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12 November 2010

Professor Steve Wesselingh
Chair of Review Committee
Faculty of Medicine Nursing & Health Sciences
Monash University
Building 64 – Wellington Road
Clayton
VICTORIA 3800

Dear Professor Wesselingh,

Re: Review of Australian Blood Donor Deferrals Related to Sexual Activity

AFAO is the national federation for the HIV community response. AFAO's members are: the National Association of People Living with HIV/AIDS; the AIDS Councils in each state and territory; the Australian Injecting & Illicit Drug Users' League (AIVL); the Anwernekenhe Aboriginal and Torres Strait Islander HIV/AIDS Alliance (ANA); and Scarlet Alliance, the national organisation representing sex workers. AFAO advocates for its member organisations, promotes medical and social research into HIV/AIDS and its effects, develops and formulates policy on HIV/AIDS issues, and provides HIV policy advice to the Commonwealth Government.

AFAO commends the Red Cross for its decision to commission an independent review of blood donor deferrals related to sexual activity. The review represents an opportunity to consider the implications of improvements in testing and disease surveillance mechanisms, changes in community practices, and understanding of those practices informed by current social and behavioural research. Such considerations are vital to ensuring Australia's internationally esteemed response to HIV remains evidence based.

This review is also an ideal opportunity to facilitate better engagement with the Red Cross Blood Service regarding policy development that impacts on HIV prevention. Ongoing partnership, consultation and dialogue involving HIV community organisations must guide communicating the results of this review to the public, regardless of whether the outcome results in a change in policy or if the status quo is maintained.

AFAO's work is based on the premise that an effective HIV response requires an 'enabling environment' dependent on the minimisation of homophobia and HIV-based stigma. Frequently, that work includes a focus on HIV transmission risk informed by the experience of people living with HIV. In particular, HIV prevention strategies are 'sex positive', grounded in

the understanding that sex is a natural, healthy part of life. Traction around this approach has increased since the 1980s as treatments have become more effective and people living with (PLHIV) on treatment experience better general health and longer life expectancy. HIV sex-based prevention practices must be applicable across a person's lifetime. HIV prevention policy requires the development of strategies that identify and eliminate unfounded discrimination on the grounds of sexuality.

AFAO's views are informed by the diversity of our membership. We note that mechanisms for delivering state-based HIV services have changed considerably during the last decade, with many services broadening their focus to include lesbian, gay, bisexual and transgender health. This is partly a response to the fact that the majority of people diagnosed with HIV infection in Australia continues to be gay and other men who have sex with men (collectively referred to as MSM for the purposes of this submission), and AFAO recommends and endorses the submission to this review provided by the National LGBT Health Alliance.
HIV prevention messages are likely to be most effective if understood as part of a broader, holistic approach to health promotion. AFAO is uniquely placed to comment on issues regarding HIV prevention and sex and sexuality which routinely affect gay men and other MSM. The Red Cross Blood Service preclusion policy regarding MSM is a case in point.

The absence of a Red Cross Blood Service donor deferral policy outlining the evidence base for each category of deferral or a similarly framed discussion paper to inform this preliminary stage of the review has hampered analysis of the current MSM deferral policy. The different deferral periods for specific population groups were presumably developed on the basis of scientific and epidemiological evidence, however, it would seem that current MSM deferral policies, as well as deferral policies in respect of other groups, may be based on rationales that are no longer relevant in 2010.

This submission covers issues relating to MSM deferral policies. Scarlet Alliance is making separate submissions regarding sex worker deferral policies.

Bearing in mind that a discussion paper will be produced by the Committee later in the review process, this submission seeks to provide background and contextual information regarding the HIV response in Australia as a means of contextualising and questioning the continuing application of the twelve month deferral policy for MSM.

