centres is vital for discrimination cases to be run successfully, and for results to be disseminated, subject to privacy considerations. It would be helpful if discrimination cases were considered public interest matters for the purpose of Legal Aid eligibility. A large hurdle for affected individuals is the potential for liability of legal costs to be made against a complainant if the matter is appealed from human rights agencies to Tribunals and/or Courts - this is a particular concern in the Federal jurisdiction.

Recommendations

4. *Improve accessibility of discrimination complaints mechanisms by decreasing delays and backlogs, and increasing timely investigations and early conciliations through additional funding and other measures.*
5. *Increase funding for advocacy by community groups and/or legal centres to support discrimination case representation, as well as mapping barriers in cases that do not proceed to finalisation by complaint agencies or Tribunals.*
6. *Consider indemnifying complainants in respect of respondents’ legal costs, except in vexatious cases.*

²⁹ UNAIDS, *Getting to Zero: 2011-2015 Strategy*, pp. 43-44.

7. *Increasing funding for community groups, legal centres and human rights agencies to engage in outreach, community education and rights awareness for priority populations.*

E. Systemic monitoring of discrimination

It is important for discrimination laws to be monitored locally and nationally to ensure that they are being complied with. There could be improvements in the collection of relevant complaint data by agencies to track trends in discrimination complaints on the basis of blood borne diseases, as well as vulnerable statuses in order to frame strategic responses to minimise stigma, as well as assisting academic research of cases.

The *HIV Futures Six* Report of 2009 analysed data from 1106 respondents, with the following four main areas of discrimination: health services (26.4%); insurance (17.3%); employment 16.3%) and accommodation (7.9%).³⁰ In a study of over 600 people living with Hepatitis C in NSW, 50% indicated that they had experienced discrimination by a health worker. This was reported by participants who indicated that they had acquired Hepatitis C medically, and those who had acquired Hepatitis C from injecting drug use.³¹ Also community groups have performed valuable research in documenting discrimination and providing an evidence base to work on, such as the *People Living with HIV Stigma Index: Asia Pacific Analysis*.³²

The administration of discrimination law could be improved by more systemic and 'own motion investigations' (ie not necessarily prompted by individual or representative complaints), and auditing powers of Commission/ers in relation to discrimination experienced by people living with blood borne diseases and members of vulnerable priority groups.

Public attitudes could be better measured through devices such as online or other surveys. For example on 1 December 2009 the ACT Human Rights Commission released an online Survey it conducted in collaboration with the ACT Ministerial Advisory Council on Sexual Health, HIV/AIDS, Hepatitis C and Related Diseases and local NGOs (including the AIDS Action Council and the Hepatitis Resource Centre). Of the 158 respondents who completed the survey through stakeholder contacts, 70% believed that they had been unlawfully discriminated against, mainly on the grounds

³⁰ Living with HIV Program at Australian Research Centre in Sex, Health, and Society, La Trobe University *HIV Futures Six: Making Positive Lives Count* (2009).

³¹ Grebely, J., J. Bryant, et al. "Factors associated with specialist assessment and treatment for Hepatitis C virus infection in New South Wales, Australia," (2011), *Journal of Viral Hepatitis* 18(104-16).

³² UNAIDS, Global Network of People Living with HIV, International Council of Women Living with HIV, and International Planned Parenthood Federation, 2011.

of sexuality and disability (half in relation to a blood borne virus), and with the largest areas being employment and services such as healthcare.³³

Recommendations

8. *Ensure monitoring of compliance with discrimination laws through comprehensive and coordinated de-identified data collection across human rights agencies, as well as communities.*
9. *Increase powers and funding for human rights agencies to conduct systemic work and on an own motion basis, ie without the need for a complaint.*
10. *Ensure regular measuring of public attitudes, through for example community surveys.*

F. Education

The theme for World AIDS Days in 2009-2010 was 'Take Action. Stop Discrimination,'³⁴ and discrimination was noted as a central issue in the establishment of the World Hepatitis Day in 2008. However, there is a need for ongoing education programs to challenge stigma, expose stereotypes, and confront discrimination on a more sustained basis, and with a broader range of disease statuses. A mass media campaign targeted at the general public in NSW noted positive results in both awareness and attitude change following the campaign.³⁵ An important area of focus is in training health care workers on their legal obligations to not discriminate against clients, co-workers and others.

Recommendations

11. *Provide funding to relevant government, expert and community stakeholders to conduct sustained anti-discrimination education programs in relation to blood borne viruses.*
12. *Work with professional bodies and fund human rights agencies to incorporate training modules on discrimination obligations and laws for health care workers.*

³³ See www.hrc.act.gov.au.

³⁴ See A.P. Mahajan et al 'Stigma in the HIV/AIDS Epidemic: A review of the Literature and Recommendations for the Way Forward', *AIDS*. August; 22 (Suppl 2): S67–S79.

³⁵ Smith, B., A. Bauman, et al. (2006). "Hepatitis C in Australia: Impact of a mass media campaign." *American Journal of Preventive Medicine* 31(6): 492-498.

Jurisdiction	Legislation
Federal	<i>Disability Discrimination Act 1992</i>
ACT	<i>Discrimination Act 1991</i>
NSW	<i>Anti-Discrimination Act 1977</i>
Victoria	<i>Equal Opportunity Act 2010</i>
Queensland	<i>Anti-Discrimination Act 1991</i>
SA	<i>Equal Opportunity Act 1984</i>
WA	<i>Equal Opportunity Act 1984</i>
Tasmania	<i>Anti-Discrimination Act 1998</i>
NT	<i>Anti-Discrimination Act 1992</i>

Legal and Discrimination Working Group Paper 3
Addressing discrimination against people living with blood borne disease
in immigration law and policy

Australian immigration law and policy discriminates against prospective migrants on the basis of the estimated cost of any disability they may have, including blood borne virus status. Mandatory HIV testing, combined with strict health criteria relating to the estimated cost of future treatment, make it extremely difficult for people living with HIV/AIDS and their family members to obtain a permanent visa to live in Australia. This regime can have a particularly harsh impact on offshore asylum seekers and their families as there may be no available treatment and support for an individual who discovers their HIV positive status as a result of the mandatory testing and is then refused entry to Australia. The health criteria may also have a discriminatory effect on people living with other blood borne diseases such as Hepatitis C.

The *Migration Act 1958* and actions taken under that Act have been specifically exempted from the provisions of the *Disability Discrimination Act 1992*, which means that the Department of Immigration and Citizenship is not required to demonstrate that it would cause unjustifiable hardship to accommodate migrants with a disability. At present the health requirement does not represent an accurate assessment of individual treatment costs and fails to take into account the social and economic contributions that could be made by an individual and their family. It does also not anticipate the implementation of the proposed National Disability Insurance Scheme. There is a strong argument that the health requirement and mandatory testing regime is inconsistent with the *Convention on the Rights of Persons with Disabilities* which was ratified by Australia in 2008.

Health Requirement

The *Migration Act* and the *Migration Regulations 1994* prevent the granting of visas to applicants with active tuberculosis or another disease that is a public health threat to the Australian community. In addition, the health requirement precludes applicants for permanent visas with a disease or condition likely to require health care or community services that would result in a 'significant cost' to the Australian community, or prejudice the access of Australians to the health care or community service (subject to the waiver process discussed below).³⁶ The current threshold for 'significant cost' is where the potential costs are likely to be more than \$21,000.³⁷

³⁶ Migration Regulations 1994, Schedule 4, Public Interest Criteria and related provisions.

³⁷ Joint Standing Committee on Migration, *Enabling Australia: Inquiry into the Migration Treatment of Disability* June 2010 at 32.

An HIV/AIDS test is mandatory for permanent visa applicants aged 15 years or older. Permanent visa applicants less than 15 years old must also take this test if being adopted or there is a history of blood transfusions or other clinical indications. Screening for hepatitis is mandatory only where the applicant is pregnant, a child for adoption, an unaccompanied refugee minor child or a temporary visa applicant intending to work or study in certain health related occupations.³⁸

While Hepatitis C and HIV/AIDS are not generally regarded by the Department of Immigration and Citizenship as posing a public health threat to the community, the cost of future treatment and care for people living with HIV/AIDS is almost always estimated as above the significant cost threshold, precluding people living with HIV from obtaining permanent visas unless they are able to secure a waiver of the health requirement.³⁹

Waiver

A waiver of the health requirement is available only for limited sub-classes of visas, and where granting the visa would be unlikely to result in 'undue cost' to the Australian community or 'undue prejudice' to Australians' access to health care or services, allowing compassionate and humanitarian factors to be taken into account. However, the number of waivers granted to applicants living with HIV/AIDS or other blood borne viruses is unclear. Szaraz noted that in 2005, almost all HIV health waivers were rejected by the Department and required an appeal to the Migration Review Tribunal, which resulted in extensive delays, and no guarantee that the visa would eventually be granted.⁴⁰ More recently, the Australian National Audit Office found serious shortcomings in the health waiver process and that the Department was not able to show whether it had considered the health waiver for all eligible visa applicants.⁴¹

Joint Standing Committee on Migration Report 2010

The Joint Standing Committee on Migration in its 2010 *Report on the Inquiry into the Migration Treatment of Disability* criticised the health requirement, finding that the current Health Requirement 'reflects old-fashioned approaches to disability in particular and so unfairly discriminates against those who have disability.' The Committee noted that:

³⁸ Department of Immigration and Citizenship, Fact Sheet 22—The Health Requirement

³⁹ Australian Federation of AIDS Organisations Inc. *Migration Law and HIV, the case for reform of Australian Migration Law and Policy*, May 2011.

⁴⁰ Les Szaraz, Australia's immigration response to HIV/AIDS, in The Australasian Society for HIV Medicine, *HIV and hepatitis C, policy, discrimination, legal and ethical issues* at 104.

⁴¹ Australian National Audit Office, *Administration of the Health Requirement of the Migration Act 1958, 2007*, 27.

‘In the vast majority of cases, no account is taken of the applicant’s or their family’s ability to contribute socially and economically to the Australian community and, if this is indeed an economic cost to their immigration, whether or not this is outweighed by other factors such as the potential contribution of other skilled family members whose immigration is linked to or even dependent on the individual with a disability.’⁴²

The Committee made a range of recommendations relating to the health requirement, including raising the significant cost threshold, and revising the test so that it reflects a tailored assessment of individual circumstances in relation to likely healthcare and service use rather than a standard estimate of costs. It also recommended that the regulations be amended to allow for the consideration of the social and economic contributions to Australia of a prospective migrant and their family to the overall assessment of a visa.⁴³ These recommendations have not yet been implemented.

Convention on the Rights of Persons with Disabilities

The Convention on the Rights of Persons with Disabilities was ratified by Australia in 2008. Although the Convention does not contain a specific right in relation to migration, Article 5 provides that State Parties to the Convention must recognise that all persons are equal before and under the law and are entitled without any discrimination to the equal protection and equal benefit of the law. State Parties must also prohibit all discrimination on the basis of disability and guarantee to persons with disabilities equal and effective legal protection against discrimination on all grounds.

Although there may be some justification for health requirements in relation to migration to safeguard scarce medical resources, the test imposed under the *Migration Act* does not accurately assess likely health care costs or adequately balance the right to non discrimination against the preservation of health resources. In an advice prepared for the National Ethnic Disability Alliance, Dr Ben Saul concluded that the health requirement is inconsistent with Article 5 of the Convention, leading to unjustifiable indirect discrimination for some refugees and migrants with disability.⁴⁴

⁴² Joint Standing Committee on Migration, *Enabling Australia: Inquiry into the Migration Treatment of Disability* June 2010.

⁴³ Joint Standing Committee on Migration, *Enabling Australia: Inquiry into the Migration Treatment of Disability*, June 2010, Recommendations 1, 3 and 8.

⁴⁴ Dr Ben Saul, Advice on the UN Convention on the Rights of Persons with Disabilities, 15 May 2008, annexed to the Report of the National Ethnic Disability Alliance: *Refugees and Migrants with Disability and the United Nations Convention on the Rights of Persons with Disabilities* July 2008.

Exemption from the Disability Discrimination Act

The health requirement under the *Migration Act* discriminates against people on the basis of disability by imposing an initial condition (regarding estimated costs of treatment) which people living with HIV/AIDS (and possibly other blood borne disease) are unable to meet, and subjecting them to an uncertain and restrictive waiver regime. Prima facie this would amount to unfavourable treatment on the grounds of disability under the *Disability Discrimination Act 1992*. However, the *Migration Act*, and anything permitted or required under that Act, is specifically exempted from the provisions of the *Disability Discrimination Act*.⁴⁵ The Federal Government is thus not required to establish in each individual case that allowing a visa would impose an unjustifiable hardship in terms of the cost associated with treatment, or to take into account the contribution that the individual would be likely to make to the community.

