3 October 2025

To the Community Affairs Legislation Committee

Re: Australian Centre for Disease Control Bill 2025

Thank you for the opportunity to provide feedback on the Australian Centre for Disease Control Bill 2025 and related bill enabling the establishment of the Australian Centre for Disease Control (CDC).

Formed in 1989, Scarlet Alliance is Australia's national peak sex worker association. Our membership includes sex worker organisations and individual sex workers across unceded Australia. We advocate for equality, justice, work health and safety and better health outcomes for sex workers, using evidence-based best practices including peer education, community development and engagement.

Through our work and the work of our member organisations, Scarlet Alliance has more contact with sex workers and access to sex industry workplaces than any other organisation in Australia. We represent sex workers on a number of government and non-government committees and advisory mechanisms, and provide expertise on sex work in a variety of federal, jurisdictional, research, service provision and civil society arenas.

As the peak body representing sex workers and sex worker organisations, Scarlet Alliance is a member of Health Equity Matters. Health Equity Matters is the national federation for Australia's leading HIV organisations, who are recognised as vital partners in developing and delivering Australia's world-leading HIV response.[1]

The strong partnerships and collaboration between governments, affected communities, NGOs, clinicians and research bodies have been essential to delivering successful public health responses. Establishment of Australia's CDC must recognise and support the expertise and capabilities of peer and community organisations in responding to existing and emerging public health challenges, and provide frameworks to ensure that affected communities can share knowledge and provide input into the decisions that impact them.

Yours faithfully,

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[1] 'Australia's world-leading HIV response,' *Health Equity Matters* (19 June 2024).

Peer-led organisations are community health leaders

For over four decades, partnerships between governments, researchers, clinicians and peer-led and community organisations have been integral to Australia's public health responses. This partnership approach is supported by a strong evidence base,[2] and is reflected in Australia's National Strategies for HIV,[3] hepatitis B,[4] hepatitis C[5] and sexually transmitted infections (STI).[6]

Particularly in relation to blood-borne viruses (BBV) and STI, many impacted populations experience stigma, criminalisation and surveillance. Stigma and criminalisation can result in public health advice that frames our communities as 'vectors of disease' or existential threats to public health. Poorly-framed evidence can also be used to validate the role of police and the criminal legal system in 'deterring' behaviours (such as sexual practices or drug use) and in 'monitoring' communities (LGBTQI+ people, Aboriginal and Torres Strait Islander peoples, migrants, sex workers and people who use drugs) deemed to be 'responsible' for disease transmission.

Further, failure to see sex work as work also often results in decision-making about the lives of sex workers being made based on stigma rather than evidence, and without or against advice from peer-led organisations. This has real-world impacts in undermining Australia's public health responses.

For example, in 2007, an ACT sex worker living with HIV was prosecuted for providing a sexual service while 'infected with a sexually transmitted disease.' Despite there being no evidence of transmission or unsafe behaviour, the worker's name, HIV status and other personal details were released to the media by the ACT Department of Health, resulting in publication by media outlets all over the world.[7] The publicity resulted in ACT sex workers becoming fearful of STI screening, leading to a 'dramatic drop' in attendance at the outreach testing service from an average of 40 workers per night to just three in the weeks following the court case.[8]

During the COVID-19 pandemic, 'the lack of willingness of state and federal health departments to engage directly with sex worker peer organisations on COVID-19…missed an important opportunity to create a

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[2] See, e.g., Christine Sturrock et al., 'Community-based sexual health care works: a review of the ACT outreach program' (2007) 4(3) *Sexual Health* 201;
Susan Kippax, 'Effective HIV prevention: the indispensable role of social science' (2012) 15 *Journal of the International AIDS Society* 17357;
Graham Brown et al., 'Mobilisation, politics, investment and constant adaptation: lessons from the Australian health-promotion response to HIV' (2014) 25(1) *Health Promotion Journal of Australia* 35;
Julie Bates and Rigmor Berg, 'Sex Workers as Safe Sex Advocates: Sex Workers Protect Both Themselves and the Wider Community From HIV' (2014) 26(3) *AIDS Education and Prevention* 191;
Graham Brown et al., 'A Systems Thinking Approach to Understanding and Demonstrating the Role of Peer-Led Programs and Leadership in the Response to HIV and Hepatitis C: Findings From the W3 Project' (2018) 6 *Frontiers in Public Health* 231;
Sara Fiona Elisabeth Bell et al., 'Online HIV Self-Testing (HIVST) Dissemination by an Australian Community Peer HIV Organisation: A Scalable Way to Increase Access to Testing, Particularly for Suboptimal Testers' (2021) 18(21) *International Journal of Environmental Research and Public Health* 11252.

