BUILDING OUR COMMUNITY'S
HEALTH & WELLBEING

Submission to:

Human Rights and Equal Opportunity Commission
Listening Tour

April 2008

1. ACON (AIDS COUNCIL OF NSW INC)

ACON is a community-based non-government organisation promoting the health and wellbeing of a diverse gay, lesbian, bisexual and transgender community, and a leading agency in HIV/AIDS policy development and program delivery.

ACON provides education, health promotion, care, support, and advocacy services for members of the GLBT community, including drug users and Indigenous people, sex workers, and all people living with HIV/AIDS (PLWHA).

ACON has offices in Sydney, Illawarra, Northern Rivers, Hunter and Mid North Coast with an extensive range of outreach services. ACON is also home to the Community Support Network (CSN), the Positive Living Centre (PLC), the Lesbian and Gay Anti-Violence Project (AVP) and the Sex Workers Outreach Project (SWOP).

2. INTRODUCTION

ACON provides services to women in a range of projects and activities, including the Lesbian Health Project, the Women and Families Project and the Sex Workers Outreach Project.

This submission will discuss the issues facing same-sex attracted women, women working in the sex industry and HIV positive women in Australia today. It will focus on the three themes of the Sex Discrimination Commissioner's Listening Tour: economic independence; work and family balance across the life cycle; and freedom from discrimination, harassment and violence.

3. SAME-SEX ATTRACTED WOMEN

3.1 Introduction

There are numerous issues particular to the experience of same-sex attracted women that warrant consideration in the Listening Tour. Whether it is financial discrimination, the absence of parenting rights, or homophobic abuse, same-sex women are socially, economically, legally and politically disadvantaged across a range of areas.

3.2 Economic independence

As the Human Rights and Equal Opportunity Commission outlined in its 2006 *National Inquiry into Discrimination against people in Same-Sex Relationships: Financial and Work-Related Entitlements and Benefits* (Same-Sex: Same Entitlements Report), there are numerous areas of law in which women in same-sex relationships are not afforded financial equality with their heterosexual counterparts.[1] This impacts on the ability of same-sex attracted women to be economically independent.

The Same-Sex: Same Entitlements Report covered topics including employment, tax, superannuation, aged care, workers' compensation, family law, health, migration and

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[1] *National Inquiry into Discrimination against people in Same-Sex Relationships: Financial and Work-Related Entitlements and Benefits*, Human Rights and Equal Opportunity Commission, 2007.

veteran's entitlements. According to the Report, same-sex couples have to spend more money on medical expenses to enjoy the Medicare and PBS Safety Nets. Whereas opposite-sex couples can access the safety nets as couples, or as families, members of same-sex couples can only access the safety nets as individuals. This means same-sex couples cannot combine their medical expenses to reach one safety net, after which significant discounts apply. This is especially significant for same-sex attracted women, as a greater proportion of lesbian women than gay men have children. Approximately 20% of lesbian couples in Australia are raising children.[2]

Same-sex attracted women are not guaranteed the right to take carer's leave to look after a sick partner. This means that they may have to take unpaid leave or no leave at all, in the event that their partner becomes ill. Having to choose between remuneration or time to care for a partner puts women in same-sex couples at a great disadvantage, and creates a great degree of instability and insecurity in same-sex couples' lives. Other kinds of leave that can legally be denied to members of same-sex couples are compassionate leave, parental leave and travel entitlements.

Other basic financial discrimination suffered by same-sex attracted women includes being denied a wide range of tax concessions available to opposite-sex couples, and for the partners of federal government employees, being denied access to superannuation and workers' compensation death benefits available to opposite-sex couples. A same-sex partner of a defence force veteran is denied a range of pensions and concessions available to an opposite-sex partner. And, older same-sex attracted women will generally pay more than opposite-sex couples when entering aged care facilities.