The UN Committee on Economic, Social and Cultural Rights in 2009 noted with concern that the exemption allows for negative immigration decisions based on disability or health conditions, and expressed concern that the situation had a particularly negative impact on the families of asylum seekers. It recommended that the *Migration Act* and *Disability Discrimination Act* be amended to ensure that the rights to equality and non-discrimination apply to all aspects of migration law, policy and practice.⁴⁶

Although it did not go as far as recommending the repeal of the migration exception, the Joint Standing Committee recommended that as part of its proposal to amalgamate Australian discrimination law, the Australian Government review the *Disability Discrimination Act 1992* with particular reference to the s.52 migration exemption, to determine its legal implications for migration administration and conduct expert consultations on its impact on people with a disability.⁴⁷

Effect of the health requirement and mandatory testing

The Australian Federation of AIDS Organisations notes the serious impact of this discriminatory regime and mandatory HIV testing on prospective migrants who are

⁴⁵ *Disability Discrimination Act 1992* s52.

⁴⁶ Committee on Economic Social and Cultural Rights, Concluding observations of the Committee on Australia (E/C.12/AUS/CO/4).

⁴⁷ Joint Standing Committee on Migration, *Enabling Australia: Inquiry into the Migration Treatment of Disability*, June 2010 (Recommendation 18).

refused entry due to HIV status, particularly where they are refugees without access to support or treatment:

There are generally minimal health care and support services available in refugee camps for people who discover that they have HIV as a result of testing associated with the Health Requirement. Off-shore refugee applicants who are refused Australian residence on the grounds of their HIV status are effectively left in the lurch – remaining in camps with the knowledge that they are HIV positive but with no or limited access to appropriate counseling, including pre-test, post test and diagnosis counseling...Knowledge that their own HIV positive status means that all their family will be refused protection by Australia can place an enormous burden on a person diagnosed with HIV, in terms of guilt and shame and in terms of the reaction of the rest of their family⁴⁸

The National Ethnic Disability Alliance note that the ‘one fails all fail’ policy makes the situation much harder for families supporting a family member with a disability such as HIV:

‘many families supporting people with disability make a difficult decision to leave behind a family member in order to build a life in Australia. In cases involving humanitarian entrants, these family members with disability will remain in extremely vulnerable situations, having also been displaced by war, persecution, or civil unrest, but unable to join their families in Australia.’⁴⁹

Other jurisdictions

A number of comparable jurisdictions impose health conditions on prospective migrants, although in many cases the application of these tests takes greater account of individual circumstances. In a number of countries specific exceptions are made for humanitarian migrants, including offshore applicants.

Canada provides an exception to the health cost requirement for all spouses/partners and family members of Canadian sponsors, and for refugees and protected persons and their families. By contrast under Australian migration law all offshore are subject to the health requirement.⁵⁰

⁴⁸ Australian Federation of AIDS Organisations Inc. *Migration Law and HIV, the case for reform of Australian Migration Law and Policy*, May 2011, p10.

⁴⁹ *National Ethnic Disability Alliance: Refugees and Migrants with Disability and the United Nations Convention on the Rights of Persons with Disabilities July 2008*

⁵⁰ Joint Standing Committee on Migration, *Enabling Australia: Inquiry into the Migration Treatment of Disability*, June 2010, 41.

The Joint Standing Committee Report notes that New Zealand, among a number of other countries, provides quotas for people with a disability or for specific health conditions, and that it accepts up to 20 known HIV positive refugees every year under a quota system.⁵¹

A number of comparable jurisdictions do not subject prospective migrants to mandatory HIV testing as part of the health screening process. The United Kingdom does not require a compulsory HIV test except in relation to specific occupations such as health care workers.⁵²

Conclusion

Australian immigration law and policy discriminates against people with blood borne viruses, particularly people living with HIV/AIDS. The health requirement fails to recognise the social and economic contributions of migrants with a disability (including blood borne virus status) and their families, and imposes an unfair and inaccurate assessment of potential treatment costs. This approach is inconsistent with Australia's obligations under the Convention on the Rights of Persons with a Disability, and would amount to unlawful disability discrimination under the *Disability Discrimination Act* were it not for a specific exemption for migration law. This discriminatory approach is exacerbated by mandatory HIV testing of all offshore applicants, which has a particularly harsh impact on refugees and their families refused entry due to HIV/AIDS status, who may be unable to access counseling and treatment following their diagnosis.

Recommendations

1. *The exemption of the Migration Act 1958 from the Disability Discrimination Act 1992 should be repealed.*
2. *The health requirement in the Migration Act and Regulations should be amended to ensure that people with disabilities are not subjected to unjustifiable discrimination in migration decisions.*
3. *Mandatory testing for HIV should be replaced with voluntary testing, with appropriate counseling and support provided to all applicants who undertake HIV testing for migration purposes.*

⁵¹ Ibid, 42.

⁵² Australian Federation of AIDS Organisations Inc. *Migration Law and HIV, the case for reform of Australian Migration Law and Policy*, May 2011, 17.

Legal and Discrimination Working Group Paper 4
Criminalisation of people living with HIV
for non-disclosure, HIV exposure and HIV transmission

There have been at least 32 prosecutions for HIV exposure or transmission in Australia.⁵³ Prosecutions are attracting growing concern among affected communities.

Central to ‘criminalisation’ debates is the potential for prosecutions to undermine the public health response. A whole-of-government HIV response should be based on shared understanding of transmission risk and the appropriate use of public health and justice systems to maximise HIV prevention efforts and protect rights.

Although there may be exceptional circumstances in which prosecutions are warranted, Australia’s robust public health framework should remain the dominant setting for managing HIV risk. UNAIDS urges governments to limit criminalization to cases of intentional transmission, ie where a person knows his or her HIV positive status, acts with the intention to transmit HIV, and does in fact transmit it.⁵⁴

Australia’s HIV Response: the public health framework

The public health framework is driven by principles outlined in the *National HIV Strategy*:

- individuals and communities have a mutual responsibility to prevent themselves and others from becoming infected;
- application of law and public policy should support and encourage healthy behaviours and respect human rights;
- timely and quality research should provide the evidence base for action.

Social research confirms that most people living with HIV take very seriously their responsibility to prevent HIV transmission, but it also confirms that although rare, some persons living with HIV will engage in unsafe sex without disclosure. When a person is considered at risk of endangering others, each jurisdiction has a process defined by public health legislation and related guidelines to enable referral to health authorities. Although these state-based systems differ, all are required to be consistent with the *National Guidelines for the Management of People with HIV who Place Others at Risk*. The Guidelines outline a series of escalating interventions, ranging from counseling to detention and referral for prosecution. There were approximately 100 persons under public health management at March 2011, with the majority at the lowest level, acquiring minimal assistance/intervention.

⁵³ Since 2000, between one and six prosecutions have occurred per year in Australia.

⁵⁴ UNAIDS: Criminalization of HIV Transmission

Application of criminal law to HIV exposure or transmission

Although there are National Guidelines for public health agencies, there are no national guidelines or agreed principles relating to the role of the criminal law and prosecutions.

All States and Territories have criminal laws that may be applied to HIV transmission, and some States have used criminal laws to prosecute 'exposure', ie unprotected sex that has not resulted in HIV transmission. Laws include those based on endangerment, assault or causing harm. In theory, none of these laws is HIV specific although HIV appears to have been the only disease targeted by the criminal justice system in recent history.

Prosecutions are difficult to track as there is no centralised reporting mechanism. Evidence to date reported by the Australian Federation of AIDS Organisations ('AFAO') to the Legal Working Group suggests:

- *Prosecutions are occurring with increasing frequency*

Prosecutions have occurred at a rate of about one per year since the early 1990s. However, 16 cases have been run between 2007 and 2011. Other cases are currently being investigated.

- *Prosecutions have occurred in most jurisdictions*

Almost all prosecutions prior to 2000 occurred in Victoria. However, most jurisdictions have now had at least one prosecution, with many states having had multiple prosecutions.

- *Charges are being applied in a very broad range of circumstances*

Behaviours subject to prosecution include: exposure only, exposure and transmission, or transmission only; single or multiple 'victims'; male or female 'victims'; sex during casual or committed relationships; and during new or long-term relationships. Two recent cases relate to events that occurred a decade before prosecution. Some accused have previously come to the attention of public health officials, while others have not. Heterosexual men and African men are overrepresented among accused.

Harmful impact of prosecutions

Use of criminal laws to instigate behaviour change or provide sanctions for risk behaviours is problematic in the Australian context for the following reasons:

1. *HIV-related prosecutions negate mutual responsibility messages*

Prosecutions have relied on the premise that an accused's behaviour has been unlawful because they have not disclosed their positive status prior to sex. This premise places legal responsibility for prevention exclusively on those already living with HIV and dilutes the public health message of shared responsibility. Reliance on disclosure creates a false expectation that HIV-positive people will disclose,⁵⁵ and effectively enables those who believe themselves to be negative to waive responsibility for both their own, and their partners', health. As a prevention strategy, it is unworkable given not all people living with HIV disclose their status prior to every sexual encounter, and significant transmission occurs from those who are unaware they are infected.⁵⁶

2. *HIV-related prosecutions do not decrease HIV transmission risk*

There is no evidence that laws regulating the sexual conduct of people living with HIV impact sexual conduct or moderate risk behaviours.⁵⁷ Similarly, there is no evidence that Australian prosecutions have decreased transmission risk, either generally or among people in any specific population. To the contrary, many people living with HIV have reported increased fear about disclosing their HIV-positive status 'because of the current legal situation'.⁵⁸ It is possible that current attention to prosecutions is making it more difficult for individuals to disclose, which makes HIV disclosure prior to sex less likely. Private sexual conduct invariably persists in the face of possible prosecution, but when prosecution actually occurs, risk behaviours are driven underground, inhibiting access to preventive activities, testing, treatment and support.

3. *Prosecutions fail to fully consider the intersection of risk and harm*

Risk: HIV transmission during sex is not automatic. Transmission risk associated with a single act of unprotected vaginal intercourse is estimated at .07 - .08%,⁵⁹ a single act of unprotected anal intercourse 0.82%, ie less than one in 100,⁶⁰ and

⁵⁵ Dodds C, Weaterburn P, Bourne A, Hammond G, Weait M, Hickson F, Reid D, Jessup, K. *Sexually charged: the views of gay and bisexual men on criminal prosecutions*, Sigma Research, UK, 2008.

⁵⁶ Modelling suggests 30% of new HIV infections among MSM in Australia occur as a result of transmission from the estimated nine per cent of MSM who are unaware they are HIV positive (Wilson D, Hoare A, Regan D, W & 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).

⁵⁷ In fact, research on laws mandating 'disclosure' found no difference between behaviours in states mandating disclosure and those that did not, both in Australia and in the U.S. NCHSR Stigma Study & Lazzarini.

⁵⁸ ARCSHS, HIV Futures 6.

⁵⁹ Boily MC et al. 'Heterosexual risk of HIV-1 infection per sexual act: systematic review and meta-analysis of observational studies' *Lancet Infect Dis* 9(2): 118-129, 2009.

⁶⁰ Vittinghoff E et al. 'Per-contact risk of human immunodeficiency virus transmission between male sexual partners' *American Journal of Epidemiology* 150: 306-311, 1999.

unprotected oral sex so low as to be difficult to quantify, but a slightly above zero risk.⁶¹ There is a clear difference between the risk of harm associated with unprotected sex and the risk of harm from a physical assault.

Harm: Harms associated with HIV infection have dramatically reduced as treatments have improved. It is perhaps surprising then that prosecutions appear to be increasing.

Criminal law treats HIV differently from other diseases and that differential treatment is not necessarily the result of a sound understanding of harm caused by HIV infection. Out-dated notions of HIV combine with social filtering of the 'meaning' of HIV infection, affecting the decisions of all parties involved: complainants, police, prosecutors and judges.

A more sophisticated understanding of harm and risk is required to inform whether cases merit criminal law attention, particularly given the general principle that criminality requires a weighing up of the degree of risk that conduct will cause harm, and the degree of seriousness of the harm caused to the 'victim'.

4. Prosecutions ignore the reality that failure to disclose HIV status is not extraordinary

Regardless of ethical considerations about what people living with HIV should and should not do, not all people disclose their HIV-positive status before every single risk event. People may fail to disclose for a range of reasons including:

- the use of risk reduction strategies, such as condoms;
- the belief that having a low viral load equates to low or no transmission risk;
- the belief that a behaviour, such as oral or insertive sex, contains no risk;
- the belief that the other person is already HIV-positive and/or has consented to the risk of transmission;
- fear of loss of privacy (including ongoing gossip about an individual's HIV-positive status);
- fear of rejection (in new or long term relationships); and
- fear of violence, ostracism and abandonment

Recognising that not all people living with HIV disclose before every risk event is not an argument against encouragement of disclosure, but an argument against disclosure as core HIV prevention policy. The potential to maximise disclosure is

⁶¹ Baggaley, R et al: 'Systematic Review of Orogenital HIV-1 Transmission Probabilities', *37 International Journal of Epidemiology* 1255-1265 (2008).

most likely in a social environment in which HIV disclosure is facilitated by the absence of fear, blame or hysteria.

5. *Prosecutions reduce trust in healthcare providers*

Healthcare practitioners are the frontline in HIV prevention, yet concern about confidentiality and official reporting of behaviours make people living with HIV less likely to seek support relating to risky behaviour, or to disclose behaviours and seek treatment for symptoms from a single service provider. Healthcare practitioners' capacity in prevention and care is undermined.