Time limited versus lifetime ban: international comparison

A lifetime ban applies to men who have had sex with men in many countries (with upper age limits on donations ranging from ages 61 to 81), including Austria, Belgium, Canada, Denmark, Finland, France, Germany, Ireland, Netherlands, Norway, Portugal, Singapore, Switzerland, the UK and the United States. Recently, New Zealand reduced its deferral of MSM blood donations from 10 years to 5 years. Comparatively, Australia's 12 month deferral policy for MSM is short and notably, Sweden recently moved to a similar 12 month preclusion period for MSM based on risk practices.

Italy and Spain use different policies to assess HIV transmission risk among MSM. AFAO understands that in Spain deferral is applied to any person who has had more than one sexual partner during the previous 12 months. Given the extremely low prevalence of HIV in the Australian heterosexual population, that exclusion would be unwarranted in the Australian

context (and the Spanish policy may in fact be an attempt to remove discrimination against MSM, rather than a response to risk associated with multiple sexual partners). In Italy, it appears potential donors are interviewed by a doctor and their individual risk factors assessed, although some centres continue to operate a blanket exclusion of MSM. AFAO does not support such a methodology given concerns about the limitations of an individual interview based system (as outlined above).

Broad repercussions of changing blood donor policy

AFAO acknowledges the utility of the deferral policies put in place by the Red Cross Blood Service to date, and recognises that any consideration of reducing the 12 month deferral for MSM must have regard to the public's fear of transfusion-related infection in the early 1980s, the consequences of medically acquired HIV, and the consequent stigma resulting in vitriolic attacks against gay men and other non-medically infected HIV-positive people. AFAO is aware of only one recorded case of HIV transmission through the Australian blood supply since 1985 (not MSM related), and understands that there have been no infections traced to the Blood Service since the adoption of Nucleic Acid Testing in the year 2000.

AFAO notes that the Blood Bank relies on very broad groupings of people when defining those precluded from donating blood (understood to exclude some 32% of the Australian population at any one time). AFAO recognises that these broad groupings have provided an effective screening mechanism and that the Blood Bank has been able to secure adequate blood donations to satisfy demand for blood and blood products. Given the apparent absence of pressure to increase blood donation, the Red Cross would perhaps lack a strong motivation to change current policy.

The Red Cross may wish to avoid significant changes to blood donor policy given workplace and workforce implications. For example, the current use of a short and simple form does not require the undertaking of complex assessments or the exercising of value judgements. A change to policy requiring staff to conduct detailed evaluations about a potential donor's sexual history or to make judgements about an individual's level of risk would pose significant issues for workforce selection, training and skills development.

- *AFAO remains absolutely committed to the ideal that HIV must not be transmitted through transfusion of blood or use of blood products. This submission argues that the 12 month deferral of MSM is no longer necessary or supportable in terms of maintaining the safety of the blood supply, given the reliability of the HIV testing currently used by the Blood Service, and the short window period applying to that test.*

The HIV testing 'window period' and safety of the blood supply

There have been significant technological advances in HIV testing since 1985 which have enabled fundamental changes to Blood Service procedures regarding HIV tests. Importantly in terms of this review, we understand that prior to 1 July 2010, the Red Cross Blood Service tested donations for blood borne viruses by testing pooled samples. When a pool tested positive for a blood borne virus, each sample donation was then tested individually. That

process was clearly labour intensive. Since 1 July 2010, testing practices have changed to allow every individual blood donation to be tested for HIV: no back-tracking or re-testing of large numbers of donations is required.

The type of testing currently employed, Nucleic Acid Testing, enables identification of the presence of the HIV virus rather than the development of antibodies. Consequently, the window period between a person being infected with HIV and identification of HIV in their blood has been significantly reduced to a median of 11 days.

Discrimination issues

AFAO notes that the Tasmanian Anti-Discrimination Tribunal recently found that discrimination against MSM in Red Cross blood donor deferral policy is not unlawful.

AFAO acknowledges that donating blood is not a right, and that the Red Cross Blood Service has an obligation to put procedures, policies and guidelines in place to protect the blood supply. AFAO accepts that the 12 month deferral policy for MSM who have had oral or anal sex during the previous twelve months is not directly related to a potential donor's sexuality per se; the policy was developed to address considerations relating to increased risk of HIV infection attributable to sexual practices. That being said, the MSM deferral policy effectively discriminates against sexually active MSM. The question is whether that discrimination is warranted.