> *My partner and I have a daughter together, yet she cannot claim us as dependents. She cannot be included on our Medicare card and thus we don't qualify for the family Medicare safety net. She cannot get carers' leave should one or both of us fall ill. If I died tomorrow she would not automatically receive my superannuation. She cannot sign off on medical treatment for our daughter or even write her a sick note for school. I am sick of being treated like a second-class citizen in my own country, and do not wish to see my daughter grow up as one.*[3]

The Human Rights Commissioner has already recommended that the 58 recommendations be implemented as soon as possible, backing the Gay and Lesbian Rights Lobby's 58 '08 campaign to have the laws implemented by the end of 2008. It would be beneficial for same-sex attracted women to have their rights advocated for in a women's rights context, and not in just a gay and lesbian rights context. However, putting an end to the legal discrimination will not, in itself, achieve economic independence for same-sex attracted women. Once the reforms are put through, an education campaign for same-sex attracted women will be necessary so that they understand, and can take advantage of, their new rights and responsibilities.

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[2] Australian Bureau of Statistics, *Year Book Australia,* 'Same-Sex Couple Families', p142 (2005). See also J Millbank, 'Recognition of Lesbian and Gay Families in Australian Law – Part Two: Children', *Federal Law Review*, vol 34, no 2, 2006, p206, referencing M Pitts et al, 'Private Lives: A Report on the Health and Wellbeing of GLBTI Australians' (2006); Victorian Law Reform Commission, *Assisted Reproductive Technology and Adoption Position Paper Two: Parentage*, (July 2005), para 3.1.

[3] Liz (NSW) letter to the Federal Attorney-General, as part of the GLRL's 58 '08 campaign.

3.3 Work and family balance across the life cycle

Without having access to the same financial benefits and entitlements as opposite-sex attracted women, a disproportionate number of same-sex attracted a women find it harder to achieve a work-life balance, often working longer hours, and in a number of jobs in order make ends meet. In addition, without being recognised as legal parents of their children, many lesbian parents find it difficult to provide stability for their children, and to have confidence in the legal standing of the decisions they make about their children's welfare. The financial disadvantages imposed on same-sex parents will inevitably have an impact on their children.

Currently, non-biological co-parents are not recognised as the legitimate parent of their children under NSW or Federal law. This leaves many families uncertain about their future in the event of the death of the biological parent or relationship break-up. Currently, there are no guarantees that the non-biological co-parent would have any rights or responsibilities in relation to their child. The necessity to spend thousands of dollars on court costs to obtain a parenting order, or to prove parentage, creates a large degree of stress for lesbian families.

> *I am 11 weeks pregnant with our first child and my partner has no legal parenting rights or rights to make medical decisions for our child. We have recently been informed that the same rights that are extended to any defacto or married heterosexual couple, for free, when they have a family (equal parenting rights, medical/legal rights of attorney etc) will cost us approx $3000 in legal fees and court costs to obtain. [...] We can't really afford these extra costs when planning for maternity leave etc and don't believe we should have to pay for the same legal protection as another couple get for free.*[4]

In addition, same-sex couples cannot access the Family Court for property settlements. A child living in a same-sex family may be denied equal rights to child support under the Child Support Scheme. Definitions of 'parent' in federal family law create uncertainty for a child on the separation of his or her parents or the death of a parent.

3.4 Freedom from discrimination, harassment and violence

A number of studies undertaken over the last ten or so years indicate that same-sex attracted women are much more likely to be subject to harassment and violence than their heterosexual counterparts. The NSW Attorney-General's 2003 'You shouldn't have to hide to be safe': A Report on Homophobic Hostilities and Violence', identified the following:

- Over half of the respondents experienced homophobic abuse, harassment or violence in the past 12 months
- 85% reported these experiences at some time in their lives

[4] Simone and Laurie (NSW) letter to the Attorney-General, in GLRL's 58 '08 campaign.