[3] Australian Government, *Ninth National HIV Strategy 2024-2030* 12.

[4] Department of Health, Disability and Aging, *Draft Fourth National Hepatitis Strategy 2023-2030* 7-8.

[5] Department of Health, Disability and Aging, *Draft Sixth National Hepatitis C Strategy 2023–2030* 7-8.

[6] Department of Health, Disability and Aging, *Draft Fifth National Sexually Transmissible Infections Strategy 2024–2030* 10-12.

[7] Elena Jeffreys et al., 'HIV criminalisation and sex work in Australia' (2010) 18(35) *Reproductive Health Matters* 129, 130.

[8] Ibid.

collaborative, community-centred approach.'[9] In Queensland, sex workers experienced targeting from police under now-repealed laws while following self-isolation protocols.[10] Individual sex workers also reported police turning up at their private residences and demanding proof that they were not providing in-person services. Some of these workers were not advertising at the time, and reported that their addresses were likely obtained from police records relating to crimes reported by these workers - a gross misuse of the personal data of victims of crime.[11]

In Victoria, media statements concerning sex work from Victoria Police directly contradicted COVID-19 directions by the Department of Health and Human Services and advice issued to sex worker peer organisation Vixen, causing confusion and misrepresenting sex workers as a threat to wider public health.[12]

Without government recognition or funding, sex worker peer organisations mobilised to create our own national response to meet the needs of our communities. Scarlet Alliance and its membership of sex worker organisations established a national committee to share information and develop a national response. The committee engaged directly with government health advisors and departments of health, and was able to fast-track information sharing with the sex worker community while dispelling misinformation that could have increased risk.

From March to early December 2020, Scarlet Alliance and our members raised $180,998 from private donations (without government support), making 760 crisis support payments to sex workers unable to access government supports.[13] We also created two extensive COVID-19 community resources, each translated into five languages.

Our member organisations were also integral to developing best-practice protocols appropriate to local situations, sourcing and distributing PPE, and providing wellbeing support. In South Australia, our member organisation SIN engaged in grassroots health promotion informed by the unique and diverse needs of criminalised sex workers. With the absence of targeted formal COVID-19 guidelines, SIN acted as a conduit for SA sex workers to share information and develop best practice health and safety protocols. In NSW, the Sex Workers Outreach Project (SWOP) NSW provided over 500 counselling sessions to sex workers during this period.[14]

The national committee also enabled sex worker organisations to function as an essential bridge between the sex worker community and government teams working on COVID-19. The Northern Territory Government collaborated directly with SWOP NT, the local sex worker peer organisation, to develop official COVID-safe guidelines for the industry. With technical support from Scarlet Alliance, SWOP NT drafted directives that aligned the Chief Health Officer's advice with NT WorkSafe regulations and the practical realities of sex work. The Government adopted these peer-developed guidelines, which were then published by the NT Department of Health. This direct partnership demonstrates the essential role of community leadership in creating trusted, evidence-based, and effective public health responses during a rapidly evolving crisis. This type of rapid response must be facilitated within CDC structures.

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[9] Scarlet Alliance et al., *COVID-19 and Sex Work in Australia* (September 2020) 10.
[10] Ibid 5.
[11] Ibid 6.
[12] Ibid 6.
[13] Scarlet Alliance, 'Ahead of the Curve' (Event Flyer, 10 December 2020).
[14] Ibid.

Most recently, in August 2025, a cluster of mpox cases was identified among sex workers in Sydney. Acting on timely intelligence from the NSW Ministry of Health, SWOP NSW immediately mobilised a targeted, peer-led response. In this instance, the partnership approach was swift and effective. Using Ministry data, peer educators conducted direct outreach in affected workplaces, networks and areas. SWOP NSW ran a sex worker-only clinic to provide vaccination and care in a safe and stigma-free environment, and worked with public health clinics to ensure sex workers and their clients could easily and quickly access vaccination. This targeted response achieved a very high mpox vaccination rate amongst NSW sex workers, and the outbreak was shut down in a matter of weeks.