The following comments are made in the context that all forms of discrimination, including sexuality based discrimination, are undesirable. Discrimination can be hurtful and damaging to individuals, is frequently socially harmful and can substantially undermine HIV prevention, care and support initiatives.

Direct Discrimination: With regard to the suite of Blood Service deferral and preclusion policies, direct discrimination occurs as a result of the Red Cross identifying groups of people at increased risk of carrying blood-borne viruses rather than the specific identification of individuals at increased risk. In many instances, individual members of those risk groups are actually at no risk of infection with a blood-borne virus (for example, HIV-negative gay men in a monogamous relationships where neither has had sex outside the relationship), and some groups are only at minimally increased risk of infection when compared to those outside the group (for example MSM who only engage in oral sex).

Groups that are precluded or deferred from donating blood include those who:

- have had acupuncture (4 to 6 months for full donation)
- have had a tattoo (6 months)
- have a partner who has injected drugs (6 months)
- have had sex with a sex worker (12 months)
- have had sex with a person who lives or comes from a country with high HIV prevalence (12 months)
- have been in prison (12 months)

- gave resided in the UK between 1980 and 1996 for a cumulative period of 6 months or more or have received blood transfusions in the UK since 1 January 1980 (lifetime)[1]
- have ever injected drugs (lifetime)

MSM are precluded from donating blood on the grounds that particular attributes apply to them as a member of a group: not as individual MSM. Given the many broad categories of people precluded or deferred from making blood donations, AFAO considers that the identification of MSM as a risk group in this context is reasonable (more details on 'risk' are included below).[2]

Indirect Discrimination: HIV transmission risk relates to a variety of factors, not the least of which are physiological. Risk of HIV transmission during each instance of unprotected vaginal intercourse has been calculated at between one chance in 1250 and one chance in 333 (HIV-positive man to woman), and between one chance in 2500 and one chance in 263 (from HIV-positive woman to man)[3]. Risk from each instance of unprotected anal intercourse has been calculated at between one chance in 122[4] and one chance in 70[5] (from HIV-positive insertive partner), and between one chance in 909 and one chance in 161 (from HIV-positive receptive partner)[6].

Of course, condom use (see below), low viral load, frequency of sex and numbers of partners impact risk of HIV transmission whether sexual partners are heterosexual or same sex, however, HIV risk may generally be understood as higher across populations of MSM compared to the general population. In 2008, 89% of HIV transmission was the result of sex between men. Clearly, male to male sex is the primary transmission route for HIV in Australia, and being a person who engages in male to male sex puts a person at increased risk of HIV transmission.

The actual prevalence of HIV in Australia is not known given not every person infected with HIV has been tested and diagnosed. NCHECR estimates that between 5 and 10 percent of MSM are HIV-positive. That suggests 90% or more of MSM are not HIV-infected and most will not become infected, however, MSM remain some 100 times more likely than non-MSM to be HIV-positive.

While AFAO acknowledges the utility of maintaining a deferral period for MSM, a deferral period for MSM that extends far beyond the HIV test window period appears to be without rational foundation. AFAO proposes that in the absence of a rational justification for a deferral period of 12 months, the current MSM deferral policy unreasonably discriminates against MSM – particularly sexually active gay men.

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[1] as a result of the absence of a blood test for Variant Creutzfeldt-Jakob disease (the human form of 'mad cow' disease)

[2] Note: it is a similar argument that enabled the 2009 decision by the Tasmanian Anti-Discrimination Tribunal that a gay man had not suffered unlawful discrimination when refused the opportunity to donate blood.

[3] Boily M, Baggaley R, Wang L, Masse B, White R, Hayes R, Alary M. Risk of HIV-1 infection per sexual act: systematic review and meta-analysis of observational studies. Lancet Infectious Disease 9: . 2009.

