

**PUBLIC HEALTH ASSOCIATION  
OF NEW ZEALAND**

**SUBMISSION ON THE  
Prostitution Reform Bill**

**March 2001**

**Submission to the  
Parliamentary Justice and Electoral Select Committee  
on the Prostitution Reform Bill**

***from the New Zealand Public Health Association of NZ (PHA)***

***8th March 2001***

The Public Health Association supports prostitution law reform to improve health. It indicates how the current law inhibits healthy behaviors, and cites evidence and international consensus that law reform works to promote health.

**The PHA supports prostitution law reform**

The PHA supports prostitution law reform, and this Bill, for three main reasons:

- 1     *The Bill addresses a significant injustice and cause of inequality in our society.*
- 2     *The Bill will assist in promoting safer sex and hence disease prevention.*
- 3     *The Bill will enable health and occupational safety legislation/ employment legislation to be more rigorously applied to the workplaces of sex workers.*

**The Public Health Association of New Zealand**

The Public Health Association of New Zealand (PHA) is a voluntary association which provides a major forum for the exchange of information and stimulation of debate about public health in New Zealand (PHA website<sup>1</sup>). Membership of PHA is open to all individuals interested in public health and covers more than 300 individual members from the public, private and voluntary sectors. The PHANZ is a member of the World Federation of Public Health Associations.

Public health is defined as the improvement of the health of the whole population ‘*through the organised efforts of society*’ (Acheson, 1988<sup>2</sup>)

**Why is the PHA interested in prostitution reform?**

The PHA is committed to the improvement of health outcomes for the total population and population groups through disease prevention, health protection, and health promotion programmes. This includes advocating for policies that recognise the major influence that socio-economic factors have on health, and for policies that enable people to make individual and collective choices that will reduce harm and improve their health.

While addressing the wider social and economic determinants of health is a priority, the PHA also advocates equitable access to health services. Everyone should have the right to accessible, acceptable health care services. Social and criminal marginalisation of individuals or population groups creates a major barrier to access to appropriate health information and services. Health service policy should prioritise prevention and first line treatment services by removing such barriers to access.

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<sup>1</sup>     <http://www.pha.org.nz/>

<sup>2</sup>     Acheson, D. *Public health in England*. London: HMSO, 1988.

We support the principles of the Government's New Zealand Health Strategy that seek to ensure

- Good health and wellbeing for all New Zealanders throughout their lives
- An improvement in the health status of those currently disadvantaged
- Collaborative health promotion and disease and injury prevention by all sectors
- Timely and equitable access for all New Zealanders to a comprehensive range of health and disability services, regardless of ability to pay

(Ministry of Health 2000)

We see this Bill as an important step towards achieving those goals for a population group who are at present socially stigmatised, discriminated against by law and who consequently do not have access to appropriate health care services.

Our submission is not concerned with questions relating to the desirability or morality of sex work. Our concern is whether legislative changes would reduce the harm that results from social and legal marginalisation, and enhance the health status of all those involved with the sex industry: sex workers, their clients, and their partners, friends, families and communities.

## **The PHA supports prostitution law reform**

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### **1 The Bill addresses a significant injustice and cause of inequality in our society.**

The present law, which allows clients to seek sex but does not permit workers to offer it, reflects and perpetuates historical inequalities and double standards in relation to women and men<sup>3</sup>, workers and clients, owners and staff<sup>4</sup>. This inequality before the law makes sex workers vulnerable to intimidation and exploitation by clients and employers. It denies them the protections other workers have a right to expect, such as, the right to negotiate the terms and conditions of their employment, the right to a healthy and safe working environment, and freedom from sexual harassment.

Laws against prostitution reflect historical stigma associated with sex outside marriage and the traditional role of women in society. Neither stigma nor criminalisation nor more liberal approaches to sex and marriage have ever stopped prostitution; they have, at most, driven it underground. While decriminalisation would not on its own remove the stigma associated with sex work, it would reduce some of the significant abuses associated with it.

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<sup>3</sup> New Zealand research shows that most sex workers are women (Plumridge and Abel, 2000). There is no research on the extent of sex work among males, but anecdotal evidence indicates that this is a significant minority.

