



AUSTRALIAN FEDERATION
OF AIDS ORGANISATIONS
Leading the community response to HIV



Mandatory Disease Testing Options Paper – NSW Department of Justice

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Australian Federation of AIDS Organisations

The Australian Federation of AIDS Organisations (AFAO) is the national federation for the HIV community response in Australia. AFAO works to end HIV transmission and reduce its impact on communities in Australia, Asia and the Pacific. AFAO's members are the AIDS Councils in each state and territory; the National Association of People with HIV Australia (NAPWHA); the Australian Injecting & Illicit Drug Users League (AIVL); Anwernekenhe National HIV Alliance (ANA); and Scarlet Alliance, Australian Sex Workers Association. AFAO's affiliate member organisations – spanning community, research and clinical workforce – share AFAO's values and support the work we do.

National Association of People with HIV Australia

Founded in 1989, The National Association of People with HIV Australia (NAPWHA) is Australia's peak non-government organisation representing community-based groups of people living with HIV (PLHIV). NAPWHA's membership of national networks and state-based organisations reflects the diverse make-up of the HIV-positive community and enables NAPWHA to confidently represent the positive voice in Australia. NAPWHA provides advocacy, policy, health promotion, effective representation, and outreach on a national level. Its work includes a range of health and education initiatives that promote the highest quality standard of care for HIV-positive people. NAPWHA also contributes to clinical and social research into the incidence, impact and management of HIV.

Our Position

AFAO and NAPWHA strongly oppose the mandatory testing of people whose bodily fluids come into contact with emergency services personnel.

The odds of HIV being transmitted to an emergency services worker during their ordinary work are extremely low. Less than 0.1% of the Australian population is living with HIV and HIV is not easily transmitted. The likelihood of transmission is decreasing as treatments continue to reduce population-level transmission risk.

Saliva can not transmit HIV, and transmission through exposure to other bodily fluids is not automatic. HIV transmission requires specific elements to be present. These elements are usually absent during incidents involving emergency services officers. In fact, emergency services personnel in NSW are not acquiring HIV through occupational exposure and no recent example of this kind have been identified anywhere in Australia.

AFAO and NAPWHA acknowledge the difficult and confronting situations that emergency services personnel regularly encounter and the need to reduce the impact of these experiences. This submission does not seek to minimise the offensive and sometimes traumatic nature of such events in any way. We share a genuine desire to reduce anxiety among emergency services personnel who come into contact with bodily fluids but oppose mandatory testing because it is an ineffective tool to meet the objective stated in the *Options Paper – Mandatory Disease Testing*.

The HIV testing window period means an HIV test can only show that that a person was recently HIV-negative, not that they are HIV-negative at the time of the incident. Consequently, Post-Exposure Prophylaxis (PEP), which can stop an HIV-negative person from developing HIV after an episode of accidental exposure to HIV, would need to be considered regardless. The possibility of a potential source person having HIV cannot be confirmed or discounted by an initial test, and PEP is available regardless of an initial test result to prevent HIV in the emergency services worker where a real risk of transmission occurs.

Mandatory testing is also problematic because it undermines the integrity and effectiveness of voluntary, consent-based HIV testing as a key strategy in NSW's successful HIV response. Further, it marks a fundamental shift in the rights of individuals to privacy as stipulated in Australian and state law and to the integrity of their own bodies. It proposes a fundamental change to Australian policy which generally requires consent for HIV testing and other medical procedures as detailed in a number of places including NSW Health's Consent to Medical Treatment policy directive¹ and the Your Health Rights and Responsibilities package².

The imposition of mandatory testing on the rights of those being tested is disproportionate to any relief this initiative will provide to emergency services personnel. AFAO and NAPWHA are deeply concerned that those who are most marginalised in our communities, including those with limited health literacy, will bear the brunt of the mandatory testing guidelines, and it is these same people for whom the impact will be most severe.

In summary, mandatory testing raises a number of significant concerns, including:

- 1) Mandatory testing can only provide a false reassurance or create unnecessary anxiety for an individual emergency services officer (depending on the initial test result) given the operation of the HIV test window period.