[4] Vittinghoff E, Douglas J, Judson F, McKirnan D, MacQueen K, Buchbinder SP.Per-contact risk of human immunodeficiency virus transmission between male sexual partners. American Joural of Epidemiology. 150(3), 1999.

[5] Jin F, Jansson J, Law M, Prestage G, et al. Per-contact probability of HIV transmission in homosexual men in Sydney in the era of HAART. AIDS, published online ahead of print, 2010.

[6] Boily, op cit.

Defining MSM as a high risk group

Anal sex with a condom

The Red Cross deferral policy includes male to male sex using a condom, a policy which appears at odds with safe sex messages which stress the reliability of condoms when used correctly, with significant effort having been applied to education on the mechanics of correct use. HIV cannot pass through condoms, however, HIV may be transmitted when people use condoms incorrectly or when condoms slip or break during sexual activity. AFAO accepts that not every man who has engaged in male to male anal sex using a condom will be aware that the condom has not been used effectively or that it has slipped or torn. Such persons have been put at risk of HIV infection during high risk sexual activity but may be unaware of that risk.

- *AFAO supports the deferral of blood donations from men who have used condoms while engaging in anal sex with a male partner, given that HIV transmission is known to have occurred as the result of incorrect condom use and condom slippage and breakage. That support is also informed by the understanding that that some MSM who have used condoms may be unaware of the condom failure and so may not realise that they have recently been put at risk of HIV infection.*

Oral Sex

The Red Cross deferral policy includes male to male sex, including oral sex and oral sex using a condom. AFAO questions the rationale and application of this measure. The risk of HIV transmission through oral sex is generally acknowledged to range from zero to very low. Risk for the insertive partner in fellatio is so low that it is impossible to calculate a risk. Risk for the receptive partner is also understood to be very low, although no definitive studies exist, given the difficulty of identifying a large enough sample of MSM who only engage in unprotected oral sex. Still, researchers suggest the throat is less susceptible as a site of transmission than genital and anal tissue, that saliva actually inhibits HIV, and that digestive enzymes in a person stomach may destroy HIV. The few verified cases of HIV transmission through oral sex (from outside Australia) appear to have occurred when significant sores or lesions have also been present in the receptive partner’s mouth. There are no documented cases of HIV transmission through oral sex when a condom has been used and the likelihood of incorrect condom use or unrecognised condom breakage or slippage in this instance appears remote.

- *While AFAO supports a deferral policy affecting sexually active MSM who engage in anal sex, imposing a period of deferral far beyond the testing window period is excessive and unnecessarily discriminatory, as is extending deferral to MSM who solely engage in risk-free sexual practices.*

- *AFAO submits that the deferral policy applying to men who have engaged in oral sex with a male partner is unsupportable in relation to HIV and should be reconsidered (noting particular consideration of syphilis risk may be required).*

Monogamous Relationships

Monogamous HIV-negative MSM are not at risk of HIV infection, however, not all people who believe themselves to be in monogamous relationships are in fact in monogamous relationships due to the unknown actions of their partners. This understanding is widely enough understood to have prompted HIV educators to include work on negotiating relationships and/or developing relationship agreements which outline individual understandings and responsibilities related to sexual relationships within and outside an ongoing relationship. Inevitably, some individuals break agreements without alerting their sexual partners. In short, an individual cannot vouch for their partner's sexual practices outside the boundaries of their shared relationship.

- *AFAO recognises that it is not possible to assess the sexual practices of any individual's partner, the partner's risk of HIV infection and hence the individual's risk of HIV infection. Moreover, a person who believes themselves to be in a monogamous relationship who has been put at risk of HIV infection will be unaware of that risk. While this issue may apply equally to those in heterosexual and other non-MSM relationships, the issue is of particular relevance to MSM, given their greater risk of HIV infection due to HIV prevalence among MSM (sexual partners).*

Men who only ever engage in safe sex

As noted above, the Red Cross processes well over a million donations each year. Staff are trained to administer the current form identifying risk, but there would be significant workforce resourcing and training implications if detailed evaluations of each potential donor's sexual history and assessment of each potential donor's level of risk were required.

