To Test or Not to Test?
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The issue of whether sex workers should be tested on a compulsory basis for HIV and other STIs (sexually transmitted infections) and if this should be legislated for has been an issue of much contention and debate since the first laws were enacted to control the sex industry.

It appears that the first legislative response to the fear of STIs spreading to the general community through sex workers occurred in Europe in the mid 1500s as a response to the syphilis epidemic. It was then that the venereal nature of the disease had been recognised and combined with the moral fervor of the various sixteenth-century reformers lead to a reaction against prostitution. Although, rather than enact STI specific legislation aimed at the sex industry, the response was to widen regulations on prostitution related activities per se. In 1536 the Imperial Diet of the Holy Roman Empire issued an edict that prohibited all concubines or other extramarital sex relations such as prostitution. An edict of 1530 in Frankfurt provided for fines for those caught with a sex worker; in London brothels were closed in 1546 and in Paris in 1560[1]. The punishment imposed on sex workers were severe and included for example in France being paraded through the town with a label indicating that the woman was a sex worker, then being made to undress, placed in an iron cage and dunked into a river three times, the woman remaining under water until she was nearly but not quite drowned. She was then taken to serve the rest of her sentence in jail.

Legislation which was contagious diseases specific (rather than regulating forms of prostitution) and linked to sex work appear in England through the passage of the *Contagious Diseases Acts* in 1864, 1866 and 1869. These were intended to root out STIs among men in the army and navy. It provided for the compulsory examination of sex workers in British naval ports and garrison towns[2]. If they were found to be infected they were detained in lock hospitals for a period of up to nine months. While in the lock hospitals sex workers were given moral and religious instruction, and lessons in personal hygiene and domestic labour[3]. Inspection of defence force men was considered unnecessary since it " would be extremely unpopular to the well-conducted and steady men."[4] The demarcation between sex workers and clients thus constructed the sex worker body as diseased and dangerous, and the client body as reacting to an uncontrollable natural urge and in need of protection. This construct symbolises a recurring theme in the role of sex workers and clients in the sex industry which continues to this day and is particularly reflected in sex work legislation which places a greater onus on sex workers to be free of STIs but not clients.

The Australian colonies of Queensland and Tasmania followed the British example and enacted *Contagious Diseases Acts* in 1868 and 1879 respectively. The rationale (just as in Britain) being to protect military personnel and like the British Acts

[1] Bullough, V., 1987. Women and Prostitution: A Social History, pg. 152. Prometheus Books, Buffalo New York.
[2] Roberts, N. 1992. Whores in History, pg. 246. Harper Collins, London.
[3] Bell, S. 1994. Reading, Writing and Rewriting the Prostitute Body, pg. 57. Indiana University Press, Bloomington and Indianapolis.
[4] Op cit pg.58.

contained provisions for compulsory examination of sex workers and incarceration in lock hospitals. In Queensland there were further provisions to register all sex workers[5].The Queensland Act was not repealed until 1971.
In Western Australia, whilst contagious diseases legislation was not enacted, sex workers were required to undergo medical examinations in the 1890s at police discretion. In Victoria, selected magistrates were in collusion with police to ensure that sex workers who were suspected of being diseased by *police* were given maximum gaol sentences[6]. So, whether, the state had legislative power or not in relation to sex workers and their STI status, sex workers were labeled as diseased (even by police) and forced to undergo STI checks.

Legislative, public policy and societal responses to the issue of sex work in Australia and its prioritisation as a public policy issue has shifted from decade to decade since the second world war for a variety of reasons. Variously these have been influenced by such elements as the changing role of men and women, the changing nature of work and related employment levels, changing political philosophies, influence of feminist discourse, and sex worker organisation activism[7]. Concurrently the emphasis placed on sex workers as diseased and a response veiled under the notion of public health threats has also undergone shifts in thinking and public policy response.

In the post war period South Australia passed a venereal diseases Act in 1947 simply to come into line with the rest of the states. At this time there was little interest in STIs as there was a dramatic decrease in the levels of STIs (especially syphilis and gonorrhea) with the introduction of penicillin in the 40s[8]. Nonetheless, whilst legislation targeted specifically at sex workers was not introduced during this period; clients and their families were seen as innocent victims of venereal disease and sex workers as the vectors.