These cases highlight the effectiveness of partnership approaches, as well as the dangers of ignoring community expertise. The CDC requires legislative mechanisms to facilitate ongoing direct engagement and knowledge transmission with and between affected communities, ensuring that policy advice to governments across Australia and health promotion to our communities is culturally appropriate, reflects lived realities and responds to emerging trends.

Recognising community expertise - definition of 'public health matters' and Advisory Council qualifications

Community health expertise is distinct from clinical or academic knowledge. It includes applied understanding of how people respond to public health issues in real-world contexts, and how to improve health behaviours and outcomes through outreach, peer-led education, and culturally responsive care. This expertise is essential to building trust, ensuring equity, and achieving effective public health outcomes.

Scarlet Alliance is concerned that:

- The definition of 'public health matters' does not include explicit reference to community health.
- The expertise, qualifications and experience required for appointment to the Advisory Council do not explicitly include expertise in community health.

Without explicit recognition, there is a strong risk that advice provided to the Director-General will not be routinely informed by community health expertise. This undermines both trust among affected communities and the CDC's capacity to develop appropriate advice on marginalised populations that have historically had poorer health outcomes.

Embedding community expertise - Director-General functions, Advisory Council membership and Community Committee

Community health expertise must also be structurally embedded within the CDC. This can be achieved by:

- Requiring that the Advisory Council have at least one appointed member with community health expertise. We also recommend expanding Advisory Council membership to enable diverse expert representation, and to ensure that responses to public health emergencies do not further marginalise sectors of the community, or have reduced impact or unintended consequences
- Creating a statutory function for the Director-General to establish and resource community engagement mechanisms, including for disproportionately affected populations.
- Creating a statutory function for the Director-General in cl 11(h) to provide advice to and consult with 'bodies representing the interests of workers.' This follows the recommendation of the

Australian Council of Trade Unions.[15] Guidance material should note that this includes consultation with sex worker peer organisations.

- Establishing a Community Committee, chaired by a recognised leader in community health, with the Chair serving as a member of the Advisory Council. As a standing body, the Community Committee can facilitate the CDC's access to trusted, real-time intelligence from affected communities, especially during public health emergencies. This model is consistent with the NHMRC's approach to community advice in governance,[16] and would ensure that community expertise is integrated across the CDC's advisory structures. The CDC should consult with the national STI/BBV peak organisations (as identified in the national strategies) in the development of the Terms of Reference for the Community Committee, ensuring the mechanism is adequately supported to provide advice on priority populations.

Evaluation of CDC's partnership approaches

The establishment of the CDC is a significant policy development, and requires a statutory review provision. The Bill should require an independent review of the CDC, with specific reference to evaluation of consumer and community engagement, within three years of commencement, reporting to Parliament with scope for legislative or administrative change.

Recommendations

Scarlet Alliance recommends:

1. Amending the definition of 'public health matters' (cl 5) to explicitly include consumer engagement and community health.
2. Amending the relevant qualifications and expertise for Advisory Council appointment (cl 30(4)) to include expertise in community health.
3. Amending cl 30 to specify that the Advisory Council must have at least one appointed member with community health expertise.
4. Amending cl 30 to expand the membership of the Advisory Council. Additional community membership will be necessary to ensure responses to public health emergencies do not further marginalise sectors of the community, or have reduced impact or unintended consequences because the response has not taken into account the needs of diverse communities.
5. Expanding the Director-General's statutory function in cl 11(h) to provide advice to and consult with 'bodies representing the interests of workers.' Guidance material should note that this includes sex worker peer organisations.
6. Inserting an additional statutory function of the Director-General (cl 11), being 'establishing and resourcing consumer and community engagement mechanisms, including for disproportionately affected populations.'
7. Establishing a standing Community Committee, chaired by a recognised leader in community responses to communicable diseases, with the Chair serving as a member of the Advisory Council.
8. Consult with the national STI/BBV peak organisations (as identified in the national strategies) in the development of the Terms of Reference for the Community Committee, ensuring the mechanism is adequately supported to provide advice on priority populations.

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[15] Australian Council of Trade Unions, Submission 8 to the Community Affairs Legislation Committee, *Ensuring Future Success – Securing worker health in the Australian Centre for Disease Control* (25 September 2025) 7.
[16] National Health and Medical Research Council (NHMRC), 'Consumer Advisory Group 2024–2027' (2024).

9. Including provision for an independent statutory review of the CDC within three years of the Bill's commencement, with specific reference to evaluation of consumer and community engagement.