- The most common experiences were: verbal abuse; harassment such as spitting, offensive gestures, being followed and threatened; attempted and/or physical attack
- Young respondents (16-19 years) reported more incidents and greater impacts of the abuse.[5]

A national study of 1,749 young people and their sexuality showed that almost half of the respondents had experienced verbal or physical harassment.[6]

> *My same-sex partner and I were assaulted in Adelaide airport in 2005. We were saying goodbye to each other, in the customary manner of our heterosexual peers, by holding hands and kissing. A passerby chose to hit me, hard, in the back of the head. As you can imagine, my girlfriend and I were both extremely shocked and upset by this incident. Not just at the actions of the individual, but also at the apparent lack of concern of other onlookers, witnesses to the assault. This type of violent outburst would rarely be borne by heterosexual couples under the same set of circumstances.*
>
> *Until same-sex couples are viewed and treated as equals to their heterosexual peers in our community, this type of discrimination will continue. It is imperative that equality is granted.*[7]

It has also been shown by a number of studies that levels of homophobic abuse directly correlate with higher rates of alcohol and drug abuse and self harm in gay and lesbian people. [8] The Longitudinal Study of the Health of Australian Women (McNair et al, 2003) showed that same-sex attracted women between ages 22-27 were much more likely to be depressed, suffer from anxiety, and attempted suicide more frequently than their heterosexual counterparts.[9] Warner (2004) and Hillier et al (2005) have both found a connection between mental health problems and experiences of verbal and physical homophobic abuse.[10] A number of studies have indicated that the general health of same-sex attracted women is poorer than that of opposite-sex attracted women.[11] The Private Lives Report attributed this to the climate of discrimination, heterosexism and heteronormativity that makes it more difficult for lesbian women to access health services.

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[5] NSW Attorney-General's Department (2003).You shouldn't have to hide to be safe', A Report on Homophobic Hostilities and Violence Against Gay Men and Lesbians in New South Wales.
[6] Strategic Framework 2007-2012, Working Together: Preventing violence against gay, lesbian, bisexual and transgender people.
[7]Maree (QLD) letter to the Federal Attorney-General as part of the GLRL's 58 '08 campaign.
[8] Hillier (2005) in Pitts et al, Private Lives: A report on the health and wellbeing of GLBTI Australians, Gay and Lesbian Health Victoria and The Australian Research Centre in Sex, Health and Society, p. 28.
[9] McNair et all (2003) in Pitts et al, Private Lives: A report on the health and wellbeing of GLBTI Australians, Gay and Lesbian Health Victoria and The Australian Research Centre in Sex, Health and Society, p.32.
[10] Warner (2004) and Hillier et al (2005) in Pitts et al, Private Lives: A report on the health and wellbeing of GLBTI Australians, Gay and Lesbian Health Victoria and The Australian Research Centre in Sex, Health and Society, p.32
[11] Pitts et al, Private Lives: A report on the health and wellbeing of GLBTI Australians, Gay and Lesbian Health Victoria and The Australian Research Centre in Sex, Health and Society, p. 28-32.

Another aspect of discrimination for same-sex attracted women relates to the fact that same-sex women cannot partake in any ceremony which would legally recognise their relationship. The inability of lesbian women to get married, or partake in an equivalent socially significant ceremony and institution, means that lesbian women are unable to celebrate their relationships in the same socially, legally and symbolic manner as heterosexual women.

4. HIV POSITIVE WOMEN

This section of the ACON submission focuses on available evidence to highlight key trends, themes and issues that face HIV positive women and families.

Background

While the majority of HIV and AIDS notifications in Australia are seen in men, the proportion of sero-positive women is gradually increasing as the total number of notifications decrease (Stewart, Penny 2003). The relationship between women and health can be complex when considering gender norms, gender relations and socio-cultural conditions. Often this relationship is compounded when children and families are involved. Globally, women and girls are especially vulnerable to HIV infection due to a host of biological, social, cultural and economic circumstances (Esplen 2007). Women's entrenched social and economic inequality within sexual relationships, including marriage, is deeply linked to their susceptible position to contracting the virus.