It is questionable whether all MSM wishing to donate blood would feel comfortable being questioned in detail about their sexual practices, particularly in a clinical setting removed from the comfort of a regular or specialist sexual health practitioner. The work undertaken by social and behavioural researchers in this area is notoriously challenging and requires significant expertise.

- *AFAO believes that it is not feasible to assess the HIV risk attached to the sexual practices of every MSM who may wish to donate blood given: the intrusiveness of questions that may be required; the length of time such interviews may take; the implausibility of developing expertise on HIV risk and methods of conducting such interviews among Red Cross staff; donors' potential reticence to disclose 'having done the wrong thing'; and the absence of a means to assess sexual partners' HIV status and risk practices.*

Men who believe they only engage in safe sex

After more than 25 years of HIV epidemic, a significant change in attitudes and a range of risk reduction practices have developed. Many analysts assert a marked reduction in the extent to which affected communities now galvanise around HIV prevention. AFAO's *Think Again* campaign recognises that in the 1980s the 'default position' of gay men was, 'Assume everyone is HIV-positive. Don't ask, don't tell. Practice safe sex always'. Now many gay men think, 'If he is positive he should tell – otherwise assume he is HIV-negative'. The 2000 study *Maleout* found 79% of HIV-negative respondents expected an HIV-positive man to reveal his HIV-status before having sex, however, the recent study by the National Centre in HIV Social Research found that only 76% of HIV-positive men had disclosed to their regular partner(s), and some 38% had disclosed to their casual sex partners. (Also, scientific modelling by NCHECR has indicated that 30% of new HIV infections among MSM occur as a result of transmission from the estimated 9% of HIV-positive MSM who are unaware that they are HIV positive.)

Men may fail to disclose their HIV-positive or HIV–negative status every time before they have sex with a new partner through the course of their lifetime for a range of reasonsincluding that:

- An individual cannot always correctly disclose because they may be unaware of their HIV-positive status- data on disclosure from the HIM study suggests that disclosure of serostatus in the context of casual sex remains low amongst HIV-negative men, while recent findings from the National Centre in HIV Social Research's E-male study found that using a condom with casual sexual partners is <u>less</u> likely following disclosure[7].
- A person may believe they have disclosed (non-verbally) while 'sero-sorting' (checking their potential partner is of the same HIV status). However, HIV service providers' concerns about the breadth and fallibility of serosorting is backed up by 2009 research into serosorting which identifies instances of miscommunication, including instances when an HIV-positive person believes an HIV-negative person has communicated their HIV-positive status, and vice-versa[8].
- they may use risk reduction strategies including using condoms and/or knowing they have a low viral load and reduced infectivity[9].
- A person may be unwilling to disclose their HIV status, as once disclosed, that information can and does travel. Notably, HIV Futures 6[10] reports that 51% of HIV-positive respondents (from all Australian states and territories) have had their HIV status disclosed without their permission.

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[7] Rawstorne P, Holt M, Kippax S, Worth H, Wilkinson J, Bittman M. E-male survey 2008: key findings from a national online survey of men who have sex with men in Australia. (Monograph 3/2009). Sydney: National Centre in HIV Social Research; 2009.

[8] Zablotska I, Imrie J, Prestage G, Crawford J, Rawstorne P, Grulich A, Fengy J, Kippax S. Gay men's current practice of HIV seroconcordant unprotected anal intercourse: serosorting or seroguessing? AIDS Care, 21, 2009.

[9] Prestage G, Mao L, Kippax S, et al. Use of viral load to negotiate condom use among gay men in Sydney, Australia. AIDS and Behaviour, (In press). Van De Ven P, Kippax S, Crawford J, Rawstorne P, Prestage G, Grulich A, Murphy D. In a minority of gay men, sexual risk practice indicates strategic positioning for perceived risk reduction rather than unbridled sex. AIDS Care, 14, 2002, p. 471–480. Van de Ven P, Murphy D, Hull P, Prestage G, Batrouney C, Kippax S. Risk management and harm reduction among gay men in Sydney. Critical Public Health, 14, 2004, p. 361–376. Van de Ven P, Mao L, Fogarty A, Rawstorne P, Crawford J, Prestage, G., Grulich, A., Kaldor, J., Kippax, S Undetectable viral load is associated with sexual risk taking in HIV serodiscordant gay couples in Sydney. AIDS, 19: 2005, p. 179–184.