During the period between the mid 50s to the late 60s the public discourse on prostitution shifted and as did laws regulating prostitution, with the resultant focus on law and order issues rather than disease. Criminal sanctions were introduced especially on street solicitation, procuring and living off the earnings of prostitution. Brothels in Western Australia and Queensland were closed down.
From the early to mid seventies this trend continued with increased criminal sanctions against the industry.

The next period of focused activity in relation to STI legislation specifically targeted at sex workers occurs as a response to fears of HIV/AIDS in the mid 1980s to early 90s. In NSW, to this day legislation does not require sex workers to undertake mandatory STI testing, but under the *Public Health Act 1991* (NSW), sex workers are required to inform their clients if they have an STI and must get consent from the client. What is unusual here is that it is the operator of the premises who is held liable if this does not occur[9]. Condoms can still be used as evidence to prosecute sex workers in premises 'held out' as being for massage.

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[5] Sullivan, B. 1997. The Politics of Sex: Prostitution and Pornography since 1945, pg. 21-23. Cambridge University Press, Cambridge.
[6] Op cit., pg. 25.
[7] For a comprehensive discussion of some of these shifts see B. Sullivan, Op cit.
[8] Op cit., pg. 46-47.
[9] *S.13 (2), s. 13(3) & s.13 (4) Public Health Act 1991* (NSW)

In the Northern Territory under the *Prostitution Regulation Act 1992* (NT) the only reference to STIs is that certificates of attendance at STI clinics cannot be used to induce clients to believe that the sex worker is free of STIs[10]. In his Tabling Statement the Attorney-General acknowledged that implementation of a mandatory system of testing for STIs would discourage sex workers from co-operating with health authorities and encourage clients to avoid taking precautions to protect themselves against infection[11]. In order for escort agency operators to obtain an escort agency license they must attend a face to face meeting with the Prostitution Licensing Board. The operator is questioned on their knowledge of health and safety issues in the workplace, work contracts, knowledge of the Prostitution Act, and general business practice issues and based on their response the board decides whether to grant the applicant a license or not. The operator's license states that operators must take all reasonable steps to ensure that persons providing sexual services do so in a safe manner and that prophylactics are used for all services. Operators should not discourage the use of prophylactics and they must distribute educational material on safe sex practices to workers at the direction of the Escort Agency Licensing Board[12].

With the introduction of the *Prostitution Act 1992* in the ACT, we encounter for the first and only time an offence related to providing or receiving commercial sexual services without the use of prophylactics[13], and whilst this element of the legislation is hard to police, it has served as an empowering tool for sex workers to insist on the use of prophylactics. The legislation does not make it explicit that sex workers ought to be mandatorily tested for STIs, but provisions cover the need for sex workers to 'take reasonable steps' to ensure that they are free of STIs[14], and brothels operators/employers to also take reasonable steps to ensure that sex workers are free of STIs[15]. It is unlawful to provide or receive services whilst infected with an STI including HIV/AIDS[16] and in addition certificates of attendance for STI screening cannot be used to induce others to believe that a sex worker is free of STIs[17]. Many have interpreted the "reasonable steps" provisions which apply to sex workers, and operators as implying mandatory testing[18]. I argue that without a court determination on this issue, 'reasonable steps' for a sex worker could mean accessing the latest information on safe sex practices, knowing how to use prophylactics correctly, checking clients for visible signs of STIs, practising safe sex and regularly attending STI screenings on a voluntary basis. For operators, it means providing sex workers and clients with the latest safe sex information and adoption of a compulsory prophylactic policy and a condom breakage and slippage policy[19].