Women are even further disadvantaged when HIV is present and they are a single mother, indigenous, a migrant or refugee, an injecting drug user, a sex worker, or a same-sex attracted woman. In many societies, these terms are value laden as deviant or morally bankrupt positions which place further psycho-social burdens on many.

A snapshot of those living with HIV/AIDS in Australia and NSW specifically shows a rise of infection among minority groups, particularly Aboriginal and Torres Strait Islander women and women from Culturally and Linguistically Diverse (CALD) backgrounds. These communities already face high levels of stigma and discrimination. When this is compounded with seropositive status women and families encounter further barriers to accessing adequate healthcare and social support.

4.1 Economic circumstances

Inaccessibility to appropriate services is often a major barrier. Most women and families living with HIV live in outer city suburbs and owning a car with costs involved is not feasible, thus affecting access to regular support. Many women living with HIV experience financial difficulties. In *The Journey Continues: Women Living with HIV/AIDS in Australia*, 33% of positive women were living under the poverty line and nearly all the women surveyed (89%) reported difficulty with meeting the costs of daily living (McDonald, Thorpe, Grierson 2005). The financial difficulties experienced by women living with HIV creates significant barriers to their ability to access support and services given that the little resources they do have may often go to the needs of children or families. For example, childcare, which is a considerable concern for many, is more acutely felt by HIV affected mothers or caregivers.

4.2 Work and family balance across the life cycle

4.2.1 HIV, mental health and family responsibilities

Psychological distress is a common finding among people living with a chronic illness and this is seen particularly in those newly diagnosed with HIV (Catz et al. 2002). Higher levels of psychological distress have an adverse affect on quality of life and this has been linked to poor treatment adherence and higher rates of risk behaviour (Catz et al. 2002). In a study conducted in the US around health related quality of life in positive women, a large proportion of the participants reported experiencing negative emotions some or all of the time. (McDonnell, Gielen, Wu, O'Campo, Faden 2000).

Some of the distinct distress levels that may be assumed in the negative mental health state of many HIV positive women can be attributed to disparities in socio-cultural contexts, such as poverty, childcare responsibilities, care giving responsibilities to others, and the differential experience of stigma and social isolation specific to women (Catz et al. 2002).

Looking at the mental well-being of positive women in Australia, the HIV Futures 4 report shows that 23.2% of the women surveyed had been taking medication for depression which is considerably higher than the 4.7% of the Australian population as described by the National Health Survey (McDonald, Thorpe, Grierson 2005). The study also found that 21.8% were taking anxiety medication and 11.2% reported taking medication for both depression and anxiety.

In the *Men and Women Living Heterosexually with HIV* report, depression was common among the participants. The women expressed feelings of shame based on cultural stereotypes that positioned them as 'dirty', 'polluted', and infectious (Persson, Barton, Richards 2006). Many women identified the lack of appropriate services for positive heterosexuals as a barrier to accessing services.

4.2.2 Women with children & families

As well as experiencing stigmatisation and consequent discrimination, women are often further faced with the added burden of protecting those close to them from stigmatisation by association (Lawless, Kippax, Crawford 1996). Many women with children and families often choose not to disclose their sero-status to others. Silencing themselves may be a way to protect personal self-esteem and relationships intact but can also be an indication of serious negative effects to the individual personal value system, patient outcomes, and mental health (DeMarco, Lynch, Board 2002).

Silencing behaviour is not just about disclosing their positive status in a public environment but equally about discussing personal health needs to those closest to them. Gender learned and reinforced behaviours of silencing needs and feelings related to disease prevention and treatment by caring for one's children's needs first is rarely addressed.(DeMarco, Lynch, Board 2002). Women often deny the importance of their own feelings and needs to meet the needs of others and recent studies have shown that mothers who have HIV/AIDS put the welfare of their children above all other needs (DeMarco, Lynch, Board 2002).