6. *Prosecutions increase stigma*

The few criminal trials that have occurred have generated substantial media coverage. In some instances, coverage had been accusatory and vitriolic, as has public 'commentary' on the internet. It has also contained factual errors, including at least two cases where multiple headlines proclaimed those individuals had infected others, despite convictions relating only to exposure to risk. Prosecutions reinforce stigma based on the 'othering' of all people living with HIV. Such stigma makes it difficult for individuals to come to terms with and manage their HIV infection and undermines prevention efforts. Stigma also impacts on willingness to be tested and seek treatment, and hence can have profound effects on the course of the HIV epidemic.

7. *Prosecutions are unacceptably arbitrary*

While prosecutions may be warranted in cases of intentional transmission, they should not be pursued in cases of reckless or negligent transmission, or exposure without transmission. Prosecutions to date are at odds with this principle. There has only been one known prosecution that has successfully argued 'intent', although intent was defined as transmission being 'a foreseeable consequence', rather than the 'intention' of the accused to transmit HIV. All other known cases have related to people who intentionally engaged in unprotected sex without disclosing their HIV-status but did not require or failed to provide evidence that the accused intended to actually transmit HIV.

28,000 HIV diagnoses have been made during Australia's 30 year epidemic, yet only 32 known prosecutions have occurred. In many instances, it is unclear why cases are dealt with by prosecution, as they appear to involve circumstances similar to those managed under public health systems. As court cases occur more frequently, those working in HIV services have become unsettled by the possibility of prosecution of their clients.

Gaps in Australia's response

Australia lacks a cross-sectoral or whole-of-government response to HIV prosecutions. Other countries are responding proactively by developing prosecutorial guidelines (eg Canada) and policing guidelines (eg United Kingdom), and suspending operation of penal provisions pending review of their public health implications (eg Denmark).

A number of factors have militated against strategic thinking on the intersection of public health and criminal law in the context of HIV. Criminal law and public health systems conceptualise behaviours in distinct ways, with different imperatives and frameworks. HIV-related expertise is largely located in the health sector. Those working in criminal law and public health systems have focused areas of expertise, ie individuals are expert in 'health' or 'law', with minimal understanding of the alternate system, and little will or capacity to undertake cross-sectoral coordination or analysis.

Areas for action include:

1. Promote cross-sectoral linkages

Mechanisms are required to ensure consistent approaches and coordinated responses between justice (prosecutors, police, Attorneys-General) and health agencies (government, medical profession and community sector). Given at least four State Health Departments have recently been drawn into criminal law matters relating to HIV exposure or transmission, their observations could inform development of a best practice police and prosecution response. Further, the impact of prosecutions on public health officials' work must be duly considered. The development of protocols (both from health to police, and police to health) should be pursued.

2. Expand capacity of HIV support services

HIV agencies need to have an improved understanding of:

- relevant legislation (Crimes Acts, Public Health Acts, Mental Health Acts etc);
- the legal process (eg bringing charges, bail, committal hearings, trials and sentencing, victim impact statements, victim's compensation);
- obligations of the accused and witnesses;
- the impact on individuals and sub-populations (HIV-positive gay men, sex workers, migrants from high prevalence countries etc); and,
- their own professional obligations.

Australian HIV community agencies have had minimal involvement in criminal prosecutions. This contrasts with experiences in other countries. The New Zealand AIDS Foundation and Body Positive Inc have ensured prosecution and defence

lawyers have been well informed about the science of transmission risk. In Canada, HIV organisations have intervened in court cases to assist in the development and delivery of legal arguments around the definition of ‘significant risk’, and have raised funds to contribute to an accused’s legal costs in an exceptional case.

Issues for HIV agencies include identifying cases pre-trial so support may be offered to individuals, and advocacy with lawyers and justice agencies to build capacity in relation to HIV issues. Differences between jurisdictions mean that capacity development for HIV agencies needs to be carefully targeted. Agencies need to ensure that people encountering the criminal justice system are aware of the range of HIV support services available to the accused, ‘victims’ and witnesses. Specialised services for people from culturally and linguistically diverse communities, and people with disabilities would be beneficial.

3. Work with Police

Policing directly influences the experience of accused and witnesses, as well as the likelihood of cases proceeding to court. There is anecdotal evidence that police handling of witnesses in some cases has been less than optimal (eg they are outside protocols implemented for sexual assault cases despite involving detailed invasive questioning about people’s sexual practices, including the sexual practices and experiences of ‘victim’ witnesses). Improved protocols are required for gathering evidence and liaising with health authorities, witnesses and other stakeholders. For example, in the UK the Terrence Higgins Trust, the Association of Chief Police Officers, the Metropolitan Police and other community groups conducted a review of police handling of cases. The findings from this review are now being developed into guidelines for police.

4. Work with justice agencies

Directors of Public Prosecutions directly influence whether cases proceed and how they are run. While it is a requirement that prosecution of a criminal case must be in the public interest, it is not known how the ‘public interest’ is determined in the context of criminal cases involving HIV transmission. In the UK, for example, the Crown Prosecution Service has produced policy guidelines on prosecutions relating to sexual transmission of HIV. This policy has greatly clarified the issues and risks for people with HIV, as well as providing important guidance for police and prosecutors.

5. Better inform lawyers, magistrates and judges

The expertise of lawyers, judges and magistrates directly impacts evidence, instructions to juries, sentencing, and future trials (through the use of precedents). Consultation with legal organisations is required to consider how to educate lawyers and the judiciary about relevant scientific developments (eg limitations of

phylogenetic analysis), the need to consider both criminal and public health law in particular cases, and the relationship between HIV prosecutions and public health outcomes.

6. Develop a better informed media response

Sensationalist or inaccurate media reporting of prosecutions can be damaging to people living with HIV and public health programs. In many instances, press coverage arises from coverage of court cases. However, in notable exceptions substantial damaging press has resulted from health department press alerts. A review of government media strategy in this area is urgently required. It is also important to work pro-actively to educate journalists about HIV and the issues involved in prosecutions. A central access point for information, such as a website on criminalisation issues hosted by a community group or legal centre could be helpful for journalists and researchers.

7. Ensure prosecutions for HIV transmission are a research priority

This includes the identification and analysis of individual cases and research into the effects of prosecutions on public health and affected communities. This lack of research impacts negatively on capacity to develop an evidence-based response or to identify policy priorities.

8. Address implications for HIV educators

The increase in prosecutions requires HIV educators to address implications such as issues of trust with clinicians. The concentration of prosecutions among particular groups suggests a need for targeted education among particular populations (eg heterosexuals, and culturally and linguistically diverse communities).

9. Provide support to health care professionals

Clinicians at the front line of HIV diagnosis and treatment must be well informed about legal issues (particularly their own legal obligations), so that they can provide optimal information and support to patients.

10. Educate correctional authorities

The imprisonment of people with HIV for offences related to transmission raises issues about appropriate management of these offenders, pre-, during, and post-release. Processes for coordination of correctional and public health management of individuals upon release are currently unclear and uncoordinated.

Recommendations

1. It is recommended that the Commonwealth Government in cooperation with the States and Territories develop **National Guidelines on Prosecutions and Policing** for HIV exposure and transmission. Issues to address include:
 - (i) a consistent approach to criteria for initiating prosecutions, to ensure prosecutions are restricted to exceptional cases, eg principles to inform prosecutions, or a set of 'model' guidelines for State and Territory adoption;
 - (ii) explanation of issues relating to transmission risk and harm;
 - (iii) promotion of the development of formal mechanisms for cooperation and coordination between health and criminal justice authorities (departmental staff, police and prosecutors) and clarification of the relationship between agencies involved in public health management under public health legislation and agencies involved in prosecutions under criminal legislation. National guidelines can support development of protocols for cooperation in management of cases or referral both from health to police and police to health;
 - (iv) consideration of the role of mental health laws and services;
 - (v) the need for governments to systematically monitor and analyse prosecutions and to research their social and public health impacts, to inform the national response.

2. It is recommended that the Commonwealth Government in cooperation with the States and Territories, and civil society partners develop **National Guidelines on Restricting the Role of Criminal Laws** to address exposure and transmission. This would include:
 - (i) consideration of the need for a nationally consistent approach to the definition of offences, to address the prevailing confusion among clinicians and communities that results from the patchwork of current offences;
 - (ii) national agreement on what constitutes exceptional cases that warrant criminal punishment, or the criteria that should inform criminality (ie clarifying the nature of intent or malice that in principle should be required by law to warrant a criminal penalty); and
 - (iii) a shared understanding of the potential public health harm caused by enactment of HIV-specific offences.

Implementation of these recommendations will require a cooperative approach between Departments of Health and Attorneys-General. A partnership approach

between DOHA and the Standing Committee on Law and Justice (formerly the Standing Committee of Attorneys General) is required to ensure a whole of government approach. For example, this may require cross-agency working parties at both Commonwealth and State/Territory level, involving the Departments of Health, Attorneys-General, Police, Directors of Public Prosecutions and key HIV services.

Legal and Discrimination Working Group Paper 5 Criminalisation of People Who Inject Drugs

The Global Context:

Criminalisation associated with illicit drug use generates adverse public health outcomes including increased risk of disease transmission and drug related overdose, poorer levels of general health and higher levels of morbidity. Increased risk of disease transmission results from direct and indirect barriers to HIV, hepatitis B & C prevention strategies, and limited access to harm reduction and other health and social services. The June 2011 report of the Global Commission on Drug Policy states:

*The global war on drugs has failed. ... It is clear that the policy of harsh criminalization and punishment of drug use has been an expensive mistake, and government should take steps to refocus their efforts and resources on diverting drug users into health and social care services.*⁶²

The above report reflects an emerging sensibility among senior public health analysts that strong public health policy requires urgent and strategic drug law reform. The Vienna Declaration states that *'the criminalisation of illicit drug users is fuelling the HIV epidemic and has resulted in overwhelmingly negative health and social consequences'*.⁶³ It argues for a *'full policy reorientation'* regarding illicit drug use. Similarly, the World Health Organization states effective policy to reduce HIV/AIDS among injecting drug users requires *'bringing major policies and strategies together (such as the national illegal drug strategy and the national AIDS strategy)'*.⁶⁴

In Australia, although harm reduction principles have been fundamental to our national HIV and viral hepatitis responses, the inclusion of such approaches are far less evident in Australian drug policies and laws. A whole-of-government response is required to maximise efforts to prevent transmission of blood borne viruses, including HIV and hepatitis C, and to enable the human rights of people who inject drugs. This paper calls for evidenced based reform of drug law and policy because current laws and policies undermine efforts to prevent transmission of HIV, Hepatitis C, and other blood borne viruses.

⁶² GSDP. (2011). *War on Drugs: 2011 Report of the Global Commission on Drug Policy*.

⁶³ <http://www.viennadeclaration.com/the-declaration/>

⁶⁴ WHO. (2005). *Policy and Programming Guide for HIV/AIDS Prevention and Care among Injecting Drug Users*. WHO. Geneva.

Injecting Drug Use in Australia:

Early interventions have been very successful in minimising HIV transmission through injecting drug use. Only 3% of those diagnosed HIV-positive between 2005 and 2009 had acquired HIV through injecting drug use, although notably, injecting drug use was the route of HIV transmission among 20% of Aboriginal or Torres Strait Islander people diagnosed HIV-positive.⁶⁵ Official data is not available, however rudimentary Kirby Institute calculations suggest at least 500 people living with HIV are understood to have acquired HIV through injecting drug use.⁶⁶

Efforts to prevent hepatitis C infection have been far less successful, with an estimated 284,000 people exposed to hepatitis C by the end of 2008, 212,000 of who had developed chronic hepatitis C infection. Of those with chronic hepatitis C infection, estimates suggest at least 80% are people with a history of injecting drug use.⁶⁷ Hepatitis C transmission remains a major public health issue, with approximately 10,000 new infections likely each year: over 90% of these among people who inject drugs.⁶⁸

Individuals' risk of acquiring a blood borne virus is affected by numerous factors including broad social factors (social determinants of health) and specific risk taking behaviours: behaviours which are influenced by both social determinants and social setting.⁶⁹ These factors operate to increase vulnerability among specific populations. Although individuals from all cultural and socio-economic groups in Australian society use illicit drugs, drug related illness and death are disproportionately higher among people living in poverty and those from Indigenous and CALD backgrounds.⁷⁰ In some settings, most notably prisons, aspects of social disadvantage are clearly compounded: up to two-thirds of female inmates are hepatitis C-infected, compared to one-third of their male counterparts, and 43% of Indigenous prison detainees screened are infected with Hepatitis C, compared with 33% of non-Indigenous detainees.⁷¹

⁶⁵ NCHECR (2010). *HIV, viral hepatitis and sexually transmissible infections in Australia Annual Surveillance Report 2010*. National Centre in HIV Epidemiology and Clinical Research, UNSW, Sydney.

⁶⁶ from phone conversation 16 June 2011.

⁶⁷ NCHECR. (2009). *2009 HIV/AIDS, Viral Hepatitis and Sexually Transmissible Infections Annual Surveillance Report*. National Centre in HIV Epidemiology and Clinical Research, UNSW. Sydney.

⁶⁸ Razali, K. et al (2007). 'Modelling the hepatitis C virus epidemic in Australia'. *Drug and Alcohol Dependence*, Vol.91, No 2-3, 228-35.

⁶⁹ Southgate, E. Day, C. Weatherall, A. et al (2003). *Dealing With Risk: a multidisciplinary study of injecting use, hepatitis C and other blood borne viruses in Australia*. Australian National Council on Drugs, Canberra.

