

**The criminal law/public health dichotomy in disclosure laws –  
Address at the launch of  
*Criminalisation of HIV transmission – A guide for legal  
practitioners in NSW***

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***The tension between public health and popular opinion***

As is to be expected of criminal laws which intersect with issues of public health, there is a critical tension in the debate about the prosecution of people with HIV for transmitting or exposing others to the virus.

On the one hand there is an extraordinary range and depth of the public health forces marshaled against laws that criminalise people with HIV. They include almost every non-government organization and research centre and many of the health care practitioners working in the HIV sector in Australia.<sup>i</sup> They extend across regional and international HIV/AIDS organisations, academic legal researchers and include practically every human rights organisation working in the field.<sup>ii</sup> These sections of the community – actively engaged as most of them are in combating HIV disease – hold that laws which make it an offence to transmit or expose another to the virus and prosecutions under those laws hinder rather than help the fight against the disease.

On the other hand, if we conducted a poll of people on the street passing

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by this building tonight I suspect that a substantial majority would be in favour of penalties for people who knowingly or recklessly transmit or expose others to the risk of contracting the disease. I suspect also that most would be in favour of laws requiring people with HIV to disclose knowledge of that fact before having sex. A recent study of gay and bisexual men in the UK<sup>iii</sup> found that most were supportive of criminal sanctions in circumstances where a person with HIV had failed to disclose their status before sex.<sup>iv</sup> Gay men comprise by far the largest component of the Australian population living with HIV.<sup>v</sup> While I have not researched their views on criminal penalties, a majority certainly expect that HIV positive men will self-disclose and this expectation is held particularly strongly by non-gay community attached men.<sup>vi</sup> I will return to the issue of disclosure in a moment.

### *Reasons for not criminalizing HIV exposure or transmission*

Getting the balance right in the criminal law\_public health dichotomy is not an easy task. The list of reasons given for not criminalising HIV exposure or transmission is compelling.<sup>vii</sup> Invoking as it does the triple taboos of blood, sex and death, and the transmission vectors of homosexual sex and injecting drug use, HIV disease is seriously stigmatised. Globally, HIV has been and remains a disease of marginalised groups. Laws applying to people because of their HIV and prosecutions of them for HIV non-disclosure, exposure or transmission obviously reinforce that stigma.<sup>viii</sup>

In the public arena, the key note of HIV has always been blame. The key mechanism for responding to HIV has been described as 'othering' – the processes of making people with HIV different from people without HIV,

and of making HIV someone else's problem.<sup>ix</sup> This has two particular consequences, both of them bad for public health.

The most important public health message about HIV is that, viewed without context and as process, it is easy to avoid contracting the virus. One only has to ensure one takes steps to protect oneself – using condoms in penetrative sex and clean equipment when injecting drugs. Laws and prosecutions for HIV non-disclosure, exposure or transmission, however, send to the uninfected the wrong message about the disease – that the risk of contracting HIV comes from bad people who fail to disclose their infection or who knowingly or recklessly transmit the disease. These laws and prosecutions teach that you can avoid the risk of disease so long as people with HIV “do the right thing” and disclose and don’t recklessly or willfully have unprotected sex. In so teaching, criminal laws and legal proceedings against people with HIV are a positive menace to public health.

The second consequence is that such laws and prosecutions don’t just add unnecessary stress to the lives of people with HIV. In the jargon of public health, they send the infected and those at risk of infection underground. Paradoxically HIV laws and prosecutions provide *disincentives* to disclose to potential sex partners. The question has to be asked: what contribution do laws criminalising people with HIV make to the failure of some to disclose their HIV status to unsuspecting partners, thereby risking infection of those partners?<sup>x</sup>

Laws and prosecutions also provide disincentives to disclose to counselors and health care providers. Search warrants and subpoenas are used to obtain records of HIV service providers that can be used to prove that,

sometimes many years ago, a client or patient knew they had HIV and knew they were obliged to use condoms with sex partners. It doesn't take long for word to get around: either steer clear of counselors and health care providers or else give them false information, at least as to your identity. *Not* a great way of instilling confidence in health care providers on the part of the affected communities.

On the other hand, there is surprisingly little evidence that laws and prosecutions against people based on their HIV status actually deter people at risk from testing for HIV<sup>xi</sup> – although they may give rise to a greater use of false names.

### *Disclosure offences*

I want to speak at a little more length about Disclosure offences.