Although the needs of children can enhance the stressors in the mother, they have often been identified as being a major support. In the *Journey Continues: Women Living with HIV/AIDS in Australia*, 63.8% of respondents had children and 63.1% went on to rate their children as the second highest form of social support in their lives next to partners/spouses , and women with dependent children were significantly more likely to rate their health as good or excellent (McDonald, Thorpe, Grierson 2005).

4.2.3 Other Considerations

While women are often marginalised in strategic planning around HIV education, prevention and interventions, there are groups of women that lie in the periphery of an already existing minority group. This section will point out small yet significant groups of women that have particular needs and varied socio-cultural experiences that can affect health outcomes in relation to HIV.

Aboriginal & Torres Strait Islander women
The number of notifications of HIV in people who identify as Aboriginal between 2000 and 2005 ranged between 1 and 8 per year, a total of 28 in the six year period (NSW Health 2006). This population group faces ongoing vulnerability as a consequence of their disadvantage in regard to all social determinants of health (NSW Health 2006). Research that looks specifically at Aboriginal and Torres Strait Islander women's experience of HIV/AIDS is mostly understood by their vulnerable position and connection to Aboriginal MSM (men who have sex with men). While the numbers of HIV positive women in these communities remains low it is apparent that this population group is highly at risk of transmission without adequate sexual health education campaigns and intervention.

Lesbians & Women who have sex with Women (WSW)
Lesbians and WSW's have been overlooked for a variety of reasons, one being the dynamics in identity shifting that have allowed women in certain communities to practice a variety of sexual identities (Arend 2005). Historically the medical community has worked with 'at risk' populations and has not adequately considered the risks involved in lesbians and WSW's (Arend 2005). Invisibility of this hidden population stems from homophobia on a large scale as well as the social disadvantage experienced by lesbians and WSW's living with drug addiction, poverty and homelessness (Arend 2005).

Women from Culturally and Linguistically Diverse (CALD) backgrounds
As global migration increases, so does the challenge of providing health education and social support to groups who exist within historically and culturally constructed social behaviours that differ from an Anglo-Celtic perspective (Korner 2005).

The report titled, *Living with HIV and cultural diversity in Sydney* 2005, included 7 HIV positive women, all who identified as heterosexual (Korner 2005). The issues specific to women from CALD backgrounds is particularly complex when a language barrier and lack of familiarity with the health care system exists (Korner 2005). Some women from CALD backgrounds may depend on their husbands or another English-speaking person to assist in their contact with a health care professional and this may inhibit the possibility of being tested or treated for HIV if they are controlled by a spouse or family member (Korner 2005).

Language is discussed as a major issue for participants with limited knowledge of English in contacting HIV/AIDS services as was the matter of immigration status and ineligibility of Medicare. Immigration status was reported as a significant reason for not accessing health care after diagnosis as well as notably affecting treatment adherence. Some participants revealed they made concerted efforts to limit their medication intake in order to save medication in case they had to leave Australia and return to their home country where treatment costs were unaffordable. This means many put their health at risk in situations where their wellbeing is already being compromised.

4.3 Discrimination

The *Men and Women Living Heterosexually with HIV* study discusses how the fear of discrimination can greatly impact on people's lives. Discrimination operates through internalised stigma by encouraging stigmatised people to believe that they should not enjoy full and equal participation in life, be it social, economic, sexual or otherwise (Persson, Barton, Richards 2006).

The fear of further discrimination is faced by many when accessing medical and/or social services. The most common forms of discrimination were breaches of confidentiality, being treated with suspicion or curiosity by doctors and hospital staff, and having assumptions made about how they became infected, or about the HIV status of partners (Persson, Barton, Richards 2006).