⁷⁰ p.27 models of care

⁷¹ Butler, T., Papanastasiou, C. (2008). *National prison entrants' blood borne virus and risk behaviour survey 2004 & 2007*. National Drug Research Institute (NDRI) and National Centre in HIV Epidemiology and Clinical Research (NCHECR), Perth and Sydney. Ministerial Advisory Committee on AIDS, Sexual Health and Hepatitis (MACASHH). (2008). *Hepatitis C prevention, treatment and care: Guidelines for Australian custodial settings: Evidence base for the guidelines*.

Criminalisation of illicit drug use directly impacts risk of harm by defining the social setting in which drug use occurs. Risk is heightened when drug source is illegal and drug quality is unknown, physical environment is clandestine, new/clean injecting equipment is not accessible, the act of injecting is often hurried due to fear of police, and expert medical/health advice is unavailable. In the alternative, the removal of the criminalised environment for people who inject drugs can allow substances of known quality and dosage to be legally acquired from a regulated source. Access to new injecting equipment, as well as harm reduction information and health and medical assistance, can also be provided in an environment free of fear of police and/or arrest. Such changes to the social context and therefore the risk environment in which injecting occurs are central to reducing the likelihood of HIV and/or hepatitis transmission from such practices.

Australia's HIV/Hepatitis C Policy Response:

The *National Hepatitis C Strategy 2010-2013* and the *National HIV Strategy 2010-2013* both identify the need to focus on the further development of supportive and enabling policy and legislative environments, in order to promote the health and human rights of those living with and at risk of hepatitis C, HIV and other BBVs. In addition, both strategies highlight the need to identify and address legal barriers to the implementation of evidence-based BBV prevention strategies.

In relation to people who inject drugs, the strategies specifically identify the need for law reform (referring to the 1992 IGCA Legal Working Party Report recommendations) and harmonisation between drug control laws and public health policy as priority actions. The HIV Strategy highlights that a demonstrated commitment to a supportive and rights based policy and legal environment is central to establishing partnerships and cooperation between governments and affected communities that are marginalised and disadvantaged, such as people who inject drugs.

Areas of Reform:

a) Enshrining a Human Rights-Based Framework:

In 2001, the NSW Anti-Discrimination Board found that *'protection of the human rights of people with hepatitis C, and those most at risk of infection, particularly people who inject illicit drugs, is critical to an effective response to hepatitis C'*. That argument still stands, as does its application to HIV. The Universal Declaration of Human Rights, has particular relevance to drug policy as it intersects with rights to life; health; due process and fair trial; freedom from inhuman or degrading

treatment; and discrimination. These rights are inalienable under binding treaties such as the International Covenant on Civil and Political Rights, which Australia has ratified: not an option to be addressed 'if drug policy allows'. Taking a human rights approach means creating a supportive social, policy and legal environment: as noted in the guiding principles of both the *National HIV Strategy* and the *National Hepatitis C Strategy*, which explain the efficacy of the 'formulation and application of law and public policy that support and encourage healthy behaviours and respect human rights'.

b) Aligning Current Drug Control Laws with Public Health Outcomes:

1. Expand the scope of diversionary schemes

Diversion is not a new approach, having operated through formalised programs and police discretion for decades. Since the commencement of the COAG Illicit Drug Diversion Initiative (1999/2000) there has been a significant expansion in the number and types of diversionary schemes at jurisdictional level including court-based and police diversionary practices.⁷² These measures reflect a process of positive reform, with evaluations of diversionary programs consistently identifying positive outcomes including reductions in drug use and criminal behaviour, increased physical and mental health, and improvement in inter-personal relationships.⁷³ Some jurisdictions use the expiation model, for example under s.117A of the ACT *Drugs of Dependence Act 1989* police have a discretion to issue a Simple Cannabis Offence Notice, which when paid as a civil penalty avoids criminal proceedings.

The current aims of the Illicit Drug Diversion Initiative are directly related to efforts to reduce the criminalisation of people who use illicit drugs with one of the main aims of the Initiative being 'to reduce the number of people being incarcerated for use and possession of small quantities of illicit drugs'.⁷⁴ To achieve this aim however, there needs to be a greater focus on more innovative strategies to divert people with a history of injecting drug use from the criminal justice system and reduce reimprisonment rates. Such strategies should include increased access to a broader range of opioid pharmacotherapy options in the community, greater use of

⁷² Hughes, C. and Ritter, A. (2008). *Monograph No. 16: A summary of diversion programs for drug and drug related offenders in Australia*. DPMP Monograph Series. National Drug and Alcohol Research Centre, UNSW. Sydney.

⁷³ HOI. (2002). *Evaluation of Council of Australian Governments' initiative on illicit drugs. Volume 1 - Executive Summary*. Health Outcomes International Canberra: Department of Finance and Administration. Bull, M. (2003). *Just treatment: a review of international programs for the diversion of drug related offenders from the criminal justice system*. School of Justice Studies, QUT. Brisbane. Hughes and Ritter. (2008). Op. Cit.

⁷⁴ AIHW. (2008). *The Effectiveness of the Illicit Drug Diversion Initiative in Rural and Remote Australia*. Australian Institute of Health & Welfare. Australian Government. Canberra.

voluntary community-based support and development programs, and increased access to diversion programs for highly marginalised/isolated populations.

2. Address incarceration-based transmission risk

The *National Hepatitis C Strategy* states:

*People in custodial settings are at increased risk of exposure to hepatitis C because of the high number in prison for drug-related offences, the high prevalence of hepatitis C in prison populations and the associated use of non-sterile injecting equipment, and the sharing of tattooing and piercing equipment and other blood-to-blood contact.*⁷⁵

Having been in prison in Australia is an independent risk factor for hepatitis C infection, and national surveillance reflects increasing HIV rates among new prison entrants.⁷⁶ Given recent survey findings in which approximately a third of all inmates reported injecting drugs while in prison,⁷⁷ prison based HIV and hepatitis C prevention strategies are vital. This argument is reinforced by the alarming finding that 90% of young offenders did not know hepatitis C could be transmitted by sharing/reusing needles and syringes.⁷⁸

The *National HIV Strategy* also highlights the impediments to best practice BBV prevention in prisons including a lack of access to the means of prevention, thereby removing the ability of detainees to maintain protective practices while incarcerated. Both the *National HIV Strategy* and the *National Hepatitis C Strategy* call for:

- increased access to bleach and disinfectants;
- easily accessible education and counselling;
- increased access to drug treatment programs, including opioid pharmacotherapy, detoxification and drug rehabilitation programs; and
- trialling of prison-based needle and syringe programs (which now operate in more than 50 prisons in 12 countries in Europe and Central Asia).⁷⁹

⁷⁵ DoHA. (2010). *National Hepatitis C Strategy 2010-2013*. Op. Cit.

⁷⁶ DoHA. (2010). *National HIV Strategy 2010-2013*. Australian Government Department of Health and Ageing. Canberra.

⁷⁷ Butler, T., Papanastasiou, C. (2008). National prison entrants' blood borne virus and risk behaviour survey 2004 & 2007. National Drug Research Institute (NDRI) and National Centre in HIV Epidemiology and Clinical Research (NCHECR), Perth and Sydney.

⁷⁸ Butler, T., Papanastasiou, C. (2008). Op. Cit.

⁷⁹ Anex (2010). *With conviction: The case for controlled needle and syringe programs in Australian Prisons*. Anex, Melbourne.

The issue of incarceration is broader than one of prison-based prevention strategies. Prison-based blood borne virus transmission risk bears a direct relationship to the risk of incarceration as a consequence of the illegality of illicit drug use. The Australian Institute of Criminology study of adult detainees found that:

- 61% reported obtaining illicit drugs in the past 30 days;
- 44% reported taking drugs prior to committing an offence;
- 14% said they were looking for drugs prior to arrest; and
- 42% who tested positive for at least one illicit drug attributed at least some of their offending to their drug use.⁸⁰

The above data reinforces the importance of diverting people away from the criminal justice system wherever possible, and the need for decriminalisation to reduce the percentage of people with a history of injecting drug use incarcerated for drug and drug-related offences (see Portugal's experience, above). In pragmatic terms, criminalisation of illicit drug use leads to imprisonment of people who injecting drugs, with major implications for the transmission of blood borne viruses in prisons, as well as in the general community.

3. Decriminalise minor drug offences

Despite the expansion of some diversion initiatives as outlined above, the past decade has also seen the implementation of numerous jurisdictional policy and legislative initiatives, which have resulted in increasing the criminalisation of people who use illicit drugs. Such efforts include new or harsher drug penalties, increased police powers, search and seizure laws, sniffer dogs, mandatory sentences and 'truth in sentencing' laws for certain drug offences.

The rationale of those law and order based efforts contrast with innovative approaches implemented in a number of international jurisdictions: most notably Portugal, where use, possession and acquisition of all illicit substances for personal use (defined as 10 days' supply) has been decriminalised. These changes have not 'legalised' possession of illicit substances, but implemented a system of administrative sanctions. Growing, dealing or trafficking in illicit substances remains a criminal offence.

Since the reform, the prevalence of problematic drug use, particularly intravenous drug use, is estimated to have declined and to have reduced the burden on Portugal's criminal justice system. The proportion of prisoners in the Portuguese prison population incarcerated for drug-related offences has significantly decreased, and rates of intravenous drug use in prison have also fallen. Opioid overdose and

⁸⁰ Australian Institute of Criminology, *Monitoring Reports 09. Drug Use Monitoring in Australia: 2008 Annual Report on drug use among police detainees*, (2010) Canberra.

opioid-related deaths have decreased. HIV prevalence among prisoners has decreased, as has diagnosis of HIV among new drug users. There is no evidence of expansion of Portugal's drug market to supply individuals travelling from neighbouring countries.⁸¹

Given widespread drug use within Australian society and the potential public and individual health benefits, decriminalisation should be rigorously explored including:

- decriminalising the purchase and possession of small amounts of illicit substances for personal use; and
- developing a system of civil penalties for small-scale supply of all currently illicit substances when the supplier is a user of and/or dependent.

4. Implement innovative evidence-based models

Australia's internationally esteemed reputation in public health management draws on the success of earlier innovative strategies to manage blood borne virus transmission risk among people who inject drugs. A renewed commitment to, evidence-informed innovation is required.

- **Needle and Syringe Programs**

Two consecutive cost-benefit reports have demonstrated significant returns on government investment in Australian needle and syringe programs (NSPs) particularly in relation to HIV and hepatitis C prevention.⁸² Despite the evidence supporting NSPs, there continues to be a number of legal barriers to needle and syringe provision at the jurisdictional level in Australia.^{83 84} Such barriers need to be removed. See the paper in this series on *Removing Legislative and Policy Barriers to NSP & Injecting Equipment Access* for further information on this issue.

⁸¹ Hughes, C. and Stevens, A, *The effects of decriminalization of drug use in Portugal. Briefing Paper 14*, (2007) Beckley Foundation, United Kingdom.

⁸² Wilson, D., et al. *Return on investment 2: Evaluating the cost-effectiveness of needle and syringe programs in Australia*, (2009) Australian Government Department of Health and Ageing: Canberra. NSPs were also very cost-effective compared to other common public health interventions, such as vaccinations, in-patient interventions, and interventions to address diabetes, alcohol and drug dependence.

⁸³ International research on NSPs in prisons has demonstrated reduced needle sharing and rates of BBV transmission. See Hunt, D., Saab, S. (2009). Viral hepatitis in incarcerated adults: a medical and public health concern. *American Journal of Gastroenterology*, 104(4), 1024–1031., Jurgens, R., Ball, A., Verster, A. (2009). Interventions to reduce HIV transmission related to injecting drug use in prison. *Lancet Infectious Diseases*, 9, 57–99, and Lines, R., Jurgens, R., Betteridge, G., Stover, H. (2005). Taking action to reduce injecting drug-related harms in prisons: The evidence of effectiveness of prison needle exchange in six countries. *International*

⁸⁴ A more extensive analysis is available at AIVL. (2010) *Legislative and Policy Barriers to Needle & Syringe Programs and Injecting Equipment Access for People Who Inject Drugs*. Australian Injecting and Illicit Drug Users League.

- **Safe Injecting Rooms**

The Medically Supervised Injecting Centre in NSW provides a best practice method to engage with people who are regularly engaged in injecting drug use particularly dependent street-based injectors. More than 200,000 needles and syringes have been dispensed from the premises, indicating the Centre's role in minimising transmission of blood borne viruses. Reviews have consistently found that as a result of the Centre's operation, the number of overdose related ambulance callouts has decreased by 80%, and the number of publically discarded needles and syringes in the area has halved.⁸⁵ Of the more than 3500 cases of drug overdose requiring medical management, none had resulted in death. As well as immediate clinical care, the Centre provides drug treatment, health care and social welfare support through referral: some 8500 referrals have been made. All reviews to date have failed to identify any of the negative outcomes predicted by critics at the trial's inception, and local residents have expressed strong support for the Centre's continued operation. Further centres should be developed particularly in areas with street-based drug scenes and evidence of public and high risk injecting practices.