- 2) Mandatory testing undermines the integrity and effectiveness of voluntary, consent-based HIV testing as a key strategy in NSW's successful HIV response.
- 3) Mandatory testing does not alter the need to consider PEP, which is an effective medication to prevent HIV acquisition following an exposure to HIV risk in an occupational setting.
- 4) Operationalising mandatory testing will be expensive, diverting funds that would be more effectively spent on strategies to bring emergency services personnel up-to-date with HIV transmission risk, support personnel who are concerned they may have been exposed to HIV, and support HIV prevention efforts more generally.
- 5) Mandatory testing undermines consent as a foundational medical and legal principle and challenges the legal principle that taking blood without permission constitutes assault.
- 6) Mandatory testing is likely to be used disproportionately against those who are most marginalised.
- 7) Mandatory testing may be used (or perceived to be used) as extra-judicial punishment.

Mandatory testing is an unnecessary, costly and dangerous policy that will not improve the health and wellbeing of emergency services personnel. It will, however, contribute to outdated stereotypes about HIV transmission risk and the 'harms' of HIV, and will increase stigma and discrimination against people with HIV, factors which continue to undermine the public health investment in HIV prevention efforts. By enacting legislation that allows for mandatory HIV testing, the NSW Government will further stigmatise HIV and people living with HIV. Mandatory testing legislation is the wrong vehicle to satisfy the stated purpose of alleviating the anxiety of emergency services personnel. It also will not improve the medical treatment or support of emergency services workers who believe they may have been exposed to the risk of HIV acquisition.

Recommendation: Implementation of *Option 1 – Improvements to Current Agency Policy and Practice*

Option one provides for an evidence-based response to improve current practice and allay concern and anxiety among emergency services personnel. In implementing this option, it will be essential that emergency services are provided with appropriate resourcing to increase the knowledge of their members. There will also be a need to liaise with HIV and viral hepatitis specialist and peer-based services to ensure that all educational material is based on current evidence applicable to the specific situations that may be encountered. AFAO and NAPWHA encourage the NSW Government to use this opportunity to improve NSW's HIV response and better support emergency services personnel.

The Proposal

The NSW Government is considering options for the mandatory testing of people whose bodily fluids come into contact with emergency services personnel.

The four options being considered are:

- 1) Improvements to current agency policy and practice
- 2) Testing by consent
- 3) Consent-based testing with option for court order
- 4) Senior police officer ordered testing following offence

The primary stated purpose of these proposals is to reduce the anxiety experienced by emergency services personnel when they come into contact with bodily fluids.

Submission

The following submission includes a number of arguments against the mandatory testing of people whose bodily fluids come into contact with emergency services personnel. Usually, a review of laws in NSW would be considered a state-based issue, and within the remit of our member organisations (ACON and Positive Life) in NSW. However, AFAO and NAPWHA make this submission on the basis that this proposal has significant national implications.

AFAO and NAPWHA strongly endorse the submissions made by our members, ACON and Positive Life.

This submission argues against mandatory testing for HIV, however, the general points may be extrapolated to testing for other blood borne viruses, including hepatitis B and hepatitis C, and the harms that may occur as a result of a perceived targeting of members of stigmatised communities despite negligible transmission risk.

This issue is of such concern that NAPWHA has recently commissioned a national audit of mandatory disease testing laws, due to be finalised in late November 2018. We would welcome the opportunity to forward that report to the NSW Government for consideration once completed.

1. Current scientific evidence

1.1 The science of HIV transmission

HIV is a relatively fragile virus that can only be transmitted through very specific routes which do not include airborne, droplet, fomite, contact or vector-borne transmission routes.³ For HIV transmission to occur, particular, conditions must exist:

- There must be HIV in specific bodily fluids (i.e. blood, semen, pre-seminal fluid, rectal fluids, vaginal fluids, or breast milk). This requires that the bodily fluids be from a person who has HIV. It also requires that HIV be present in that bodily fluid. Saliva is not a bodily fluid that can transmit HIV.

- A sufficient quantity of HIV in at least one of those bodily fluids must come into direct contact with sites in the body of an HIV-negative person where infection can be initiated: usually mucous membranes, damaged tissue or inflamed ulcers. Importantly, HIV cannot penetrate intact human skin.
- HIV must overcome the person's innate immune defences so that infection can be established and replicated.