Lawless et al. (1996) discusses how this tension is played out in women's lives when the need to access services is compounded by anxiety around assumptions made by health care workers (Lawless, Kippax, Crawford 1996). She explains how the impact of the prevailing discourse of the 'polluted' woman is internalised and leads to self-stigmatisation (Lawless, Kippax, Crawford 1996). This prevailing discourse rests on the assumption that women who become infected with the virus are sex workers or IV drug users, meaning that their sero-status/ conversion directly relates to a patriarchal idea of illicit and 'out of control' behaviour deemed unacceptable for women (Lawless, Kippax, Crawford 1996). Contrary to this supposition, 44% of transmission amongst Australian women is through heterosexual contact (Lawless, Kippax, Crawford 1996).

4.4 Violence

One issue specific to the women in this report was domestic violence. Five out of the seven women reported some form of abuse by their partners, including physical, verbal and social abuse (Korner 2005). Only one participant reported seeking and receiving support for this.

Service delivery for women from CALD backgrounds, particularly those living with HIV, must consider the several implications for support. Three crucial aspects to service delivery outlined by participants in the main report are confidentiality, a focus on the individual's self-reliance and support in the mother tongue and similar cultural values as those of the client (Korner 2005)

5.0 SEX WORKERS

Background

ACON is home to the Sex Workers Outreach Project (SWOP). SWOP peer health educators have access to virtually all premises in NSW. SWOP provided 20,000 occasions of service in 2007, reaching 850 different workplaces across NSW. The gender of sex workers in NSW is as follows:

- 87 % female
- 10 % male
- 3 % transgender

Sex workers are a target population for the National HIV/AIDS Strategy and NSW HIV/AIDS and STI Strategies. Sex workers have an excellent record in relation to the uptake of safe sex practices for the prevention of STIs and HIV. It is important to note that there is no recorded case of transmission of HIV in a NSW sex industry setting.

Sex services premises have been able to operate as legitimate businesses in NSW since 1995, subject to local council planning policies. Sex services premises, include:

- Commercial sex services premises (brothels)
- Massage parlours providing sexual services
- Home based businesses involving sex work
- Home occupations involving sex work
- Safe house premises providing rooms for street sex work

SWOP data suggests 10,000 individuals work in the NSW sex industry in any one year[12], and based on the service date SWOP estimates:

- 8,700 women and 300 transgender sex workers operate in any one year
- 5,500 women work in brothels or massage parlours [13].
- The majority work indoors, within premises or engaged as escorts
- up to 40% are private sex workers, running their own businesses such as home based businesses or providing escort services.
- a maximum of 120 street based sex workers work on any one night.[14]

Brothels or parlour workers see, on average, 26 clients per week[15]. Private workers see 6-10 clients per week, generally during daytime hours. Private sex workers tend to be older, support children and have previously worked in commercial sex services premises, and now choose to work independently.

SWOP estimates 1,300 women from Culturally and Linguistically Diverse (CALD) backgrounds work in the NSW sex industry including Australian citizens, permanent residents and visitors, such as students and working holiday makers. The main language backgrounds are Chinese, Thai and Korean.

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[12] SWOP data. See also the Rogan report, NSW Parliament 1986 which estimated 1,500 to 2,200 sex worker on any one day.

[13] SWOP outreach data

[14] *Health and welfare needs of street based female and transgender sex workers* NSW Health, 2000

[15] *Health Needs Assessment of Parlour Workers in South Western Sydney Area Health Service*, SWSAHS 2002

Research conducted with 150 sex workers in Western Sydney found the following[16]:

- The average age of a parlour based sex worker is 29.
- One in five is married or in a de facto relationship, half had never married, one in three is divorced or widowed.
- Two in three went to high school and one in four went on to tertiary studies.
- Most sex workers responding to the survey had worked for about four years; however, the average length of service was 10 months.

5.2 Economic independence for women in sex work

Most women enter the industry for purely economic reasons, and say that the money is one of the best things about the work[17]. A comparison between private sex workers and brothel workers indicated that economic motives and a drive for independence were the primary reason for both groups of women entering the sex industry, specifically citing:

- Earn more money
- Support children
- Unemployment
- Be independent[18]

Research also documents women citing autonomy, control, flexible hours and meeting people as positive aspects of their work, although some women report that there is nothing enjoyable about their work.