<sup>4</sup> Officially massage parlour workers are self-employed and may be required to pay the parlour owner a rental (Woods 1996)

## **2 The Bill will assist in promoting safer sex and hence disease prevention.**

Laws against prostitution in the nineteenth and early twentieth centuries were justified in large part as efforts to prevent the spread of sexually transmitted disease (Dalley 1995). A century later it is evident that these efforts were largely unsuccessful, whereas improved medical treatments and sexuality education have proved to be much more effective.

It is appropriate to acknowledge, at this point, the work of the New Zealand Prostitutes Collective (NZPC), and the foresight of the former Department of Health in funding the Collective from 1988 to provide sexual health information and support to sex workers. This was done initially as a response to the threat of HIV/AIDS. That the spread of HIV/AIDS in New Zealand has not occurred through the sex industry, as it has in many other parts of the world, can be attributed, at least in part, to NZPC's efforts (Chetwynd 1996).

However, because the law imposes significant barriers to reaching all people working in the sex industry, and in spite of the best efforts of NZPC, stigma and criminal status continue to be major barriers to the provision of sexual health information and access to appropriate treatment services. Sexually transmitted infections (STIs) are a serious health problem in New Zealand. Rates of chlamydia, the most frequently diagnosed STI, have been increasing since 1995 (Turley & McNicholas 2000a). The 1999 gonorrhoea statistics are "a reversal of the previous sustained decrease that began in the mid-1980s, and is of concern because gonorrhoea is considered a sensitive marker of unsafe sexual practices. An increase in gonorrhoea may precede increases in other STIs, including HIV, and may reflect failures in safe sex messages, shortfalls in contact tracing or limited access to sexual health care services." (Turley, McNicholas et al. 2000b).

It appears from a recent New Zealand study that many sex workers do not disclose their occupation to their general practitioner (Plumridge and Abel, 2000). Any move that would encourage more openness with health providers should be encouraged, in order to promote the health of both sex workers and their clients, and to reduce the risk to public health.

Both sex workers and their clients may be deterred from seeking medical advice for a variety of reasons, including:

- fear of acknowledging illegal behaviour (even though medical practitioners are required to observe confidentiality);
- shame associated with participation in sex work, especially in acknowledging this to someone who may know their family, partner or friends;
- furthermore, details of sexual activity or STIs may not be disclosed in order to avoid disclosing names of sexual contacts for partner notification purposes.

These fears may be well-founded. Medical practitioners are required to carry out partner notification in cases of certain STIs (Venereal Diseases Regulations 1982). The consequences of disclosure can include social ostracism and even violence. Police are required to act on complaints of prostitution and brothel-keeping. For example, safer sex information and products in sex workplaces may be used as evidence of an offence. This situation occurred in 1996, when the Crown used evidence of condoms from an escort agency as evidence of brothel keeping. Health promotion resources funded by Regional Health Authorities and produced by the NZPC were also presented to the Court to contribute to the pattern of evidence against the operators (personal communication with Catherine Healy, NZPC, 2001).

The NZPC is effective in providing education and support for sex workers it can contact. However youth and poverty are both factors associated with unorganised, opportunistic sex

work, beyond the reach of NZPC and sexual health services. Some sex work, especially in the more dangerous street work, is undertaken by young people who are ignorant of or misinformed about sexual health.

The greatest risk of the spread of STIs is among young adults. Those under 25 comprise the majority of those diagnosed with STIs in sexual health clinics, with “over two-thirds of gonorrhoea and chlamydia and over 60% of genital warts. Teenagers are at high risk of STIs through biological susceptibility and behavioural factors, such as unprotected sexual intercourse” (Turley, McNicholas et al. 2000). The risk of spread of STIs is high when these young people become involved in prostitution and are not known to the NZPC. For example, recent news reports showed young people, including children under the age of consent, seeking money for sex in Papatōetoe, South Auckland.

Decriminalisation will enable health and social service agencies to develop more effective and visible means of providing health services and educational strategies to prevent the spread of STIs in all young people. The sex industry must be enabled to continue to build and utilise strong community links amongst sex workers to encourage peer education about STI prevention, and to reach those workers, particularly young people who might be working underground.