[10] Grierson J, Power J, Croy S, Clement T, Thorpe R, McDonald K, Pitts M. HIV Futures 6: Making Positive Lives Count. The Living with HIV Program. Melbourne: The Australian Research Centre in Sex, Health and Society, La Trobe University; 2006.

- The individual may fear rejection. Two recent studies found 62%[11] and 80%[12] (respectively) of HIV-negative MSM avoided sex with people they believed were HIV positive. Unpublished data from the Positive Health study[13] shows that as many as 27% of HIV-positive men surveyed have been sexually rejected due to their HIV status.
- The fear of legal repercussions. HIV Futures 6 reveals that 42.4% of those surveyed reported being worried about disclosing their HIV status to sexual partners 'because of the current legal situation'.

> *AFAO recognises that MSM may erroneously presume they are practising safe sex by engaging in sexual acts that include risk of HIV transmission because they presume their sexual partner is not HIV-infected.*

Frequency of HIV Testing

Risk of an individual's HIV infection being undiagnosed decreases over time. The longer the deferral period following a risk event, the greater the chance of a person having an HIV test before deciding to donate blood. The 12 month deferral period, however, is not clearly or specifically linked to surveillance or behavioural evidence on frequency of HIV testing by MSM. Australian clinical guidelines[14] recommend annual testing for HIV for all MSM, and three to six monthly testing for those at higher risk, as defined by behavioural criteria. However, the PASH study found that of the approximately 2,300 MSM surveyed, only 85% had ever had an HIV test; of those, 9.45% had tested positive. The PASH study also found that approximately one-third of MSM tested less frequently than annually:[15]

Frequency of HIV testing among HIV-negative men (n=1738)%

How often usually tested	
Monthly	0.0%
About three monthly	12.9%
About six monthly	26.6%
Annually	26.6%
Less than annually	30.6%
No response	2.4%

Mathematical modelling would be useful for understanding the probability of an increase in instances of HIV infected blood being donated if the MSM deferral period were reduced, for

[11] Van De Ven P, Rawstorne P, Crawford J, Kippax S, 'Facts and Figures 2000 Male Out Survey', National Centre in HIV Social Research, 2001.
[12] Van De Ven P, Kippax S, Crawford J, Rawstorne P, Prestage G, Grulich A, Murphy D. In a minority of gay men, sexual risk practice indicates strategic positioning for perceived risk reduction rather than unbridled sex. AIDS Care, 14, 2002, p. 471–480.
[13] By the National Centre in HIV Social Research.
[14] Australasian Chapter of Sexual Health Medicine. Sexually transmitted infection testing guidelines for men who have sex with men (STIGMA guidelines). Sydney: Australasian Chapter of Sexual Health Medicine, 2005.
[15] Prestage G, McCann PD, Hurley M, Bradley J, Down I, Brown G (2010). Pleasure and Sexual Health: The PASH Study, 2009. Monograph, National Centre in HIV Epidemiology and Cliniocal research, Sydney Australia.

example, to two months or six months. Studies estimating the rate of HIV infection among MSM and intervals between infection and diagnosis could then be used to predict the possible uptake of blood donation by MSM. Although the percentage of MSM who may donate blood is unknown, the proportion of the Australian population who donate blood (2.5%) may suggest a starting point for estimating impact on the blood supply.

- *AFAO asks the Committee to consider current behavioural, epidemiological and scientific evidence regarding HIV testing rates among MSM and delays in diagnosis, and to commission mathematical modelling to assess probable incidence of HIV-infected blood donation should the deferral period be reduced*.