It is important to note that sex workers ONLY earn money for the services they provide. No retainer or hourly rate is paid for being "on shift" or on call. Sex workers are often in a "self-employed" relationship with the operator, and no sick leave, annual leave or other leave allowances are paid.

Superannuation, retirement and financial independence later in life can be an issue for sex workers. Most sex workers are not treated as "employees" and the superannuation guarantee (9% over salary) is not being paid. Many sex workers are in "informal" employment arrangements, and do not experience either the benefits or responsibilities of an employee or self-employed person.

Some sex workers can work until later in life, and many save or buy property as a means of creating a safety net. In line with cultural practices, Asian sex workers will give money to their families and expect their families to support them later in life. However, the majority of women in the sex industry do not have a financial, savings or superannuation plan. The stigma and discrimination surrounding the occupation, and safety and security risks make conventional financial management, including banking, problematic for sex workers[19].There are anecdotes of women with high earnings leaving the industry with little to show for the years of hard work.

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[16] *Health Needs Assessment of Parlour Workers in South Western Sydney Area Health Service*, SWSAHS 2002, op cit

[17] *Profile of workers in the sex industry, Melbourne* La Trobe University, 1995.

[18] *Call Girls. Private sex workers in Australia,* Roberta Perkins and Frances Lovejoy, 2007p32

[19] *Unjust and Counterproductive, the failure of governments to protect sex workers from discrimination*, Banach, L for Scarlet Alliance 1999

Sex workers have recently been the target of an ATO compliance program, focusing initially on GST and later on personal income tax. The impacts of poorly planned communications and compliance visits have resulted in many women facing stigma and discrimination, and family problems as they have been “outed” by the ATO process.

5.3 Work and family balance across the life cycle

Women with children who work in the sex industry are very cautious about their confidentiality, as they fear that stigma and discrimination may impact on their safety, and that of their children. They may not be “in the system” as employed or working due to their occupation. They are then not eligible for Child Care Benefit subsidies or annual refunds of out of pocket expenses. For this reason, sex working mothers have difficulty finding appropriate childcare, particularly single mothers who work in brothels, where 10 hour shifts are common. Most sex workers use private child care which acts as a barrier to them using eligible, government subsidised services.

5.4 Freedom from discrimination, harassment and violence

Sex workers cite stigma and discrimination as a negative aspect of their work, which affects them socially, economically and emotionally.[20] NSW doesn’t yet have anti-discrimination protections for sex workers, despite having decriminalised the industry. Of all occupations, sex work is the only one directly and continuously associated with HIV risk, despite evidence in Australia to the contrary. For example, a sex worker is not eligible to donate blood under the Red Cross screening policy.

5.4.1 Workplace Occupational Health and Safety

The *Health and Safety Guidelines for Brothels in NSW, 2001*[21] were developed by WorkCover, NSW Health and SWOP to provide operators and workers in the sex industry with a guide to their rights and responsibilities. The *Guidelines* set out minimum standards for creating and maintaining a safe and healthy sex services workplace environment. This resource is available in English, Korean, Thai and Chinese. The uptake of the *Guidelines* has been significant, and brothel based sex workers do not report significant OH&S related injuries or illnesses.

WorkCover have indicated that in the period 2001/2 to 2005/6 it received 34 complaints in relation to the sex industry, and that complaints have slowed over recent times[22]. In the same five year period, there were 12 claims for workers compensation under the grouping code Adult Personal Services relating to the sex industry[23].

The prevalence rates of HIV and STIs among Australian female sex workers remains one of the lowest in the world[24]. There has been no recorded case of HIV transmission in

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[20] *Unjust and Counterproductive: the failure of governments to protect sex workers from discrimination”* Scarlet Alliance and the Australian Federation of AIDS Organisations, 1999 Also, “Sex Workers want anti-discrimination laws” *The Australian*, June 03, 2007

[21] *Health and Safety Guidelines for Brothels in NSW,* 2001 Available from www.workcover.nsw.gov.au

[22] Correspondence to ACON, 1 Nov 2007

[23] ibid

[24] *NSW STI Strategy Environmental scan,* NSW Health 2006

a sex industry setting in Australia[25]. These health outcomes also demonstrate the control exercised by female sex workers over their clients in NSW.