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[10] *s.9 Prostitution Regulation Act 1992* (NT). This equally applies to sex workers and clients.
[11] Northern Territory Parliamentary Record, 6 December 1990:132.
[12] Operator's License s 1 (a), (b) & (c). Appendix 1, Fifth Report on the Operation of the *Prostitution Regulation Act* 9 May 1996-8 May 1997, pg. 9.
[13] *S.18 Prostitution Act 1992* (ACT).
[14] *S. Prostitution Act 1992* (ACT).
[15] *S. Prostitution Act 1992* (ACT).
[16] *s. Prostitution Act 1992* (ACT).
[17] *s. Prostitution Act 1992* (ACT).
[18] see Sullivan, B 1997. The politics of Sex, pg. 206-207.
[19] Scarlet Alliance policy, developed in 1997.

In Victoria, permitting a sex worker infected with a disease to work in a brothel is unlawful[20] as it is for a sex worker to work while infected with a disease[21]. It is unlawful to work with HIV[22]. There is a further requirement that sex workers take monthly swab tests and three monthly blood tests for STIs. If charged with working with an STI, having these tests are used as evidence that the worker did not know that they had an STI. Inadvertently this is compulsory testing through the backdoor as sex workers are forced to undergo testing to ensure that they are covered in the likelihood of . A proprietor must supply educational material on STIs and safe sex to clients and sex workers and they must provide safe sex tools[23].

In Queensland, whilst it is not unlawful for sex workers to work with an STI, there is a requirement for them to disclose their STI status to prospective sex partners. In sentencing an offender who is a sex worker or a client for being found on premises reasonably suspected of being used for prostitution, the court may in mitigation of sentence, have regard to evidence of an appropriate health check undergone within three months before the offence[24]. Condoms, lubricants and other safe sex material cannot be used as evidence that a place is used for prostitution[25].

In Tasmania there is no specific sex worker connected STI legislation, but under the Public Health (Notifiable Diseases) Regulations 1989, sex workers as other sexually active people have to inform prospective sexual partners that they have an infection.

In South Australia STI legislation which is specific to the sex industry does not yet exist, but it is an option in a number of legislative proposals which have come out of the Parliamentary Inquiry into Prostitution[26]. Included in the proposals are provisions on brothel and escort agency operators ensuring that sex workers are free of STIs, that knowingly transmitting an STI ought to be an offence (this applies to sex workers only), operators must provide prophylactics and STI free status cannot be used as an advertising tool. Current practice in SA is sensible in that when concerns have been raised about a sex worker being HIV positive (this was done by the police), she was spoken to face to face by officers of the health department, who questioned her on her knowledge of safe sex, as well as what services she was providing. Her responses (that she had been working a very long time and had a high level of knowledge of safe sex and that she was providing massage and relief services) were enough to assure the Health Department officer that she did not pose a threat to the public.

Whilst currently in Western Australia, sex workers are not singled out under legislation, elements of the "Guidelines for the management of HIV infected individuals who put others at risk" have been used to prevent HIV positive sex workers from working in the industry. Western Australia is one of the jurisdictions which is currently looking at altering their prostitution laws and a number of very concerning issues have been raised in relation to the upcoming Prostitution Bill. This includes the prohibition of HIV + sex workers from working in the industry, this

[20] *s.19 Prostitution Control Act 1994* (Vic)
[21] *s.20 Prostitution Control Act 1994* (Vic)
[22] *Prostitution Control Regulations 1995* (Vic)
[23] *s. 9 Health (Brothels) Regulations* 1990 (Vic)
[24] *s. 229I Criminal Code* (Qld)
[25] *s.229N Criminal Code* (Qld)
[26] Inquiry into Prostitution.

would also apply to clients seeking the services of a sex worker, sex workers cannot work whilst infected with an STI and brothel operators will be expected to ensure that sex workers do not work whilst infected with an STI. It is suggested that the Prostitution Control Board (PCB) will develop a code of practice on the frequency and content of health checks, that it should have powers to introduce mandatory testing at any time through regulations and for discretionary powers to require a sex worker to present for a medical examination if the board has reason to suspect that a sex workers has an STI. It is proposed that individual sex workers be handed identity cards and in order to acquire one of these the sex worker will have to prove HIV free status [27].

Having provided a picture of the historical legislative "othering" of sex workers as diseased, I now want to pose the following question: Is this response justified and should sex workers be compulsorily tested for HIV and other STIs as a public health measure, what purpose does this serve and what are the alternatives?