- **Adequate provision of opiate pharmacotherapy programs**

Although opiate substitution programs (initially methadone maintenance treatment and more recently buprenorphine) are available in each State and Territory, access to programs continues to be limited in terms of scope and geography. There is also the need to create more program flexibility, and increase the range of pharmacotherapy options. Without access to best practice opioid pharmacotherapy programs, individuals who are dependent on illegal opioids such as heroin are forced to continue illegal practices, which place them at risk of criminal charges, incarceration and at risk of blood borne viruses and other health problems.

- **Heroin prescription programs**

Heroin prescription programs have been implemented in numerous countries, including the Netherlands, Switzerland and the UK. Pilot and research trials are underway in others. Evaluation of those programs suggests that shifting illicit heroin use to the health system reduces criminality and improves individuals' social functioning, and psychological and physical health.⁸⁶ Legislative and regulatory reform is required to allow currently illicit substances such as heroin, amphetamines and cocaine to be provided on prescription. Pharmacotherapy

⁸⁵ At least 11 evaluations have been conducted.

⁸⁶ Lintzeris, N. Strang, J. Metrebian, N. Byford, S. Hallam, C. Lee, S. and Zador, D. (2009). 'Methodology for the Randomised Injecting Opioid Treatment Trial (RIOTT): Evaluating injectable methadone and injectable heroin treatment versus optimised oral methadone treatment in the UK'. RIOTT Group. London.

treatment options could be expanded to include heroin prescription programs provided through existing community prescriber and pharmacy dosing models currently used for methadone and buprenorphine, or through the development of selective models.

Recommendations:

1. It is recommended that the Commonwealth Government in cooperation with the States and Territories and civil society partners **expedite efforts to roll out drug use related public health commitments** as agreed under the *National HIV Strategy* and *National Hepatitis C Strategy*. This would include:
 - (a) harmonising drug control laws to ensure they align with evidence-based, cost-effective public health policies and outcomes;
 - (b) implementing methods to further enshrine human rights protections in public health practice, particularly in relation to people who inject drugs;
 - (c) reviewing and reforming anti-discrimination laws to ensure people with a history of injecting drug use access to discrimination complaints mechanisms; and
 - (d) scaling up of corrections based BBV prevention initiatives (including access to new injecting equipment, bleach and disinfectants, evidence-based drug treatment, peer education and harm reduction information, and development of appropriate infection control standards).

2. It is recommended that the Commonwealth Government in cooperation with the States and Territories and civil society partners **develop human rights informed drug policy with the potential to increase beneficial public health outcomes** including:
 - (a) a commitment to trialling innovative interventions (with strong evaluation mechanisms), particularly where those interventions have demonstrated success in other jurisdictions and/or countries;
 - (b) funding an independent audit of the net benefits and harms resulting from current drug control laws, policies and criminal justice system practices and approaches; and
 - (c) commissioning research to provide the evidence-base for staged legislative and regulatory reform to address the issues outlined in this paper.

Legal and Discrimination Working Group Paper 6

Sex work regulation, human rights & alignment with evidence: Decriminalisation is the international best practice approach to sex work legislation

A substantial body of research illustrates the need to align criminal laws and law enforcement practices with public health objectives in relation to sex industry regulation in Australia. Sex workers have played a longstanding and pivotal role in health promotion by establishing partnerships in community health initiatives, acting as pioneers in peer education programs, enjoying one of the lowest rates of HIV/STIs in the world, and being safe sex educators of their clients.⁸⁷

In Australia, sex industry legislation has historically sought to regulate sex work under the guise of managing disease, nuisance, criminality and corruption. In various jurisdictions in Australia, sex workers can experience criminalisation, forced medical testing and police registration, with penalties including fines and imprisonment. Sex workers continue to report discrimination, stigma, human rights violations and a lack of access to justice. In their study, Harcourt and others found that legal climates continue to affect the delivery of health promotion and the occupational health and safety of workers.⁸⁸ While a range of structural, social and cultural barriers impact on the health of sex workers, Ally Daniel states that ‘the overarching factor affecting the sexual health of sex workers can be found in the legal context in which they work.’⁸⁹

Increasing international literature supports the decriminalisation of sex work by demonstrating that the best regulatory approach is a human rights approach that treats sex workers as partners in prevention and education. The research establishes that excessive regulation actively negates positive health outcomes of peer education and community health development. UN Secretary General Ban Ki-Moon states in the *UNAIDS Guidance Note on HIV and Sex Work*:

In most countries, discrimination remains legal against women, men who have sex with men, sex workers, drug users, and ethnic minorities. This must change. I call on all countries to live up to their commitments to enact or enforce legislation outlawing discrimination against people living with HIV and members of vulnerable groups...In countries without laws to protect sex workers, drug users, and men who have sex with men, only a fraction of the

⁸⁷ Janelle Fawkes, ‘Peer Education’ in Melissa Hope Ditmore (ed), *Encyclopedia of Prostitution and Sex Work*, Greenwood Press, Connecticut and London, 2006, Volume 2, 350.

⁸⁸ C Harcourt, J O’Connor, S Egger, C Fairly, H Wand, M Chen, L Marshall, J Kaldor, B Donovan, (2010), ‘The Decriminalisation of Prostitution is Associated with Better Coverage of Health Promotion Programs for Sex Workers’, *Australian and New Zealand Journal of Public Health*, 34:5 at 482.

⁸⁹ Ally Daniel (2010) ‘The Sexual Health of Sex Workers: No Bad Whores, Just Bad Laws’, *Social Research Briefs*, NSW Health, 19 at 1.

population has access to prevention. Conversely, in countries with legal protection and the protection of human rights for these people, many more have access to services. As a result, there are fewer infections, less demand for antiretroviral treatment, and fewer deaths. Not only is it unethical not to protect these groups: it makes no sense from a public health perspective. It hurts us all.⁹⁰

The UNAIDS *Report on the Global AIDS Epidemic 2010* states that ‘countries should now take action to decriminalize sex workers.’⁹¹ The Australian Government’s *Sixth National HIV Strategy 2010-2013* states that ‘Australia’s approach to HIV/AIDS has demonstrated the protection of human rights to be compatible with and *essential to* the effective protection of public health.’⁹² The Commonwealth HIV/AIDS Action Group and the International HIV/AIDS Alliance state:

Removing legal penalties for sex work assists HIV prevention and treatment programmes to reach sex workers and their clients. Rather than arresting sex workers and closing down brothels, the most effective approach to preventing HIV is to view sex workers as partners in prevention, and encourage them to engage in sexual health promotion as peer educators and advocates.⁹³

Legal frameworks

In Australia, each State and Territory administers their own sex work legislation. Broadly, these regulatory models fall into one of three legal frameworks: criminalisation, licensing and decriminalisation.

Criminalisation

Under a criminalised system, brothels, escorts and sex work may be illegal, both sex workers and their clients may be prosecuted, and sex workers may be criminalised for working with a Sexually Transmissible Infection (STI) or HIV.

Licensing

Under a licensing system, brothels and workers may be required to record their names on a police or other register, workers are subject to mandatory STI and HIV testing, and sectors operating outside licensed systems remain criminalised.

⁹⁰ UNAIDS, Joint United Nations Program on HIV/AIDS, UNAIDS Guidance Note on HIV and Sex Work, Geneva, 2009, 2.

⁹¹ UNAIDS, Report on the Global AIDS Epidemic, 2010, 137.

⁹² Australian Government Department of Health and Ageing, *Sixth National HIV Strategy 2010-2013*, Commonwealth of Australia, Canberra, 2010 at 6.4, emphasis added.

⁹³ Commonwealth HIV/AIDS Action Group and the International HIV/AIDS Alliance, *Enabling Legal Environments for Effective HIV Responses: A Leadership Challenge for the Commonwealth*, 2010, 23.

Decriminalisation

A decriminalised framework repeals criminal laws specific to the sex industry, thus removing police as regulators, and instead regulating sex industry businesses through standard planning and industrial codes, and does not single out sex workers by specific legislation. Sex work businesses are treated like other businesses, subject to existing regulatory mechanisms such as local council planning and zoning regulations, employment law, including WorkCover and taxation.

In practice, each Australian jurisdiction implements these models uniquely, and employ a mixed combination of elements of these models.

Criminalisation impedes public health objectives

Criminalisation of sex work has significantly undermined health promotion initiatives in Australia and overseas. Ally Daniel writes that criminalisation ‘has the potential to increase STI/HIV transmission rates and is more likely to increase the stigma and discrimination experienced by sex workers.’⁹⁴ The criminalisation of sex workers and associated law enforcement practices has undermined public health efforts by:

- forcing the invisibility sex workers, especially street-based sex workers, perpetuating isolation and marginalisation. Street-based sex workers are often harassed in order to suppress the visibility of sex work, while health professionals and outreach organisations report obstacles in identifying workers due to their invisibility;⁹⁵
- acting as a barrier to sex workers practising safer sex. Police have used condoms as evidence of offences to arrest sex workers, or posed as clients in cases of entrapment; and
- limiting sex workers’ ability to seek information, support and health care. In criminalised regimes such as Western Australia, studies have found that individual sex workers’ ability to seek support is severely limited by the risk of prosecution.⁹⁶ The *National Needs Assessment of Sex Workers who Live with HIV* demonstrates that laws which criminalise working with HIV engenders fear in some workers to undertake sexual health tests.⁹⁷

Models which criminalise the clients of sex workers also act as a barrier to sex workers’ health and safety. Petra Ostergren and Susanne Dodillet report that in

⁹⁴ Ally Daniel (2010) ‘The sexual health of sex workers: no bad whores, just bad laws’, *Social Research Briefs*, NSW Health, 19, 1.

⁹⁵ Christine Harcourt, Sandra Egger and Basil Donovan, (2005) ‘Sex Work and the Law’, *Sexual Health*, 2, 122.

⁹⁶ Christine Harcourt, Sandra Egger and Basil Donovan, (2005) ‘Sex Work and the Law’, *Sexual Health*, 2, 123.

⁹⁷ Elena Jeffreys, Kane Matthews and Alina Thomas, ‘HIV Criminalisation and Sex Work in Australia’, *Reproductive Health Matters* (2010), 18 (35); 129-136; Kane Matthews, *The National Needs Assessment of Sex Workers who Live with HIV*, Scarlet Alliance, 2008.

Sweden they have found:

serious adverse effects of the *Sex Purchase Act* – especially concerning the health and well-being of sex workers – in spite of the fact that the lawmakers stressed that the ban was not to have a detrimental effect on people in prostitution.⁹⁸

Criminalisation of the clients of sex workers undermines public health efforts by:

- forcing the sex industry underground. The Prostitution Licensing Authority (PLA) Queensland reports that the prohibition on the purchase of sexual services in Sweden has ‘driven the sex industry underground’;⁹⁹
- increasing sex workers’ perceptions of insecurity and fears of violence. The PLA Queensland reports, ‘sex workers feel less secure and consider themselves at greater risk of violence’;¹⁰⁰
- decreasing sex workers’ choice in selecting one’s own work and clients. Clients of street workers are predominantly targeted, thereby sex workers are denied the autonomy that comes with selecting one’s own work and clients;¹⁰¹ and
- spatial displacement of sex workers forced into working in more isolated, poorly-lit, industrial and outdoor areas, where they are in effect more vulnerable. In Sweden this has been the case for sex workers, who are worried about losing their client base.¹⁰²

In their 2011 Report from the first Asia and the Pacific Regional Consultation on HIV and Sex Work, UNAIDS and UNFPA state that:

In reality, sex workers are one of the social groups least protected by law, most harassed by law enforcement agencies and most seriously discriminated against within their communities.¹⁰³

A report by a UNAIDS NGO Delegate states that laws criminalising sex work ‘do not do not reduce the demand or the number of people selling sex.’ Rather, they

⁹⁸ Susanne Dodillet and Petra Ostergren, ‘The Swedish Sex Purchase Act: Claimed Success and Documented Effects’ Conference paper presented at the International Workshop *Decriminalizing Prostitution and Beyond: Practical Experiences and Challenges* The Hague, March 3 and 4, 2011, page 3, accessed at <http://www.petraostergren.com/upl/files/54259.pdf> on 17 May 2011.

⁹⁹ B Wallace (Principal Policy Officer), *The Ban on Purchasing Sex in Sweden*, Office of the Prostitution Licensing Authority Queensland, 19 accessed at <http://www.pla.qld.gov.au/Resources/PLA/reportsPublications/documents/THE%20BAN%20ON%20PURCHASING%20SEX%20IN%20SWEDEN%20-%20THE%20SWEDISH%20MODEL.pdf> on 11 May 2011.

¹⁰⁰ B Wallace, (Principal Policy Officer), *The Ban on Purchasing Sex in Sweden*, Office of the Prostitution Licensing Authority Queensland, 16 accessed at <http://www.pla.qld.gov.au/Resources/PLA/reportsPublications/documents/THE%20BAN%20ON%20PURCHASING%20SEX%20IN%20SWEDEN%20-%20THE%20SWEDISH%20MODEL.pdf> on 11 May 2011.

¹⁰¹ Christine Harcourt, Sandra Egger and Basil Donovan, (2005) ‘Sex Work and the Law’, *Sexual Health*, 2, 123.