5.4.3 Violence

According to SWOP, the decriminalisation of sex work has increased safety for sex workers, and reduced violence in most indoor settings. However, the implementation of the laws by local councils expose sex workers to poor workplace health and safety, particularly where council policies have been prohibitive, or do not allow for the range and variety of workplaces to be lawful. Private sex workers have been omitted in most council planning policies exposing them to risk of corruption and violence.

Depending on the nature of the work, but more importantly the location and organisation of the work, sex workers in some sectors, particularly street sex workers, experience high levels of stress and violence[26].

Crimes of violence against sex workers in NSW in the last ten years include assault, sexual assault, rape, kidnapping, robbery; and murder[27]. More than half of the incidents were reported by street based sex workers, yet they comprise less than 2% of the sex working population. Street sex workers face additional risks of violence as the laws, poor policing practices, and the less controllable aspects of the workplace environment impact on negotiations, decisions and outcomes. The perpetrators are rarely prosecuted, sending a message to society, and to the women themselves, that street sex workers are an “easy” target.

Sex workers are less likely to report crimes due to a lack of appropriate responses from police. Police are not a trusted, confidential service provider for sex workers, and poor responses can increase risks. The Police Sex Worker Liaison Officer program that SWOP supports is not resourced, is voluntary and attracts no professional recognition.

5.4.4 Trafficking into Australia for the purposes of sexual servitude

There have been some cases of trafficking into the sex industry in Australia, with two cases prosecuted in NSW. The cases to date have not been limited to “illegal” brothels, nor to the sex industry. The US Trafficking in Persons Report 2007[28] states:

> *Australia is a destination country for some women from East Asia and Eastern Europe trafficked for the purpose of commercial sexual exploitation. The majority of trafficking victims were women who travelled to Australia voluntarily to work in both legal and illegal brothels, but were subject to conditions of debt bondage or involuntary servitude.*

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[25] *National HIV/AIDS Strategy 2005-2008*, Commonwealth of Australia, 2005

[26] *Sex workers and sexual assault in Australia. Prevalence, risk and safety, Australian Centre for the Study of Sexual Assault Issues No 8, 2008, also*

[27] Reports of violence made to SWOP analysed in *Safety Issues in Sex Industry settings Final Report to City of Sydney* Elton Consulting, 2006 and media reports where the murder victim was a sex worker

[28] *Trafficking In Persons Report 2007*, US Department of State, 2007 pp 57-58

Scarlet Alliance estimates that there are 300 to 400 migrant women arriving in Australia in any one year who have voluntarily undertaken to work in the sex industry[29]. Of these, very few will have been deceptively recruited. SWOP and their multicultural outreach team work closely with the AFP, Immigration and community based responses to trafficking in order to ensure the human rights of migrant sex workers are respected in relation to trafficking issues.

Australia's anti-trafficking measures are currently discriminating against the sex industry, and people working in the sex industry. There are anecdotal reports of DIAC "warning" student visa holders in brothels "not to be seen here again".

There has been no funding to provide best practice peer education for the sex industry on trafficking crimes. In addition, Scarlet Alliance and SWOP have long been advocating for more access to working holiday visas for all women, which would remove the need for contracts, and reduce opportunities for traffickers.

For more information on this submission please contact either Maria McMahon, Sex Work Policy Adviser on 02 9206 2085 or Veronica Eulate, Planning, Evaluation, and Policy Officer on 02 9206 2061.

[29] *Submission to Parliamentary Joint Committee on the Australian Crime Commission Inquiry into Trafficking in Women- Sexual Servitude"* Scarlet Alliance 2003 (scarletalliance.org.au)