Generally, the more serious the harm involved, the more likely the law will criminalise harm-causing conduct only if the harm-doer has a morally blameworthy state of mind – in modern terms, if the offence has a fault element. Relevantly to a potentially fatal sexually transmissible infection, therefore, the law will require proof that the harm was done either *knowing* that harm would be the outcome or *being reckless* as to whether harm would be the outcome.<sup>xii</sup>

However, while that is the general rule, summary or less serious offences relating to HIV are an exception.

So, for example, where the harm at which the law is aimed is only a failure

to take specified measures then, although the prosecution must prove knowledge of infection with HIV, it is not otherwise required to prove a fault element. Nor is it required to prove a physical element that includes harm to another person. Rather, the lawmakers would say, the potential for harm is the policy underlying creation of the offence.

In this State, the latter type of offence is committed under the *Public Health Act*<sup>xiii</sup> by every person who knows that they have a sexually transmissible medical condition and who has sexual intercourse *unless*, beforehand, the sexual partner (to use the words of the statute) has been informed of the risk of contracting a sexually transmissible medical condition from the person with whom intercourse is proposed and has voluntarily agreed to accept the risk. A similar offence is committed by brothel-owners in respect of the people who have sex on the premises.

The law does not allow a defence of taking steps to prevent the sex partner contracting the medical condition (eg, using a condom or other safe sex strategies). This is in sharp contrast to public health policy. Public health policy has as the primary measure for prevention of the spread of the disease – rather than disclosure of infection or risk of infection – the *use of measures to prevent* transmission – typically the use of a condom.

In Australian health care settings, as a consequence of the HIV epidemic, standard precautions are required to be taken for infection control irrespective of knowledge as to the patient's status.<sup>xiv</sup> In sexual and injecting drug use transactions, public health policy likewise favours taking precautions against the risk of transmission irrespective of knowledge as to infection status. As a result, a culture of condom use has evolved in the

communities where there is the greatest concentration of behaviours risky for HIV transmission, namely the gay male communities across the country.

Because disclosure invites rejection and because condoms are safer than disclosure, it will come as no surprise to learn that the Failure to Disclose offence is committed probably thousands of times a week across the State and that this has been the case since its enactment in 1985.<sup>xv</sup> But by contrast, the offence has rarely been charged. Its most frequent use has been as a back-up to charges of Intentionally or Recklessly Cause Grievous Bodily Harm.

This does not mean however that the Failure to Disclose offence is a dead letter. Under Canadian law, failure to disclose HIV can vitiate consent to sexual intercourse.<sup>xvi</sup> Last month, a Toronto man was charged with attempted murder and aggravated assault on the bare allegation of having had unprotected sex with another man and not disclosing that he is HIV-positive.<sup>xvii</sup> In Sydney, on the complaint of a casual female sex partner a man was recently charged with the Failure to Disclose offence after allegedly having *protected* sex but failing to disclose his positive status. The problems with non-disclosure prosecutions in these cases are obvious.

But apart from the potential for abuse of prosecutorial discretion, let me return to the policy arguments against reliance upon disclosure of HIV status to potential casual sex partners as a disease prevention measure.

One concern often ventilated is that disclosure laws provide a disincentive to learning one's HIV status by getting tested. While this sounds right in

theory, the evidence for it is difficult to find particularly in New South Wales with its very high testing rates for gay men.<sup>xviii</sup> There are a number of reasons people might be disinclined to get tested but, as I will come to in a moment, such evidence as there is suggests a *lack* of a relationship between disclosure and the presence on the statute books of disclosure laws. This suggests a similar lack of a relationship with HIV testing rates. Of course, if disclosure laws were more systematically enforced this could dramatically change.

There are, however, a number of other reasons to be highly sceptical of laws requiring disclosure before sex – indeed, to fear that they are a public health menace. Taking the case of sexually active gay men in NSW, one of those reasons is that HIV negative men usually are averse to casual sex or having a relationship with someone they believe to be HIV positive. The experience of rejection after disclosure militates against positive men disclosing their status. And there is no reason to think that the experience of heterosexual positive men is any different to that of their gay counterparts. At the least, the response of uninfected people to people who do disclose they have HIV provides no incentive to disclose as a matter of course.<sup>xix</sup> In addition, it cannot be assumed that people with HIV all have the skills and the confidence to impart knowledge about their HIV status in what for anyone is often a psychologically challenging moment.