1.2 The latest HIV surveillance data

The most recent HIV surveillance report records 963 new HIV diagnoses in Australia in 2017, the lowest number of diagnoses since 2010, with a 7% decline over the last five years, and a 5% decline between 2016 and 2017. Male-to-male sex continues to be the major HIV risk exposure in Australia, reported for 607 (63%) HIV diagnoses in 2017, with heterosexual sex reported for 238 (25%) diagnoses, both male-to-male sex and injecting drug use for 53 (5%) diagnoses and injecting drug use for 33 (3%) diagnoses. The last confirmed case of HIV infection in a health care worker following an occupational exposure in NSW was in 1994⁴, prior to the availability of PEP and before effective HIV treatments became available.

1.3 The context of the proposals

As outlined in the *Options Paper – Mandatory Disease Testing*, the proposal to establish a legislative scheme to allow mandatory disease testing of people whose bodily fluids come into contact with police and emergency services personnel was motivated by concern about violence against emergency services personnel. The Options Paper provides an average number of incidents of exposure to bodily fluids/year involving emergency services personnel in NSW although the type of bodily fluid is not defined.

Agency	TOTAL incidents of exposure to bodily fluids (Per Year Average)	SUBSET – incidents involving human bite or needle stick injury (Per Year Average)
NSW Police Force ¹	450	60
Corrective Services NSW ²	130	16
NSW Rural Fire Service ³	1	0
Fire & Rescue NSW ⁴	20	1
NSW State Emergency Service ⁵	1	0
NSW Health ⁶	2,218	1,627

The NSW Legislative Assembly Committee on Law and Safety report (August 2017):

- Recommends that the NSW Government consider introducing legislation to allow mandatory disease testing of people whose bodily fluids come into contact with police and emergency services personnel, in consultation with affected stakeholders (*Recommendation 47*); and
- Finds that the power to conduct mandatory disease testing should only be available in circumstances where there is a risk of transmission of listed diseases. The legislation should clearly define the factual circumstances in which

there is a risk of transmission of listed disease and this definition should be based on up to date medical evidence (Finding 13).

AFAO and NAPWHA strongly oppose the introduction of mandatory testing and are particularly concerned that such powers might be used frequently, including in instances where risk of HIV transmission does not exist. Other states have not ensured that current scientific evidence informs their approaches. This is an issue that is particularly difficult to address if decisions are made by police officers instead of experts in HIV science and medicine.

1.4 Possible exposure to HIV through deliberate exposure to bodily fluids

The Options Paper does not describe the severity of bites that trigger mandatory testing, even though such actions are likely common amidst the types of assault against emergency services personnel involving transfer of bodily fluids. This submission includes reference to the most recent scientific evidence showing there is no possibility of HIV transmission from spitting or from bites that do not include elements described below.

1.4.1 There is scientific consensus that

- **there is no possibility of HIV transmission via spitting, and**
- **no to negligible possibility of HIV transmission during biting**

In July 2018, twenty of the world's leading HIV scientists co-authored the *Expert consensus statement on the science of HIV in the context of criminal law* (Expert Consensus Statement)⁵, a peer-reviewed article published in the Journal of the International AIDS Society. Led by the Nobel prize-winning scientist Françoise Barré-Sinoussi and co-authored by Andrew Grulich (Program Head, HIV Epidemiology and Prevention Program, Kirby Institute for Immunity and Infection, University of New South Wales), the statement describes current evidence on HIV transmission and treatment effectiveness.

The authors undertook analysis of all available scientific data on HIV transmission and treatment effectiveness, prioritising the highest quality research data from a systematic review of randomised clinical trials and comparative studies. They then applied those findings to describe the possibility of HIV transmission from a single, specific act, describing that possibility as ranging from low possibility to no possibility.

Table 2
Defining the possibility of HIV transmission during a single, specific act

Terminology for this statement	Possibility of transmission per act
Low possibility	Transmission during a single act is possible but the likelihood is low.
Negligible possibility	Transmission during a single act is extremely unlikely, rare or remote.
No possibility	The possibility of transmission during a single act is either biologically implausible or effectively zero.

This approach, describing the possibility of transmission during a single act, differs from the “low risk” to “high risk” terminology frequently used in public health, which uses population-level estimates of risk measured over extended periods. Further, public health terminology is designed to communicate the *relative* risk of different acts rather than

the *absolute* risk of transmission, to assist people to make choices to reduce the risk of transmitting or acquiring HIV (e.g., through safe sex practices).

Using this focus on single, specific acts, which is likely to be the focus of cases addressed by the proposed changes (e.g. a single instance of spitting), the Expert Consensus Statement finds that the possibility of HIV transmission during a single sexual encounter ranges from no possibility to low possibility, and there is no possibility for spitting and negligible possibility in cases of biting.