¹⁰² ‘Michelle’ cited in ‘Sex Ban Puts Us at Greater Risk’, *The Guardian*, 27 May 2009, cited in B Wallace, *The Ban on Purchasing Sex in Sweden*, Office of the Prostitution Licensing Authority Queensland, 15 accessed at <http://www.pla.qld.gov.au/Resources/PLA/reportsPublications/documents/THE%20BAN%20ON%20PURCHASING%20SEX%20IN%20SWEDEN%20-%20THE%20SWEDISH%20MODEL.pdf> on 11 May 2011.

¹⁰³ UNAIDS and UNFPA, *Building Partnerships on HIV and Sex Work: Report and Recommendations from the first Asia and the Pacific Regional Consultation on HIV and Sex Work*, 2011, 14.

contribute to 'violence [against sex workers] that is largely perpetrated by law enforcement agencies.'¹⁰⁴ Kane Matthews, Alina Thomas and Elena Jeffreys note that laws criminalising sex workers living with HIV: fail to recognise that safe sex is a mutual responsibility; ignore existing public health and criminal laws that cover deliberate transmission; create a situation where sexual activities that are lawful within the wider community become a criminal act when performed by a sex workers; and do not take into account epidemiological evidence that sex workers are experts at identifying, assessing and managing different degrees of risk. This perpetuates discrimination against people who already suffer the dual stigma attached to sex work and HIV: 'Having HIV is not a death sentence and neither should it be a prison sentence.'¹⁰⁵

Licensing hinders public health objectives

Some jurisdictions in Australia have implemented licensing systems, whereby individual sex workers, agencies and brothels are required to obtain licenses to carry out their work. Licenses may require: private sex workers to work alone, without security or support; mandatory medical testing; permanent registration of one's legal name on a police register; or ban sex workers from residential areas, forcing them into industrial and isolated locations. Research shows that systems of licensing have, in effect, created a two-tiered industry, with only a small number of businesses able to meet stringent licensing requirements, and a large sector of the industry continuing to operate outside of the legal framework.¹⁰⁶

Some have argued that licensing effectively establishes a group of '*clandestinas*' who fall outside health interventions and miss targeted health programs.¹⁰⁷ Usually they only 'capture' a minority of sex industry workers.¹⁰⁸ Sex workers and businesses often avoid licensing because of the legislative burdens that they view as threatening their safety and rights. In Queensland, 11 years of licensing has resulted in only 25 brothels being registered, while the majority of workplaces operate outside the licensing system.¹⁰⁹ In NSW, research shows that 'decriminalisation has helped to ensure that the benefits gained in one sector are not denied to people working in less well-tolerated sectors.'¹¹⁰

¹⁰⁴ NGO Delegate (Asia and the Pacific) to the 2011 UN AIDS Program Coordinating Board, 'Sex Workers Fight Back', 18 April 2011, accessed at <http://unaidspcbngo.org/?p=13011challenges%20facing%20current%20sex%20worker%20advocacy%20and%20rights> on 29 June 2011.

¹⁰⁵ Elena Jeffreys, Kane Matthews and Alina Thomas, 'HIV Criminalisation and Sex Work in Australia', *Reproductive Health Matters* (2010) 18 (35); 129 at 135.

¹⁰⁶ Harcourt et al.

¹⁰⁷ Christine Harcourt, Sandra Egger and Basil Donovan, (2005) 'Sex Work and the Law', *Sexual Health*, 2, 125.

¹⁰⁸ Christine Harcourt, Sandra Egger and Basil Donovan, (2005) 'Sex Work and the Law', *Sexual Health*, 2, 126.

¹⁰⁹ Scarlet Alliance and Nothing About Us Without Us, *Submission to Shadow Attorney General Chris Haatcher on Sex Industry Regulation in NSW*, September 2010 at 6.

¹¹⁰ Christine Harcourt, Sandra Egger and Basil Donovan, (2005) 'Sex Work and the Law', *Sexual Health*, 2, 126.

Licensing issues hindering public health objectives – mandatory testing and registration

Mandatory Testing

Mandatory STI and HIV testing for sex workers is contrary to best practice models of voluntary testing outlined in the National HIV Testing Guidelines, and the National Strategies, and is not evidence based according to current epidemiology in Australia.¹¹¹ Compulsory testing creates an unnecessary and expensive burden on public health funds, leads to sex workers hiding their profession from medical service providers, jeopardises sex worker privacy, consumes resources that could be better spent on preventing high risk behaviours, and can engender a false sense of security among clients, leading to increased requests for unsafe practices.¹¹²

Australia has not recorded a single case of HIV transmission from sex worker to client, and sex workers have consistently low rates of sexually transmissible infections,¹¹³ with very high rates of prophylactic use.¹¹⁴ STI/HIV prevalence remains low among sex workers in jurisdictions with voluntary testing.¹¹⁵ There are indications that current testing rates are 'excessive',¹¹⁶ and Samaranayake et al. found that the use of resources in screening sex workers could be better spent. Peer education initiatives are highly effective with a proven track record in health promotion and prevention of STI and HIV transmission.¹¹⁷ As Harcourt et al. note:

Pressure on resources can lead to poor medical standards; including insensitive or inhumane treatment of sex workers, poor-quality examinations, and breaches of confidentiality.¹¹⁸

Registration

In jurisdictions where sex workers are required to register on a police or other database, sex workers consider this a significant threat to human rights,

¹¹¹ Australian Government Department of Health and Ageing, *Second National Strategy on Sexually Transmissible Infections 2010-2013*, Commonwealth Australia, Canberra, 2010, 6.2.

¹¹² Scarlet Alliance, *Mandatory or Compulsory Testing of Sex Workers for HIV and/or Sexually Transmissible Infections in the Australian context*, Briefing Paper for HASTI Committee of MACASHH, 1st August 2007, 1.

¹¹³ Australian Government, *National HIV/AIDS Strategy: Revitalising Australia's response 2005-2008*, Australian Government, Canberra, 2005, 19.

¹¹⁴ Roberta Perkins and Francis Lovejoy, *Call Girls*, University of Western Australia Press, 2007.

¹¹⁵ D Wilson, K Heymer, J Anderson, J O'Connor, C Harcourt and D Donovan (2009), 'Sex Workers can be Screened too Often: A Cost-Effective Analysis in Victoria, Australia', *Sexually Transmitted Infections*, October 2009.

¹¹⁶ D Wilson, K Heymer, J Anderson, J O'Connor, C Harcourt and D Donovan (2009), 'Sex Workers can be Screened too Often: A Cost-Effective Analysis in Victoria, Australia', *Sexually Transmitted Infections*, October 2009 2.

¹¹⁷ A Samaranayake, M Chen, J Hocking, C Bradshaw, R Cumming and C Fairley (2009) 'Legislation Requiring Monthly Testing of Sex Workers with Low Rates of Sexually Transmitted Infections Restricts Access to Services for Higher Risk Individuals' *Sexually Transmitted Infections*, 85:7, 540 - 542.

¹¹⁸ Christine Harcourt, Sandra Egger and Basil Donovan, (2005) 'Sex Work and the Law', *Sexual Health*, 2, 124.

confidentiality and health promotion. The obligation to register their legal name and address means that, in effect, sex workers are subject to surveillance and acquire a long-term record, which may affect their opportunities for employment, further education and custody cases. As Harcourt et al. note:

Registered sex workers are socially labelled, acquiring an official history that is not readily buried if their circumstances change. Depending on the severity of the regime, licensed sex workers may have their movements restricted, their travel documents identified and their choice of medical care limited to approved clinics.¹¹⁹

Registration creates a barrier to people working legally, as there is often low compliance. It affects the quality of health advice received because workers may not be candid with their health professional for fear of 'outing' themselves, or may actively avoid health services for fear of prosecution.¹²⁰ Registration does not improve the occupational health and safety of sex workers, but rather violates human rights to privacy, to work in an occupation of choice and to live and work free from harassment and discrimination, whilst diverting resources from wider public health projects.¹²¹ In the Northern Territory, sex workers with a drug conviction are excluded from being able to register. As an unregistered sex worker, it is illegal to work with another person, including hiring security guards or drivers, which further isolates workers from support, health and safety mechanisms. Also, law enforcement by police means that workers are less likely to report crime or seek police assistance in unsafe situations.¹²²

Decriminalisation supports public health objectives

A wide range of research clearly illustrates that decriminalisation is the most effective model for promoting public health objectives and the best practice model for the prevention of HIV and STIs.¹²³ New Zealand research verifies that decriminalisation does not lead to an increase in the size of the sex industry – rather

¹¹⁹ Christine Harcourt, Sandra Egger and Basil Donovan, (2005) 'Sex Work and the Law', *Sexual Health*, 2, 124.

¹²⁰ Jan Jordan, *The Sex Industry in New Zealand*, Ministry of Justice, Wellington, 2005.

¹²¹ Scarlet Alliance Executive Committee, *Sex Worker Registration: Privacy and Ethical Concerns*, Australian Federation of AIDS Organisations, accessed at

http://www.afao.org.au/view_articles.asp?pxa=ve&pxs=103&pxsc=127&pxsgc=139&id=582 on 11 May 2011.

¹²² Scarlet Alliance Executive Committee, *Sex Worker Registration: Privacy and Ethical Concerns*, Australian Federation of AIDS Organisations, accessed at

http://www.afao.org.au/view_articles.asp?pxa=ve&pxs=103&pxsc=127&pxsgc=139&id=582 on 11 May 2011.

¹²³ Australian Government Department of Health and Ageing, *HIV Strategy*, above n1 at 6.4; Abel, G., Fitzgerald, L., Healy, C. and Taylor, A. (eds) (2010), 'Taking the Crime out of Sex Work: New Zealand Sex Workers' Fight for Decriminalisation', Bristol, Policy Press; Harcourt, C., Egger, S., Donovan, B. (2005), 'Sex Work and the Law', *Sexual Health* 2(3) 121–8; Donovan, B., Harcourt, C., Egger, S., Fairley, C. (2010), 'Improving the Health of Sex Workers in NSW: Maintaining Success', *NSW Public Health Bulletin* 21(3-4) 74–7; Jeffreys, E., Matthews, K. and Thomas, A. (2010), 'HIV Criminalisation and Sex Work in Australia', *Reproductive Health Matters* 18(35): 129–36.

the numbers of sex workers have stayed approximately the same.¹²⁴ The Prostitution Law Reform Committee in New Zealand found that the decriminalisation of sex work meant ‘the majority [of sex workers interviewed] felt sex workers were now more likely to report incidents of violence to Police’.¹²⁵

In NSW where sex work is partially decriminalised, there are virtually undetectable rates of HIV and STIs, and no recorded case of HIV transmission in a sex industry setting.¹²⁶ A comparative study of brothels in Perth, Melbourne and Sydney found that of three Australian approaches to sex work legislation (criminalisation, licensing and decriminalisation), decriminalisation provided the best health outcomes.¹²⁷ The authors found that in Sydney where sex work was decriminalised, the outreach organisation had the ‘greatest financial support’ and the ‘best access to brothels for its outreach workers’. In comparison, in Perth where brothels were operating illegally ‘it had the lowest health and safety levels’.¹²⁸ In Melbourne, although proscriptive licensing rules had delivered greater availability of condoms, dental dams and lubricant, these ‘positive health and safety outcomes’ were ‘heavily biased toward the licensed sector’,¹²⁹ and were not available to sex workers working outside the licensed sector. Without the threat of criminal sanctions, and with appropriate anti-discrimination protections, sex industry businesses in a decriminalised framework have greater capacity to spend resources on the provision of personal protective equipment and the development of comprehensive occupational health and safety policies.¹³⁰

UNAIDS and UNFPA state that it is essential for governments to create an enabling legal and policy environment which insists upon universal rights for sex workers and ensures their access to justice.¹³¹ The UN Special Rapporteur on the Right to Health, Anand Grover recommends decriminalization of sex work in order to improve the health of sex workers. According to numerous studies, laws against sex work and associated activities increase vulnerability to HIV by fuelling stigma and

¹²⁴ New Zealand Government, *Report of the Prostitution Law Review Committee on the Operation of the Prostitution Reform Act 2003*, Ministry of Justice, Wellington, 2008, 13.

¹²⁵ New Zealand Government, *Report of the Prostitution Law Review Committee on the Operation of the Prostitution Reform Act 2003*, Ministry of Justice, Wellington, 2008, 14.

¹²⁶ Scarlet Alliance and Nothing About Us Without Us, *Submission to Shadow Attorney General Chris Haatcher on Sex Industry Regulation in NSW*, September 2010, 10.

¹²⁷ Christine Harcourt, Sandra Egger and Basil Donovan, (2005) ‘Sex Work and the Law’, *Sexual Health*, 2, 121.

¹²⁸ C Harcourt, J O’Connor, S Egger, C Fairly, H Wand, M Chen, L Marshall, J Kaldor, B Donovan, (2010), ‘The Decriminalisation of Prostitution is Associated with Better Coverage of Health Promotion Programs for Sex Workers’, *Australian and New Zealand Journal of Public Health*, 34:5 at 485.

¹²⁹ C Harcourt, J O’Connor, S Egger, C Fairly, H Wand, M Chen, L Marshall, J Kaldor, B Donovan, (2010) ‘The Decriminalisation of Prostitution is Associated with Better Coverage of Health Promotion Programs for Sex Workers’, *Australian and New Zealand Journal of Public Health*, 34:5 at 486.