Another significant problem with disclosure laws is their premise that people with HIV possess knowledge of their status. The fact is that a person's belief in their HIV negative status could easily be wrong – the more so if they live in an area with a relatively high prevalence of the virus. Even leaving aside the risks posed by the window period in HIV antibody testing, the risk is that untested people who are in fact infected with HIV

are likely to believe – and to assert to potential sex partners – that they do not have HIV.

Policies and laws mandating disclosure are particularly fraught for the false sense of security they engender in uninfected people. The popular paradigm for law is that it enacts the moral standards of the people. The disclosure-based norm endorsed by such policies and laws encourages people at risk to rely on prospective sex partners to disclose their HIV status, if positive, and to assume that there is minimal risk absent positive serostatus disclosure. Serostatus disclosure laws thus risk fostering a false sense of security among HIV-negative persons who may choose to forgo condom use unless notified of their partners' HIV-positive status.<sup>xx</sup>

Laws mandating disclosure have been in place in different jurisdictions around the world for many years now but there is still no evidence that associates mandatory disclosure with reduced infection levels.<sup>xxi</sup> On the other hand, to the extent that it has been studied,<sup>xxii</sup> rates of disclosure appear to have no relationship to the presence on the statute books of a law mandating disclosure. The conclusions from that study are twofold. Where disclosure does occur it is often in the absence of knowledge of the law concerned. Second, the decision to disclose is driven by other, much more complex social and psychological processes.

One ray of hope was a trial court decision in 2005 in Wellington, New Zealand. In *Police v Dalley*<sup>xxiii</sup> the defendant was prosecuted for two offences: failing to discharge a duty thereby endangering life and failing to take reasonable precautions to avoid danger. The prosecution was based on the fact that the defendant with HIV had sexual intercourse without disclosing his HIV positive status. However, he used a condom. The

judge ruled that in those circumstances the defendant did not commit those offences for failing to disclose.

Unfortunately, the case has limited relevance to us in NSW. Although the Crown case theory in that New Zealand case was the defendant's fault lay in not disclosing his HIV status, the offences charged more closely resemble the statutory offence to be found in the Northern Territory, Victoria and South Australia of Conduct Recklessly Endangering Life. In New South Wales, we have transmission offences and disclosure offences but, leaving aside the offences consisting of Attempt, we have no exposure offences as such.

Nor, thankfully, do we have offences as they do in the Australian Capital Territory<sup>xxiv</sup> which actually prevent people with HIV working in the sex industry whether they disclose their status or not and irrespective of whether any person is harmed. However that is a topic deserving much greater attention than there is time to give it tonight.

### ***What is the role for the criminal law?***

The question to be asked at this stage, though, is what *is* the role for the criminal law in relation to HIV? You will notice I don't ask *whether* there is a role? There is a reason for this.

The orthodox argument in favour of prosecuting people who transmit or expose others to HIV is the age-old function of the criminal law –

- punishing those who do harm or expose others to the risk of harm,

and

- deterring others in like position from doing the same thing.

That being so, there is, I think, an unanswerable argument that the criminal law has a role to play at least in the protection of vulnerable people from harm from unethical conduct.

There has been a brace of cases in Australia over the last few years involving allegations against particular men of multiple offences of knowingly or recklessly transmitting HIV and involving criticism of a failure on the part of health authorities to involve the police where people were clearly being put at risk of harm. Following this, the Commonwealth promulgated *National Guidelines*<sup>xxv</sup> stipulating the circumstances in which cases *are* to be referred by public health authorities to the police. In April 2009 NSW Health published its, more conservative guidelines for *Management of People with HIV Infection Who Risk Infecting Others*.<sup>xxvi</sup> These require contact with the Department to be initiated –

- 1 immediately where there are clear grounds for a charge involving intentionally causing serious bodily harm; or
- 2 after further examination and / or intervention, where the person concerned shows unwillingness to alter behaviour that may recklessly or negligently endanger or causes serious harm.

The NSW guidelines make it clear that it is to be the Department, not the health care professional, who initiates any contact with the police and that it is likely to consult its expert Assessment Panel established for the

purpose.

One group which is particularly vulnerable to the risk of harm is women as sex partners of men. There are situations where women do not have the power to control the circumstances in which they have sex with men.