Role of the Red Cross Blood Service: demarcation of testing and diagnosis

AFAO understands that the Red Cross has systems and guidelines in place to ensure that donors are notified of positive test results in an appropriate and timely manner. Whatever the result of this review, it is essential that such practices remain in place and that post-test discussion and counselling services are properly resourced, that staff are appropriately trained and supported.

- **Pre-test discussion:** pre-test discussion to enable informed consent forms the back-bone of Australia's HIV testing rationale, given consistent rejection of mandatory or compulsory testing. The HIV Testing Policy details the requirement to undertake pre-test discussion (which may require use of accredited interpreters) to gain informed consent. In fact, the policy states that 'pre- and post-test discussions form an integral part of HIV testing'.

> Pre-test information aims to prepare individuals for HIV testing and to obtain informed consent. When a person requests or is offered a test, the practitioner should give appropriate information about risk, points of referral if necessary, assurances about confidentiality and privacy, and assessment of the person's preparedness to be tested.
>
> Specifically, the HIV test discussion should provide accurate information about safe practices that are appropriate to the person's gender, culture, behaviour and language.
>
> The discussion should include:
>
> - information on how HIV is transmitted (where appropriate);
> - risk assessment and discussion of the reason for testing;
> - timing of the risk event and options for PEP;
> - possible desirability of other STI testing;
> - information about confidentiality and privacy;
> - information about the testing process including how results are to be provided, the window period, and the difference between HIV and AIDS;
> - information about what happens to test results;
> - seeking informed consent for the test to be conducted;

- assessment of the person's preparedness to be tested and assurance that the person wishes to proceed with the test;
- information about what a negative or positive result means; and
- assessment of support mechanisms while waiting for the test result and/or if the result is positive.

- **Post-test discussion:** The National HIV Testing Guidelines outline points to be covered when a person is given an HIV-positive test result.

> *If the result is positive the discussion should include, at an appropriate time, issues such as:*
> - *immediate needs and support;*
> - *safe behaviours – education, information and support;*
> - *whom the person should tell and how, including information around the person's rights regarding disclosure;*
> - *managing or understanding strong emotions, feelings, reactions and changes; including ways to deal with loss and grief, depression, anger and anxiety;*
> - *options in drug treatments and medical management;*
> - *ongoing counselling or therapy if required;*
> - *complementary/alternative management options;*
> - *strategies for managing HIV that are flexible and appropriate to the person's needs; and*
> - *legislative requirements (notification, contact tracing, storage and coding).*

- ➢ *AFAO seeks the Committee's attention to possible implications of an increase in identified HIV-infected blood donations (i.e. that pose no threat to blood safety), including the need to maintain the integrity of Australia's National HIV Testing Guidelines.*

Use of resources

Clearly, it is in the Red Cross Blood Service's interest to limit donations of HIV infected blood, as those donations are unusable and their collection, identification and destruction a poor use of resources.

- ➢ *AFAO asks the Review Committee to consider whether concerns over resource allocation are a driver of the 12 month deferral period and whether such concerns constitute valid and defensible rationales for the current deferral period.*

Public Confidence

Public confidence in the blood supply is vital, not only in negating opportunities for homophobic or anti-PLHIV media and public sentiment but, importantly, in relation to the environment in which people access medical services. Patient fear of transfusion-related HIV infection in the mid-1980s was very real and caused much anxiety in the general community and among people advocating for the rights of PLHIV. These fears and anxieties may linger but they should not be used to justify sustaining unfounded deferral policies.

- *AFAO asks the Review Committee to consider whether concerns over public confidence in blood supply safety expressed by the Red Cross Blood Service are a valid rationale for the MSM deferral period extending far beyond the testing window period. If so, we seek explanation of that rationale so as to provide informed input into the deferral policy review process.*

Further input to this review

AFAO looks forward to the Committee providing a discussion paper that addresses the issues raised above. AFAO remains committed to HIV prevention in all its forms and I thank you for the opportunity to provide input to this review. Please do not hesitate to contact me if I can be of any further assistance.

Yours sincerely

Don Baxter
Executive Director
Australian Federation of AIDS Organisations