¹³⁰ Scarlet Alliance, *A Guide to Best Practice: Occupational Health and Safety in the Australian Sex Industry* (2000) Scarlet Alliance, accessed at <http://www.scarletalliance.org.au/library/bestpractise> on 22 June 2011.

¹³¹ UNAIDS and UNFPA, *Building Partnerships on HIV and Sex Work: Report and Recommendations from the first Asia and the Pacific Regional Consultation on HIV and Sex Work*, 2011, 13.

discrimination, limiting access to health services and condoms and generally impacting negatively on sex workers' self-esteem, and ability to make informed choices. They keep the sex industry 'hidden'. Whilst removing criminal laws is essential, it is not sufficient to address all the legal and policy issues that lead to sex workers being arrested, abused and mistreated by law enforcement.¹³²

A decriminalised system removes barriers to HIV prevention, and increases opportunities for outreach, and capacities for peer education. Decriminalisation not only results in negligible incidences of STIs and HIV, but provides a sustainable regulatory approach to wider public health issues, including physical and emotional health, occupational health and safety, and human and industrial rights of sex workers, enhancing their capacity to engage in health promotion within the broader community. Decriminalisation supports sex worker self-determination in a manner that maximises compliance, increases transparency and reduces discrimination.¹³³ Decriminalisation also accords with Australia's whole-of-government approach to social inclusion, which aims to ensure that all Australians will have the resources, opportunities and capability to connect with people, use their local community's resources and 'have a voice so that they can influence decisions that affect them.'¹³⁴

Human rights support public health

Strong leadership is required, in line with the National Strategies, to promote the implementation of legal frameworks that evidence shows are best practice approaches to the human rights of sex workers, and removing barriers to health promotion. Research illustrates that the continued criminalisation of sex workers, particularly in relation to street-based and HIV positive sex workers, licensing regimes, police registration, use of condoms as evidence and mandatory STI/HIV testing, have adverse consequences upon health promotion in Australia. The World Health Organization acknowledges that 'Legislation criminalising prostitution-related activities has frequently been identified as a barrier to the promotion of safer sex practices'.¹³⁵ Australian research illustrates that 'health promotion for the sex industry is much easier when the target group is not covert, and is working without the daily fear of a criminal prosecution.'¹³⁶

¹³² UNAIDS and UNFPA, Building Partnerships on HIV and Sex Work: Report and Recommendations from the first Asia and the Pacific Regional Consultation on HIV and Sex Work, 2011, 15.

¹³³ Scarlet Alliance and Nothing About Us Without Us, *Submission to Shadow Attorney General Chris Haatcher on Sex Industry Regulation in NSW*, September 2010 at 4.

¹³⁴ Australian Government, Overview of the Social Inclusion Agenda, accessed at <http://www.socialinclusion.gov.au/SIAGenda/Pages/Overview.aspx> on 26 May 2011.

¹³⁵ Ministry of Women's Affairs cited in J Jordan, *The Sex Industry in New Zealand*, Ministry of Justice, Wellington, 2005 at 62.

¹³⁶ Christine Harcourt, Sandra Egger and Basil Donovan, (2005) 'Sex Work and the Law', *Sexual Health*, 2, 126.

The UN General Assembly's *Political Declaration on HIV/AIDS: Intensifying our Efforts to Eliminate HIV/AIDS* from the High Level Meeting in New York in 2011 committed to national strategies that promote and protect human rights, and intensify national efforts to create enabling legal, social and policy frameworks in each national context in order to eliminate stigma, discrimination and violence.¹³⁷ A nationally consistent approach can only be achieved with the decriminalisation of sex work across all States and Territories, and the establishment of further anti-discrimination measures to protect the human rights of sex workers. The Hon. Michael Kirby states:

We will insist on human rights for all, including for sex workers. Nothing else is acceptable as a matter of true public morality. Nothing else is sensible from the standpoint of responding to the urgent, ongoing global challenge of HIV and AIDS.¹³⁸

Recommendations:

1. The Commonwealth Government recognise decriminalisation as the evidence based model of sex industry regulation that supports effective health promotion, public health outcomes and the human rights of sex workers.

2. That a Working Party is formed between Commonwealth, State and Territory Governments and civil society to address legislative barriers to human rights for sex workers, and effective implementation of health promotion. This would include, but is not limited to:
 - a. Recognising voluntary testing as the optimum approach to HIV and STI testing and work with jurisdictions to address mandatory testing where it is in place.
 - b. Recommending the removal of registration of individual sex workers on the grounds of human rights and the barriers it creates to health promotion implementation.
 - c. Reviewing laws that criminalise sex workers with HIV and/or STIs and work with jurisdictions to recognise sex workers as a community affected by HIV and to effectively manage any individual who places people at risk in line with National Guidelines.
 - d. Addressing policing approaches, such as evidentiary use of condoms as adverse to health promotion.

¹³⁷ United Nations General Assembly, *Political Declaration on HIV/AIDS: Intensifying our Efforts to Eliminate HIV/AIDS*, High Level Meeting on HIV and AIDS, New York in 2011,

¹³⁸ UNAIDS and UNFPA, *Building Partnerships on HIV and Sex Work: Report and Recommendations from the first Asia and the Pacific Regional Consultation on HIV and Sex Work*, 2011, 14.

3. Review anti-discrimination protection coverage for sex workers and create nationally consistent coverage that supports the reduction of stigma and discrimination.

Legal and Discrimination Working Group Paper 7
Removing Legislative and Policy Barriers to NSP and Injecting Equipment Access:
Increasing access to injecting equipment is a national priority

The National Hepatitis C Strategy 2010-2013 identifies the need to increase access to new injecting equipment among people who inject drugs as one of the Strategy's main priority objectives.¹ Improving access to, and the availability of, new injecting equipment in order to reduce the transmission of HIV and viral hepatitis is also identified as a priority action in the National HIV, National Hepatitis B and the National Aboriginal & Torres Strait Islander Strategies 2010-2013.²

These National Strategies on blood borne viruses (BBVs) and sexually transmitted infections (STIs) comes at a time of far reaching and unprecedented reform to the Australian health system. Central to these reforms is a renewed focus on prevention and improving access to primary health care particularly for highly marginalised populations.³ In this context, this paper aims to outline the current legal and policy barriers to Needle & Syringe Programs (NSP) and new injecting equipment access for people who inject drugs, and identifies opportunities for improving access to prevention and primary health services for this group.

Why is removing legal and policy barriers to NSP and new injecting equipment so important?

NSP save lives and money:

The evidence demonstrating both the effectiveness and cost-effectiveness of NSP is extremely strong in relation to HIV and hepatitis C prevention. Between 1990 and 2000 it was estimated that NSPs had prevented at least 25,000 HIV and 21,000 hepatitis C infections with between \$2.4 and \$7.7 billion saved in prevented health and social costs.⁴ Building on these results, a more recent study in 2009 found that for an investment of \$243 million between 2000 and 2009, the Government had saved \$1.28 billion in short-term health savings - a cost benefit of \$4 saved for every \$1 invested.⁵

The rate of new HCV infections is unacceptably high:

Despite the evidence of the effectiveness of NSP in preventing HIV and other BBVs, hepatitis C remains one of the most commonly notified diseases in Australia. The National Hepatitis C Strategy 2010–2013 estimates that 284,000 people had been exposed to hepatitis C in Australia at the end of 2008, with an estimated 212,000 people with chronic hepatitis C, and up to 10,000 new infections occurring annually.⁶ It is estimated that almost 90% of new infections and 80% of existing hepatitis C infections are attributed to unsafe injecting drug use practices, such as reusing needles and syringes.⁷

Some vulnerable groups of people are at greater risk:

The rates of hepatitis C infection among Indigenous injecting drug users (IDU) are between 3 and 13 times higher than the non-Indigenous IDU population with rates varying between jurisdictions and age groups.⁸ Rates of HIV infection are also increasing among Indigenous people who inject drugs, with 22% of new HIV infections among Aboriginal & Torres Strait Islander people attributed to unsafe injecting drug use practices (compared to 3% for non-Indigenous cases).⁹ HIV prevalence has also increased among new prison entrants,¹⁰ and previous incarceration has been found to be an independent risk factor for hepatitis C infection.¹¹

Distributing more equipment can reduce HCV risk:

Recent modeling work suggests that there may be a direct correlation between the numbers of needles and syringes distributed and reduction in hepatitis C infections. This research indicates that a doubling of the number of needles and syringes currently being distributed would achieve a halving of the number of new hepatitis C infections.¹² In the alternative they suggest a one-third reduction in the availability of new injecting equipment, could lead to a three-fold increase in the incidence of hepatitis C.¹³

Current programs have not eliminated the need to reuse injecting equipment:

Strategies for effectively addressing the continued transmission of BBVs associated with injecting drug use also need to be considered in the light of recent evidence on the rates of unsafe injecting practices among people who inject drugs. The Annual NSP Survey shows that the rate of people reusing needles and syringes in the month prior to the survey has remained stable at 25-28% over the past 5 years, indicating the need to undertake more focused efforts to remove remaining barriers to NSP access, and to expand peer education activities among people who inject drugs.¹⁴ Research has also shown that people accessing injecting equipment through pharmacy-based schemes report a higher rate of needle and syringe reuse than those accessing NSP outlets.¹⁵ The urgent need to increase needle and syringe distribution levels is also highlighted by recent research estimating that up to 50% of all injections are currently occurring with used injecting equipment.¹⁶

Access to information and equipment is urgently needed among people new to injecting:

Knowledge of hepatitis C transmission is low among the general population and those 'at risk' of injecting. Research with young people attending music festivals show that approximately 25% have been exposed to injecting in the previous 12 months (ie had a boyfriend/girlfriend/friend who injects or been offered an injection). The knowledge of this group was no better, and lower on some items,

than those who did not have contacts with people who inject.¹⁷ Furthermore, the majority of young people did not know where to access injecting equipment. People new to injecting typically do not access services for information or equipment, but rely on others to provide these.¹⁸ Hence, as the risk of acquiring hepatitis C is highest in the first years of injecting,¹⁹ there is a need to provide those who are new to injecting with sterile equipment, and up to date information about prevention and risk.

One important way to distribute equipment remains illegal:

Despite evidence of high rates of equipment reuse, in the majority of States and Territories of Australia it is illegal for a person not authorised to distribute injecting equipment to provide such equipment to another person. Despite these laws, peer distribution of injecting equipment is widely practiced and constitutes an important strategy in addressing barriers to access, and reducing the need to reuse equipment. Recent national research found that onward supply (peer distribution) of needles and syringes (in the month prior to survey completion) was reported by 37% of participants nationally, with prevalence of 30% or more occurring in all States and Territories.²⁰

In addition to legislative restrictions, the majority of NSP have introduced strict limits on the amount and types of equipment individual clients can access each visit and/or per week. These limitations reduce the capacity of people to employ best practice BBV prevention, and largely relate to policy and budgetary constraints, whereby the demand for equipment is grossly outstripping supply. The urgent need to increase needle and syringe distribution levels is also highlighted by recent research estimating that up to 50% of all injections are currently occurring with used injecting equipment.²¹

Placing Barriers to NSP and Injecting Equipment Access in Context:

There are a range of complex and interrelated factors that together have informed the current legislative and policy approach to NSP and injecting equipment access and, have created and/or served to reinforce current barriers to access including:

1. **Negative Attitudes to Injecting Drug Use/Drug Users** - the fact that injecting drug use is illegal forms the backdrop to many of the barriers to accessing NSP and new injecting equipment for people who inject drugs. Illegality and criminalisation associated with injecting drug use leads to high levels of stigma and discrimination, and a strong moral abhorrence against people with a history of injecting drug use.²² Research examining hepatitis C related discrimination has demonstrated that poor attitudes towards people with a history of injecting drug use creates barriers to accessing critical health and

social services.²³ In particular, concerns about being identified as a person who injects drugs and resultant stigma and discrimination have been identified as common barriers to accessing NSP.²⁴ While the position of injecting drug use remains so highly stigmatised, there is a need to provide users with a range of options to accessing injecting equipment to respect and facilitate people's preferences for access.

2. **Inconsistent Application of Evidence in Policy Making** - attitudes towards people who inject drugs can also affect the way services associated with illicit drug use such as NSP are perceived by both the general community, policy makers, and even other parts of the health system.²⁵ Negative perceptions and incorrect assumptions about NSP, including that they promote drug use or lead to increases in injecting drug use and public discarding of used injecting equipment, have at times led to poor policy and legislative decisions that lack an evidence base.²⁶ The closure of NSP outlets,²⁷ laws preventing peer distribution of equipment,²⁸ the removal of access to certain types injecting equipment,²⁹ and the absence of NSP in Australian prisons,³⁰ are examples of non-evidenced based decision making that have created barriers to accessing NSP and new injecting equipment.
3. **Concerns About Public Opinion Can Generate Risk Aversion in Policy Decisions** – current drug laws and the associated negative attitudes towards injecting drug use has led to NSP being viewed as a politically sensitive public health initiative.³¹ Research has demonstrated a strong link between public opinion and the political process particularly in relation to illicit drugs policy.³² Concerns about NSP generating negative community or political attention and negative portrayals of NSP in the media have led to a focus on 'risk aversion' in relation to NSP policy and legislation.³³ Although maintaining a low-profile for NSP has invariably been driven by a genuine commitment to protecting the program, there have been unintended negative consequences such as barriers to access due to inadequate information on service availability, and a legal and policy environment that has been largely unresponsive to reform. Despite the perception that NSP are politically sensitive, they have also been the recipient of more than 20 years of bipartisan political and ongoing community support.³⁴
4. **The Legislative and Policy Environments are Complex and Multifaceted** – managing any potential process of reform will be challenging in relation to NSP largely due to the complex and layered nature of the legislative, policy and service delivery environment. Some of the main legal and policy mechanisms that have an impact on the planning, development and

implementation of NSP and in providing access to injecting equipment include international obligations, Federal, State and Territory legislation and policies and local area and service level policies and procedures. In addition to the health system, Federal, State and Territory policing guidelines and operational procedures, and local government by-laws also impact on the development and provision of NSP. In seeking to identify and address legislative and policy barriers to accessing NSP and injecting equipment, it will be necessary to address the challenges presented by this complex network of stakeholders, relationships and obligations.