There are situations where women are entitled to believe that their sex partner will protect them from any risk of contracting HIV. I suggest most would agree that, irrespective of their inability to come to grips with their test results or communicate it to their partners, men who know or have reason to believe they might have HIV or another sexually transmissible infection *have an obligation* to protect their female sex partner from harm. The fact that, unlike most of the rest of the world, HIV remains in Australia predominantly a disease of sexually active gay men often can have the effect of lulling heterosexual Australian women into a false sense of security. It is difficult to argue there is no legitimate role for the criminal law where a man infects a woman, the man knowing or having reason to believe he might be infected but taking no precautions to protect his partner.<sup>xxvii</sup>

If the law has a role to play in vindicating the rights of these women, why not also in the case of gay men? Perhaps the response to that question needs to take into account the fact that in Australia HIV infection remains a disease predominantly of gay men and that both the culture of gay male communities and the public health messages make it clear that condoms should be used for gay male sex. The rights and responsibilities calculus in Australia would suggest that, in situations of relatively equal power, a gay man who fails to ensure protection is used has not got as much right to complain if he contracts HIV. And most don't. Nevertheless, can it not be argued that a gay man is as much entitled to vindication of his right to not

be *knowingly* infected with a sexually transmissible infection as is a heterosexual woman?

On the other hand, for two decades now the clear public health message for gay men has been that assumptions about HIV status can be wrong. At the very least an HIV antibody test result can be out of date. The public health message in Australian gay communities is that unsafe sex in a relationship is just that – unsafe – unless partners get themselves tested, twice, and then are honest with each other about their HIV risk afterwards.<sup>xxviii</sup>

Differences in the power dynamic, however, can sometimes make a gay male relationship just as fraught with risk for HIV transmission as that of women who have less power than their male partners.

These are the conundrums which confront us as we try to arrive at a principled position on the criminalisation of people with HIV.

### ***The HALC guide for legal practitioners in NSW***

The legal practitioner doesn't usually get the chance to argue the public health ramifications of the prosecution of their client. The practitioner rarely gets the chance to advise on the public health ramifications of the course of action they are being asked to take for their angry and upset newly diagnosed HIV-positive client.

True, a lawyer is sometimes *asked* to advise on the policy implications of contemplated legal proceedings or of the application to a set of facts of a particular law. Before a client commence civil proceedings for damages

or instigates the commencement of a criminal prosecution, in particular cases their lawyer arguably has a *duty* to advise as to the impact the proceedings may have on their client's health. Where that person has HIV then the stress and duration of litigation is unlikely to be life-prolonging.<sup>xxix</sup>

But once the lawyer is presented with a specific factual matrix, it is usually their job to act according to their instructions, to find the applicable law and to pursue the case in accordance with their professional duties.

Until today, Australian lawyers have had no up-to-date materials of assistance to them when called upon to advise and act in HIV cases. I am delighted to say that is no longer the case with the publication of *Criminal Transmission of HIV: A guide for legal practitioners in NSW*.

The *Guide* provides an essential chapter on the relevant sciences – clinical, epidemiological, virological, behavioural. It furnishes important background on human rights and HIV. A large number of national and international bodies have promulgated guidelines as to the policy considerations I have mentioned this evening – and many more besides. One of those is the British policy guidelines for the commencement of prosecutions in HIV cases. In the *Guide*, these are referenced.

The *Guide* then sets out the law applicable both to criminal liability and procedure in the prosecution of HIV cases in NSW. It deals with the offence of Maliciously Inflict Grievous Bodily Disease as it existed before February 2008, now the offences of either Inflict Grievous Bodily Harm Recklessly or with Intent. (The old offence could still be charged if a person committed it before the offence was changed.)

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The *Guide* covers potential defences, analysing issues such as –

- degree of risk to which an alleged victim may have consented
- use of condoms and other safe sex practices
- mistake of fact

as well as the fraught issue of disclosure.

The *Guide* covers issues such as the enforced production of health care records under subpoena, dealing with the media and finally includes a number of useful case summaries including important cases from New Zealand and the United Kingdom.

As you will have gathered, long before tonight, the prosecution of people with HIV in NSW has the potential both to vindicate people's basic rights to protection from harm, yet also the potential to disrupt one of the world's more successful exercises in the protection of public health.<sup>xxx</sup> Lawyers involved in HIV criminal cases need to be knowledgeable and skilful to steer their client – or, in the case of prosecutors – the Crown – through the thickets of conflicting and complex issues. Since the beginning of the epidemic, NSW has had easily the highest caseload of people with HIV in the country. For NSW lawyers working in HIV, the *Guide as to the Criminal Transmission of HIV for Legal Practitioners* is a most welcome resource.