I argue that there is no factual basis for forcing sex workers to be tested and that the only outcomes served by this approach is the continual scapegoating of sex workers as diseased in the eyes of the general community, construction of sex workers as criminally minded and a denial of their basic civil liberties.
Numerous studies have shown that sex workers enjoy better sexual health than the rest of the community [28]. For example there is no documented case of a female sex worker receiving or transmitting HIV infection during a transaction with a client[29]. In relation to STIs, data from Clinic 275 in Adelaide over the period 1987-1994, show the following figures for infection attributed to sex workers compared with other female attendees of the clinic.

Table 1: Sex Workers & Notifiable Diseases[30]

	Syphilis	Gonorrhoea	Chlamydia
Sex Worker	0	22	21
Total Female Cases	324	640	4267

These figures indicate that sex workers have such low rates of STIs that they are unlikely to be a major source of transmission to the general population and correlate

[27] Briefing Note: Prostitution Control Bill 1998, prepared by Acting Sergeant J Davis, WA Police Service Legal Services.
[28] Campbell, C. (1991). *Prostitution, AIDS and Preventative Health Behaviour.* Social Science and Medicine, 32(12), 1367-1378.
Donovan, B & Harcourt, C. (1996). *The Female Sex Industry in Australia: a health promotion model*. Venereology, 9 (1):63-67.
Pyett, P., Haste, B., & Snow, J. (1996). *Risk practices for HIV infection and other STDs amongst female prostitutes working in legalised brothels*. AIDS Care, 8 (1), 85-94.
Vanwesenbeek, I., de Graaf, R., van Zeesen, G., Straver, C. & Visser, J. (1993). *Condom use by prostitutes: behaviour, factors and considerations*. Journal of Psychology and Human Sexuality, 6, 69-91.
[29] Harcourt, C. (1994). *Prostitution and public health in the era of AIDS*. In Perkins et al. 1994:203-224.
[30] Parliament of South Australia, Inquiry into Prostitution Final report, Aug 1996, pg. 91.

with figures of male clients attending the same clinic and reporting sex with a sex worker as a possible source of their infection (see Table 2).

Table 2: Males reporting a sex worker as the source of a notifiable STI 1987-1994.[31]

	Syphilis	Gonorrhoea	Chlamydia
Males reporting sex with a sex worker	0	27	20
Total cases diagnosed	25	1221	2447

In a comparative study of Sydney sex workers in 1985-86 and 1990, Lovejoy et al report that the proportion of sex workers always using condoms with clients has risen from 69.5% (Perkins, 1988) to 95.4%[32]. A similar figure (96.7%) is reported for workers in legal brothels in Melbourne in 1994[33].

It is in the best interests of sex workers to remain free of STIs since having an STI means time off work and that means inability to earn an income. The other great motivator for sex workers is that they view the use of a condom for oral, vaginal and anal sex as representing an emotional barrier with respect to their clients. What has been ignored and rarely addressed is the risk of STIs and HIV being passed on to sex workers from clients. It has been variously estimated that clients outnumber sex workers by 30:1 to 60:1[34], and 20:1 to 100:1[35], so that an infected client poses a significant threat to a sex worker if he requests or demands unprotected sex and it is more likely that a client will request services without prophylactics than a sex worker offering services without prophylactics[36]. Most legislation on STIs does not reflect this side of the commercial sex transaction

From the above figures we can deduce that educational campaigns based on peer education aimed at sex workers have worked (these were mostly introduced during 1988-1989 in most states and territories in Australia) and must continue.

As a comparison I want to examine approaches adopted to the occupational exposure to body fluids for health care workers. Many health care workers (surgeons, nurses,

[31] Op cit.

[32] Lovejoy, F., Perkins, R., Corduff, Y., Dean, M. & Wade, A. (1991). *AIDS Preventative Practices among female prostitutes and their clients and private risk*, Parts 1 (report to the Dept of Health, Housing and Community Services). Sydney: University of NSW.

Perkins, R. 1991. *Working Girls: Prostitutes, their life and social control*. Australian Institute of Criminology, Canberra.