What are the Main Legislative and Policy Barriers to NSP and Injecting Equipment Access?

Legislative Barriers:

- 1. Peer Distribution of Injecting Equipment is Effective, but Illegal** – Peer distribution of injecting equipment is an effective, convenient, and cost-effective method of increasing access to new injecting equipment.³⁵ Peer distribution can be particularly effective and important for highly marginalised IDU with over 25% of participants in a study on ‘secondary (peer) exchange’ identifying as Aboriginal or Torres Strait Islander.³⁶ Currently peer distribution is either directly or indirectly legislated against in all States and Territories (other than Tasmania), although the detail of the legislation, including any available defences, varies between jurisdictions. Even if the legislation in a particular jurisdiction does not specifically state that unauthorised distribution is an offence, if an unauthorised person does provide injecting equipment they could be prosecuted under a complex network of associated laws and regulations in relation to the use illicit drugs including: possession and supply of equipment for use in the self-administration of a prohibited drug; aiding and abetting the administration of a prohibited drug; and in the case of fatal overdose, there may be a risk of prosecution for manslaughter.³⁷ The fact that people are not being charged and prosecuted for peer distribution is often used as a reason to ‘leave well enough alone’. However, the concern is that current legislation on the supply of injecting equipment leaves people who inject drugs at the mercy of police discretion, which can include harassment, searches and confiscation of bulk injecting equipment. Perhaps most importantly, as long as the current legislative prohibitions against peer distribution of injecting equipment prevail, NSP and health departments will refrain from utilising and developing a highly effective and cost-effective method of increasing access to equipment, education and improving health outcomes for people who inject drugs.

Recommendations:

- a) Review and repeal specific legislation in each jurisdiction prohibiting peer distribution of injecting equipment.
- b) Review of unintended negative impacts of associated legislation including self-administration, and aiding and abetting legislation on peer distribution of injecting equipment.

2. **Access to New Injecting Equipment in Prisons** - there is clear and uncompromising research evidence that Australian governments must improve their response to drug use and BBVs in prisons. Research argues that the *“rationale for establishing syringe exchange programs in prisons is even stronger than in communities”*,⁴⁹ and many eminent individuals and organisations are now publicly supporting a trial of NSP in Australian prisons.⁵⁰ Within Australian prisons, one-third of all male and two-thirds of all female prisoners have Hepatitis C,⁵¹ and the rate of Hepatitis C in prisons is 40 times higher than the general community.⁵² Despite these rates, NSP are not currently available in any Australian prisons. It has been argued that the lack of access to new injecting equipment for prisoners is in breach of Australia’s obligations at international law.⁵³ WHO Guidelines on HIV/AIDS in prisons states that *“all prisoners have the right to receive health care equivalent to that available in the community without discrimination”*.⁵⁴ Evaluations of overseas programs have demonstrated high syringe return rates, no increases in illicit drug use and no documented attacks or violence associated with the programs.⁵⁵ The National Hepatitis C Strategy 2010-2013 has acknowledged the need for jurisdictions to explore opportunities to trial NSP in Australian prisons.⁵⁶ Implementation of NSP in Australian prisons will need to balance the human rights of prisoners and the right to a safe working environment for prison staff. Existing overseas programs show this to be achievable.⁵⁷ Access to new injecting equipment in Australian prisons remains a matter of policy and political will, with no primary legislative barriers preventing implementation.

Recommendations:

- c) All jurisdictions to implement NSP in prisons in line with available evidence and as part of a comprehensive approach to BBV prevention among prisoners.

3. **Local Council Development Applications for New NSP Outlets Can Create Barriers to Access** – in most jurisdictions local councils form an additional regulatory layer that often has a significant degree of impact on access to

NSP and injecting equipment. Local planning processes dictate not only the length of time an NSP planning application can take to process, but whether new fixed or outreach-based services can be established at all. Cumbersome local planning laws and regulations, councilors with limited expertise in health services planning, ideological, political and moral objections and the ‘not in my backyard’ syndrome in relation to NSP are among some of the main barriers to services implementation at the local level.⁴⁰ Even if local council planning requirements do not directly result in decisions to prevent the establishment of new NSP services, lengthy delays in negotiations and approvals can significantly impact on the ability of communities to respond to local health needs, and changes in drug use trends and patterns.

Recommendations:

- d) Review relevant legislation and policy to improve the regulatory processes in relation to NSP service planning and approval at the local level; and
- e) Strengthen partnerships between local councils, police and neighbourhood drug action teams to support greater understanding and support for NSP services.

4. **Unsafe Disposal of Used Injecting Equipment Can Threaten the Existence of NSP**— a review of current policy and legislation in relation to the disposal of used injecting equipment highlights major inconsistencies across the country. In some jurisdictions inappropriate disposal is classified as ‘aggravated littering’ and illegal to dispose in the household waste, while in other jurisdictions disposal in the household waste is ‘discouraged’ but not illegal per se. In a number of other jurisdictions, offences can range from failure to dispose, to littering and failing to ‘adequately’ dispose. In some jurisdictions disposal of used injecting equipment in the household waste is legal. The inconsistencies across the States and Territories in relation to what constitutes safe disposal of used injecting equipment is problematic, as people who inject drugs move between jurisdictions in the same way as other members of the community. Research has shown that people who inject drugs take the issue of safe disposal very seriously, but that inconsistencies in legislation and policy can create barriers to the safe disposal of equipment.³⁸

The political environment surrounding NSP demands that laws in relation to the safe disposal of injecting equipment are clear and unambiguous. Any confusion on the part of people who inject drugs about expectations and standards in relation to safe disposal could result in the unintentional inappropriate disposal of used injecting equipment and an associated

decrease in community support for the continued existence of NSPs. As demonstrated above, program closures lead to reduce access to new injecting equipment which in turn increases the risk of BBV transmission and other injecting related health problems for people who inject drugs. Uncertainty created by conflicting laws on safe disposal can also result in people not returning used injecting equipment to the NSP or pharmacy due to fear of arrest. This can restrict access to new injecting equipment if the returning of used equipment is a pre-condition for being able to access to new injecting equipment free of charge (see section below on 'Cost Recovery').

Recommendations:

- f) Review and repeal policy and legislative inconsistencies in relation to safe disposal in all jurisdictions and ensure IDU are properly informed of any changes.

5. Concerns about Mandatory Reporting Can Create Barriers to Accessing NSP

- staff of health services are duty-bound to report children under 16 years of age and young people they perceive to be 'at risk', including risks associated with a parents'/carers' drug use.³⁹ Considerations of 'risk' are usually based on the worker's observations and knowledge of the young person's situation, but the nature of the obligations under relevant legislation (and policy) can lead to concerns about the latitude given to NSP workers to 'interpret' individual situations. Concerns about mandatory reporting requirements can create barriers to accessing NSP for some of the most marginalised IDU including young people, women with children and pregnant women. While monitoring and reporting of young people at risk when assessed and managed appropriately may be of positive benefit, consideration needs to be given to the unintended consequences of 'mandatory' reporting in the NSP setting.

Recommendations:

- g) All NSP staff to be provided with training on risk-benefit analysis in relation to mandatory reporting requirements, BBV prevention and building and maintaining positive client/staff rapport with a highly marginalised clientele; and
- h) Review and address the potential for mandatory reporting requirements to directly and indirectly impact on access to NSP and injecting equipment.

Policy Barriers:

Australia enjoys the success of a public health approach to BBV that has been supported by government investment at all levels for over 20 years. However, these areas where enhanced investment in best practice could achieve greater returns in terms of BBV prevention. Further, some policies and practices may create unanticipated barriers to optimal use of NSP.

- 1. Limits on the Amounts and Types of Equipment Available** – although most jurisdictional NSP policies ensure a minimum standard of equipment access, there is no consistency in relation to maximum amounts, and increasingly there is evidence of limits being placed on the amounts and types of equipment available at NSP per visit/per week.⁴¹ NSW is the only jurisdiction with an outright ban on certain injecting equipment.⁴² Not only are these policies counter-intuitive to the principles of client-centred service delivery and efforts to prevent BBVs, policy-determined limits on equipment often seem ad-hoc and vary between jurisdictions, health areas and even individual services. To optimise the effectiveness of the NSP in preventing transmissions of BBVs, the amounts and types of injecting equipment available through NSPs should be informed by available evidence on the needs and injecting behaviours of people who inject drugs. Further, the optimal distribution of equipment in line with best practice will, in turn, require ongoing and perhaps enhanced investment in NSP services.
- 2. User Pays/Cost Recovery Systems** – At least four jurisdictions currently charge for some injecting paraphernalia other than 1ml needles and syringes, and a growing number of jurisdictions operate equipment vending machines. Some NSP have daily limits which when reached will result in the individual being charged for additional item(s), and others have certain items that are only provided on a user pays/cost recovery basis. Even within these systems there are sometimes upper limits on the amounts which can be purchased. The majority of pharmacy schemes provide a limited range of equipment at a cost set by each pharmacy and largely unregulated. Pharmacies and some NSP will provide a limited amount of equipment free of charge if used equipment is returned at the same time, but the returning of equipment is not always encouraged and people may be fearful of attracting police attention when carrying used equipment. While budgetary constraints are cited as the main policy drivers of cost recovery systems, research shows charging for equipment has the greatest impact on the most marginalised drug users.⁴³ While there is strong evidence of the cost-effectiveness of NSP in Australia, there are direct costs for individual users that operate as

barriers to use of sterile injecting equipment. Distribution of equipment at free or very low cost may enhance access to NSP and pharmacy services. This may, in turn, require an enhanced investment in these services.

3. **Protocols Governing Police Presence at NSP** – police support for harm reduction services is critical to creating an enabling legislative and policy environment. All jurisdictions have guidelines for police in relation to attending NSP services and there is a formal policing commitment to harm reduction through the National Drug Strategy.⁴⁴ Police actions can be one of the strongest determinants of whether a person will access NSP. While no NSP can be a ‘no go’ area for police, discretionary policing such as minimising patrols and personal checks within the vicinity of NSP, not arresting peer educators conducting their role and not arresting people who are only found with injecting equipment can reduce barriers to NSP access.⁴⁵ However, the current reliance on discretionary guidelines can mean they are sometimes inconsistently applied. This can result in certain individuals, particularly people who are ‘known to police’ being targeted when going to or from NSP, having their injecting equipment confiscated or used as evidence of drug use. These types of police actions are counterproductive to the purpose of existing guidelines, and to harm reduction more generally, because it can increase the risks to individuals and the community. Research shows that police activity targeting NSP sites and people who inject drugs leads to declines in the number of clients using services, increased risky injecting practices, increased numbers of clients in other sites, and drug users being reluctant to engage generally.⁴⁶ Policing guidelines in relation to NSP and harm reduction services therefore need to be routinely monitored to ensure optimal implementation in relation to both policy and practice. Further, the strengthening of relationships between NSP and local level policing services may avoid negative outcomes for all parties, including service users.

4. **Data Collection at NSP** – all NSP routinely collect personal and service related information from clients. However, the nature and scope of the data collected varies considerably between jurisdictions and even between services. The range of data includes personal identification codes, equipment dispensed and returned, gender, ethnicity, drug use, injecting practices and service usage information. Research has identified a lack of understanding by jurisdictions about the purpose, relevance and intent of some performance information, which can result in varying interpretations of what data should be collected.⁴⁷ Clients are unsure about the voluntary nature of the information requested, and for some concerns about the purpose and use of the data collected can act as a barrier to service access.⁴⁸ Given the public

nature of the majority of NSP service reception areas, questions remain about how current data collection protocols meet health records and general privacy legislation, and standard research ethics requirements. In summary, data collection policies in NSP should be reviewed in relation to privacy legislation requirements and research ethics standards including confidentiality, informed consent and data relevance.

Summary:

This paper highlights the unintended consequences of legislative and organisational frameworks that may hamper efforts to prevent BBV and promote engagement of people who inject drugs with primary health services. Cost-effectiveness is important and efforts to enhance the return on investment made in NSP will be hampered by barriers existing in other domains. Current budgetary frameworks do not allow for current spending (such as removing limits on equipment distribution) to be offset by future savings in other areas (such as reduced costs of clinical care for people with hepatitis C-related liver disease).

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