The authors of the *Guide*, the HIV/AIDS Legal Centre and DLA Phillips Fox are to be particularly congratulated for its production.

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- i Eg, joint statement “HIV is a virus not a crime”, 19 September 2008 – available from <[www.afao.org.au](http://www.afao.org.au)>
- ii Eg, UNAIDS Reference Group on HIV and Human Rights *Statement on Criminalization of HIV Transmission and Exposure*, Geneva, 2008; UNAIDS policy brief *Criminalization of HIV Transmission* Geneva, August 2008; *10 Reasons To Oppose the Criminalization of HIV Exposure or Transmission* (2008) <[www.soros.org/initiatives/health/focus/law/articles\\_publications/](http://www.soros.org/initiatives/health/focus/law/articles_publications/)>; statement of International Community of Women Living with HIV/AIDS for 10 Reasons – “Stop HIV Criminal Laws, Leading AIDS Groups Say” <<http://www.icw.org/node/412>> (viewed 15 May 2009); S Burris & E Cameron “The Case Against Criminalization of HIV Transmission” *Journal of the American Medical Association* 2008(August 6);300:578-581.
- iii C Dodds, P Weatherburn, A Bourne et al *Sexually Charged: The views of gay and bisexual men on criminal prosecutions for sexual HIV transmission* (Sigma Research, London, January 2009) <[www.sigmaresearch.org.uk](http://www.sigmaresearch.org.uk)>.
- iv Although comprising a smaller proportion of new infections than in Australia, sexually active gay and bisexual men in Britain are still significantly at risk to contract HIV and their numbers of new infections are increasing faster than other sections of the population. Source: Terrence Higgins Trust, UK <[www.tht.org.uk/informationresources/factsandstatistics/uk/](http://www.tht.org.uk/informationresources/factsandstatistics/uk/)> (viewed 15 May 2009).
- v *HIV/AIDS, Viral Hepatitis & sexually Transmissible Infections in Australia Annual Surveillance Report*, National Centre in HIV Epidemiology and Clinical Research, Sydney, 2008 <[www.nchechr.unsw.edu.au](http://www.nchechr.unsw.edu.au)>.
- vi 2000 Male Out Survey – extracted at the Australian Federation of AIDS Organisations website <[www.thinkagain.com.au/whosays2.htm](http://www.thinkagain.com.au/whosays2.htm)> (viewed 15 May 2009).
- vii See, eg, AFAO discussion paper “Criminal prosecution of HIV transmission: the policy agenda”, Sydney, May 2009, pp 3-4. See also notes 1 and 2 above.
- viii See, eg, S Burris “Disease Stigma in US Public Health Law” *Journal of Law, Medicine & Ethics* 2002;30:179-190.
- ix F Hickson “HIV Transmission during sex between men: who’s failing, what’s failing?” (CHAPS 12th Annual Conference Plenary Address, Brighton, March 2009) <[www.sigmaresearch.org.uk](http://www.sigmaresearch.org.uk)> p 2.
- x See H Worth, C Patton, D Goldstein “Reckless Vectors: The Infecting ‘Other’ in AIDS Law” *Sexuality Research & Social Policy* 2005(June);2(2):3-14 – an edited version of the paper appeared in *HIV Australia* 2007;6(4):10-12 <[www.afao.org.au](http://www.afao.org.au)>. See also M Weait *Intimacy and Responsibility: The criminalization of HIV Transmission* Routledge-Cavendish, Oxford, 2007, chap 4: “Risk, Recklessness and HIV”.