[33] Pyett, P., Haste, B., & Snow, J. (1996). *Risk practices for HIV infection and other STDs amongst female prostitutes working in legalised brothels*. AIDS Care, 8 (1), 85-94.

[34] Jordan, J. (1997). *User pays: men who buy sex*. Australian and New Zealand Journal of Criminology 30(1):55-71.

[35] Lovejoy, F., Perkins, R., Corduff, Y., Dean, M. & Wade, A. (1991). *AIDS Preventative Practices among female prostitutes and their clients and private risk*, Parts 1 & 2 (report to the Dept of Health, Housing and Community Services). Sydney: University of NSW.

[36] Kruhse-Mountburton, S. (1992). *AIDS awareness and condom use: Attitudes of male clients of heterosexual prostitution in the NT.* National AIDS Bulletin, August. 41-44.

Lowman, J., Atchison, C. & Fraser L. (1997) *Men who buy sex: summary of phase 1 Report*. Paper presented at the International Congress on Prostitution, Los Angeles, March 1997.

Plumridge, E., Chetwynd, S. & Reid, A. (1996). *Control and condoms in commercial sex: client perspectives.* Sociology of Health and Illness, 19(2): 228-43.

etc.) perform HIV exposure-prone procedures as part of their everyday work. Reports from a national network of hospitals show that the rate of exposure (though needle stick injuries) to blood or body fluids in health care workers were around 22 per 100 daily occupied beds (this is considered a low estimate as many incidences are not reported)[37]. This represents a phenomenal amount of potential for transmission of HIV, HBV (hep B virus) & HCV (hep C virus), yet at follow up no cases were reported of infection with any of these diseases in health care workers. According to Dr. Andrew Grulich (senior lecturer in epidemiology, National Centre in HIV Epidemiology and Clinical Research, personal communication) the probability of HIV transmission from a single exposure episode through a needles stick injury is in the level of 1-3%. In comparison that for vaginal intercourse is 1% and for anal sex 1-3%. Given the high level of needle stick injuries and the potential for spread of various viruses it might be thought that following the approach adopted towards sex work that health care workers and their patients would be mandatorily tested for these viruses. This is not the case and in fact the IGCARD (Intergovernmental Committee on AIDS and Related Diseases) HIV Testing Policy states that: " Routine screening of health care workers for HIV antibody is inappropriate and would be counterproductive as a means of preventing spread to patients."

From a medico-scientific perspective, all that testing can do is provide the STI status of a person at the last unsafe sex episode which falls outside of the window period for that particular disease prior to testing. For example, HIV has a window period of approximately three months. Since the test which is used to determine serostatus tests for antibodies to HIV, rather than for the virus itself, someone may not have developed enough antibodies to be detected by the test and yet be very contagious.

Testing in itself can create a false sense of security in sex workers in that they can think that a certificate saying that they have been tested and are free of STIs is enough to ensure that they are free of disease, and likewise in health care workers. For clients, thinking that sex workers are free of STIs make cause them to pressure sex workers for unsafe sex practices.

Clearly for health care workers the approach to minimise contracting and passing on diseases has been to develop and adopt universal precaution guidelines as well as guidelines for post-exposure prophylaxis, the approach to sex workers should be the same. That is, peer education campaigns based on safe sex and knowledge of how to check clients for visible signs of STIs, mandatory condom policies in the workplace (these should be enshrined in occupational health and safety legislation), and condom breakage and slippage policies. Clients should also be the focus for education campaigns and our society should adopt a positive attitude towards sex education, so that children grow up with knowledge about sexual health.

[37] HIV/AIDS and Related Diseases in Australia Annual Surveillance Report 1998.

Conclusion:

It is clear that compulsory testing serves no purpose other than to continually stigmatise sex workers for the work that they do and reinforces difference. This in itself serves as an impediment to sex workers feeling proud of what they do and keeps their confidence and self-esteem down. Systems of registration which inadvertently come into place when compulsory systems of testing are put in place have the further ramification of marking sex workers for life, with the potential to impede such things as travel, or getting another job. It needs to be acknowledged that no regulations or laws should be made which require identification or mandatory testing of individual sex workers unless they apply to the entire sexually active community.