The World Health Organisation has been advising for over a decade that:

*Successful interventions to prevent HIV infection associated with prostitution....have been most effective where prostitutes are empowered to determine their working conditions. A major effect of legal and social restrictions on prostitution has been to generate low self-esteem among sex workers and the belief that they cannot control their lives. Restrictive laws and adverse working conditions inhibit their ability to negotiate with clients and/or managers for adequate health care and safer sex practices.*

(Global Programme on AIDS and Programme on STD 1989)

It is also important to acknowledge that New Zealanders in general, while having little sympathy for sex workers, have tended to take a pragmatic view of sex work and the law. In response to the Department of Health's benchmark survey of public attitudes in 1986, 60% of respondents agreed that "prostitutes have only themselves to blame if they catch diseases", but 56% also agreed that "much more should be done to help prostitutes so they can avoid catching diseases". 65% agreed that "if we allow massage parlours, then we should be concerned for the health of the people who work there". Furthermore, 51% agreed with legalising prostitution if it would cut down on the spread of AIDS. Only 28% disagreed (Chetwynd 1987).

### **3 The Bill will enable health and occupational safety legislation and employment legislation to be more rigorously applied to the sex industry.**

Although the Health and Safety in Employment Act 1992 theoretically covers sex workplaces, the fact that some activities associated with those workplaces are illegal under present law cannot be conducive to the effective implementation of the Act. Decriminalisation of prostitution will make compliance with the Act more transparent. Employers of sex workers will be prepared to identify STIs as a potential hazard for sex workers, under their obligations in the OSH Act, and so be obliged to make provisions for employees to prevent such hazards under the provisions of Clauses 6 through 9 of the Bill.

It is also appropriate at this point to acknowledge that many owners of sex work places treat their workers with dignity and respect, and take the risk of prosecution by providing as safe

an environment as they reasonably can. However, the illegal status of brothel keeping is a major barrier to full compliance with health and safety standards and permits unscrupulous entrepreneurs. Ensuring that this Act, as well as employment legislation, can be fully implemented in relation to sex workers will assist in reducing their risk of exploitation and will redress, to some extent, inequalities vis-à-vis sex workers and their employers or the owners of the premises from which they work. Achieving this objective will enhance the health of sex workers in a direct sense, by ensuring that their workplaces are as safe as possible (e.g. by requiring prophylactics to be available); and in an indirect sense by giving them a greater degree of control and power over their work lives.

Sex workers, especially those who work on the street, also face a high risk of violence, including rape. Parlour work is safer, as the workers have more control over their working environment (Woods 1996), but the present law which bans anyone who has been convicted of a prostitution-related offence from working in a parlour forces those workers onto the street.

Because their work is criminalised and stigmatised, sex workers are unlikely to seek legal redress. Recent New Zealand research indicates that many sex workers hesitate to seek support or redress from police or other health and social service agencies after assaults or other abusive incidents. Although 66% of the women sex workers interviewed in this study thought that ‘some’ police cared about their safety, just over 20% did not believe that the police would help, and 15% did not believe that ‘any’ police cared about their safety (Plumridge and Abel 2000).

The risk posed by violent clients and unscrupulous owners of premises would be significantly reduced under the Health and Safety in Employment Act. We therefore support Clauses 7 through 9 of the Bill, which would make it an offence to coerce anyone to provide commercial sexual services or to surrender the proceeds of these services.

The intent of this Bill is consistent with UN guidelines on HIV/AIDS and Human Rights, which state that:

*Regulations should enforce occupational health and safety guidelines to protect sex workers and their clients*

(United Nations 1998)

and with health and safety guidelines for brothels published by the New South Wales Department of Health, which require proprietors to

*provide information to sex workers in the workplace about safe sex [and] written information at the workplace for clients about the transmission of STDs, including HIV infection and hepatitis A, B and C.*

(Prostitution Law Reform Campaign, unpublished paper)

## **Some specific points**

(1) The PHA supports the need for amending the definition of brothel from that currently proposed in Clause 4 of the Bill. Our preferred option would be to add the words “which is not normally used as the residence of the person or persons operating from there” after the words “prostitution”. We also support amending the definition of ‘business of prostitution’ by adding the words ‘not normally resident in the premises’ after the word ‘who’ in subclause (b).

(2) The PHA supports also the concept of a new provision to be added to the Bill to allow for “wiping the slate clean” for prostitution-related offences committed over a specified period. The injustice that this Bill seeks to remove would be perpetuated if sex workers who were convicted of minor offences prior to the passage of this legislation continued to suffer for the rest of their lives for activities no longer considered to be an offence.