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- xi See, eg, J Chalmers *Legal Responses to HIV and AIDS* Hart Publishing, Oxford, 2008 pp 152-53.
- xii Sections 33 & 35 *Crimes Act 1900* (NSW).
- xiii Section 13 *Public Health Act 1991*.
- xiv The risks attendant on reliance on disclosure in the circumstances of casual sex apply equally to health care settings where universal precautions (now called standard precautions) are considered best infection control practice – that is health care workers are trained to assume the patient or client is infectious and take precautions with all patients and clients to prevent the possible transmission of any blood-borne pathogen: NHMRC and Australian National Council on AIDS (ANCA) *Infection Control in the Health Care Setting* (1996) <[www.nhmrc.gov.au/publications/synopses/ic6syn.htm](http://www.nhmrc.gov.au/publications/synopses/ic6syn.htm)>. This policy guideline has now been replaced by equivalent documents in each Australian jurisdiction.
- xv See Tables 42 and 43 reproduced at <[www.thinkagain.com.au/whosays2.htm](http://www.thinkagain.com.au/whosays2.htm)> viewed 14 May 2009.
- xvi *R v Cuerrier* [1998] 2 SCR 371.
- xvii *Police v Mahmoodi* – “Man charged after not telling of HIV status: Two charges for alleged unprotected sex” *The Globe & Mail*, 8 May 2009 <[www.theglobeandmail.com](http://www.theglobeandmail.com)> viewed 14 May 2009.
- xviii National Centre in HIV Social Research *HIV/AIDS, Hepatitis and Sexually Transmissible Infections in Australia: Annual Report of Trends in Behaviour 2008* Sydney, 2008, pp 16-18 <[nchr.arts.unsw.edu.au](http://nchr.arts.unsw.edu.au)>.
- xix See the data collected at <[www.thinkagain.com.au/whosays2.htm](http://www.thinkagain.com.au/whosays2.htm)>.
- xx C L Galletly & S D Pinkerton “Conflicting messages: how criminal HIV disclosure laws undermine public health efforts to control the spread of HIV” *AIDS and Behaviour* 2006;10(5):1090-7165; “US criminal HIV disclosure laws may do more harm than good”; <[www.aidsmap.com/en/news/](http://www.aidsmap.com/en/news/)> 25 July 2006.
- xxi Galletly and Pinkerton, *ibid*.
- xxii S Burris, L Beletsky, J Burleso, P Case, Z Lazzarini “Do Criminal Laws Influence HIV Risk Behavior? An Empirical Trial” *Arizona State Law Journal* 2007;39:467-517.
- xxiii See S Cameron “Groundbreaking New Zealand case on disclosure” *HIV Australia* 2005;5(1):34-37; <[www.afao.org.au](http://www.afao.org.au)>
- xxiv Section 25 *Prostitution Act 1992* (ACT). In September 2008, a sex worker (Hector Scott) was sentenced to imprisonment for two months and four days for breaching the section. Despite lurid media claims of hundreds having been at risk over a number of years, no case of transmission has been publicized.
- xxv Endorsed by Australian Health Ministers’ Conference, 18 April 2008 – pp 6-7.

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- xxvi Accessible at <[www.health.nsw.gov.au/policies/pd/2009/PD2009\\_023.html](http://www.health.nsw.gov.au/policies/pd/2009/PD2009_023.html)> – p 14.
- xxvii Cf *R v Clarence* (1888) 22 QBD 23; *R v Dica* [2004] QB 1257; *R v L* (1991) 174 CLR 379 per Mason, Deane & Toohey JJ at 387-9, Brennan J at 399-401. See P Horsley, Co-ordinator, Positive Women Victoria: letter to the editor *HIV/AIDS Legal Link* 1998 (Sep);9(3):5; *Report of Workshop on Criminalisation of HIV Transmission* AFAO, Sydney, December 2006, p 4.
- xxviii The strategy is called “negotiated safety”. See AFAO briefing paper “Negotiated Safety” (July 1997) available at <[www.afao.org.au](http://www.afao.org.au)>. See eg, “Talk, Test: Test, Trust” <[www.vicaids.asn.au/content/ContentPage.asp?PageID=79](http://www.vicaids.asn.au/content/ContentPage.asp?PageID=79)> – viewed 8 June 2009.
- xxix Eg, J Leserman “Role of Depression, Stress, and Trauma in HIV Disease Progression” *Psychosomatic Medicine* 2008;70:539-545.
- xxx As to NSW’s relative success in containing HIV, see C Fairley, A Grulich, J Imrie, & M Pitts “Introductory Editorial: the analysis of a natural experiment in HIV control” *Sexual Health*, 2008;5:89; R Griew “Policy and strategic implications of Australia’s divergent HIV epidemic among gay men” *Sexual Health*, 2008;5:203—205; C Fairley, A Grulich, J Imrie & M Pitts “Investment in HIV prevention works: a natural experiment” *Sexual Health*, 2008;5:207—210; D BernardA, S Kippax & D Baxter “Effective partnership and adequate investment underpin a successful response: key factors in dealing with HIV increases” *Sexual Health*, 2008;5:193--201 - <[www.publish.csiro.au/journals/sh](http://www.publish.csiro.au/journals/sh)>.