## **Appendix: Sexually Transmitted Infections in New Zealand**

Statistics collected in 1999 through sexual health clinics and reported to the Institute of Environmental Science and Research (ESR) indicate that gonorrhoea infections have increased from 1996-1999. The greatest increases occurred in Maori, people under 25, and women. Maori and Pacific Islands peoples have been found to have consistently higher rates of STIs amongst sexual health clinic attendees as well as the general population (Turley, McNicholas et al. 2000).

Chlamydia was the most commonly diagnosed bacterial STI in sexual health clinics in 1999 and “represents a considerable burden of disease in New Zealand” (Turley, McNicholas et al. 2000). The number of confirmed diagnoses increased by 40% between 1996 and 1999, with a 45% increase in women and a 34% increase in men. Young people, Maori and Pacific Islands people had higher infection rates. Laboratory data reported to ESR indicate that women in the general population tend to have higher infection rates than men. Moreover, chlamydia incidence is likely to be underreported as not all of those with the infection have had a laboratory test to confirm the diagnosis. (Turley, McNicholas et al. 2000)

Women are targeted for chlamydia screening as they are more likely to have asymptomatic infections and are more vulnerable to long-term complications such as pelvic inflammatory disease (PID), ectopic pregnancy and infertility (Turley, McNicholas et al. 2000). Infertility can place a huge cost on secondary services such as provision of *in vitro* fertilisation etc. Other costs include antiviral drugs and other treatments such as drugs used to treat HIV.

STI surveillance data collected at sexual health clinics underestimate the incidence of STIs, as more than 50% of infections are diagnosed by other health providers. STI surveillance is to be expanded gradually to include data from family planning clinics, student and youth health clinics as well as laboratories. STI surveillance data are also limited because they provide only minimal information on risk factors for STIs (Turley, McNicholas et al. 2000).

Although the majority of those living with HIV and AIDS continue to be men who have sex with men, more females have been diagnosed with HIV recently. The latest statistics from the AIDS Epidemiology Group indicate that in the 12 months to 31 December 2000, nearly 32% (28 of 88) of those diagnosed with HIV infection were female (AIDS Epidemiology Group 2001). Nineteen of these 28 new infections in women were reported as acquired through heterosexual contact. Over 20% of men newly diagnosed with HIV infection reported acquiring the virus through heterosexual contact.

## References

AIDS Epidemiology Group. *AIDS - New Zealand*, Issue 47, February 2001. Dunedin: University of Otago Medical School, Department of Preventive and Social Medicine.

Chetwynd J. *A National Survey of New Zealanders' Knowledge, Attitudes and Behaviour Relating to AIDS*. Wellington: Department of Health, September 1987.

Chetwynd J. The Prostitutes Collective: a uniquely New Zealand institution. In *Intimate Details and Vital Statistics: AIDS, sexuality and the social order in New Zealand*. Auckland University Press 1996.

Dalley B. The Confectionary Bagnio and the Boys in Blue: the Suppression of One-woman Brothels in New Zealand 1908-1917. In *New Countries and Old Medicine: proceedings of an international conference on the history of medicine and health*, edited by Linda Bryder and Derek Dow. Auckland: Pyramid Press 1995.

Global Programme on AIDS and Programme on STD. *Consensus Statement from the Consultation on HIV Epidemiology and Prostitution*. Geneva: World Health Organisation, 1989.

Ministry of Health. *The New Zealand Health Strategy*. Wellington: Ministry of Health 2000)

Plumridge, L and Abel, G. *Services and information utilised by female sex workers for sexual and physical safety*. *New Zealand Medical Journal*, vol. 113, p 370-372, 8 September 2000.

Prostitution Law Reform Campaign. *Prostitution Law Reform 2001: A Briefing Paper*. Wellington: January 2001.

Prostitution Law Reform Campaign, unpublished information kit.

Turley M., McNicholas A. et al. *Sexually transmitted infections at New Zealand sexual health clinics, 1999*. In *New Zealand Public Health Report*, vol 7, no 11/12, November/December 2000. Porirua: Institute of Environmental Science and Research.

Turley M and McNicholas A. *STI Surveillance: Quarterly Report July-September 2000*. Porirua: Institute of Environmental Science and Research.

United Nations. *HIV/AIDS and Human Rights: International Guidelines*. Report on the international consultation on HIV and Human Rights, New York 1996. Geneva: United Nations 1998.

Woods A. Safe sex and parlour work: condom use by women parlour workers in and out of work. In *Intimate Details and Vital Statistics: AIDS, sexuality and the social order in New Zealand*. Auckland University Press, 1996.