The Expert Consensus Statement contains the following description of HIV transmission risk in relation to biting and spitting:

- *There is no possibility of HIV transmission via contact with the saliva of an HIV-positive person, including through kissing, biting or spitting.*

Numerous studies have considered the possibility of HIV transmission via saliva but none has found any evidence, including a 1997 study of 34,000 cases in the UK⁶. The absence of HIV transmission via saliva is attributed to two factors: saliva contains a very small amount of HIV⁷, and several inhibitory components in oral secretions mean saliva acts to protect susceptible cells from HIV infection^{8 9 10 11 12 13}.

- *There is no possibility of HIV transmission from biting or spitting where the HIV-positive person's saliva contains no, or a small quantity of, blood.*

Current evidence suggests HIV cannot be transmitted even when saliva contains small quantities of blood. Despite early research suggesting a theoretical risk of transmission if saliva-containing blood enters a person's body through contact with mucosal tissue (for example, landing in an eye or mouth), no cases of HIV transmission resulting from the spitting of blood have ever been reported¹⁴. Consequently, it is our expert opinion that there is no possibility of HIV transmission from saliva containing small quantities of blood.

- *The possibility of HIV transmission from biting where the HIV-positive person's saliva contains a significant quantity of blood, and their blood comes into contact with a mucous membrane or open wound, and their viral load is not low or undetectable varies from none to negligible.*

Many studies have detailed a large number of cases where bites have not resulted in HIV transmission^{15 16 17 18 19} or found transmission to be unlikely^{20 21 22 23}.

For transmission to be plausible in the case of biting, the HIV-positive person must have blood in their mouth at the time of the bite, a sufficient amount of HIV must be present in the blood of the HIV-positive person, and the bite must be deep enough to penetrate the HIV-negative person's skin causing trauma and tissue damage^{24 25 26}. Even when all these conditions are present, the possibility of transmission during a single bite is negligible at most.²⁷

The Expert Consensus Statement updates the comparable Australian consensus statement: *Sexual transmission of HIV and the law: an Australian medical consensus statement²⁸* published in 2016. Importantly, the Australian consensus statement notes that 'no transmission through biting or spitting has ever been documented in Australia': a fact which remains the case at 31 October 2018. In fact, there has never been a single recorded case of HIV transmission through saliva in the history of the HIV epidemic, anywhere globally. The NSW Ministry of Health concurs:

- HIV is transmitted through ‘blood, semen, vaginal fluid or breast milk of an infected person’, it is not possible to transmit HIV through saliva (NSW Ministry of Health, 2017).
- The risk of Hepatitis B, Hepatitis C and HIV transmission from a known positive source through blood and saliva to unbroken skin and skin-to-skin contact is zero (NSW Ministry of Health, 2017).

1.4.2 There has not been an Australian case of HIV transmission as a result of a deliberate attack using blood since 1990

During the early days of Australia’s HIV epidemic, a number of states introduced criminal laws to respond to escalating community concern about the use of hypodermic syringes filled with blood as weapons in cases of robberies and assault.²⁹ In fact, syringes are not often used as a weapon and there is only a single case of HIV transmission as a result the deliberate use of a blood-filled syringe used as a weapon, which was in the context of a custodial sentence, in 1990, prior to the availability of PEP.

Despite community concerns, the risk of transmission of HIV through this unlikely route would not be ‘automatic’, depending on a range of factors including the likelihood the potential source person has HIV, the quantity of blood injected (with less blood decreasing risk), the viral load of the person from whom the blood was taken (with a lower viral load decreasing risk), and the length of time since the blood was taken (with longer time decreasing risk). Statistics are not available but importantly, with medical intervention, i.e. use of post-exposure prophylaxis (PEP), the risk of transmission would range from none to low.

Should such an assault occur, it could be prosecuted using existing criminal law.

1.5 Possible occupational exposure to HIV through exposure to bodily fluids

As noted in the *Options Paper – Mandatory Disease Testing*, “exposure to bodily fluids is a work health and safety issue. The assumption for emergency services personnel is to treat all blood and bodily fluids as potentially infectious thereby minimising risk of transmission.” A number of guidelines and agency policies then guide health and safety and medical responses.

The *Options Paper* includes an extract from ASHM’s *Emergency Service Providers and Blood-borne Viruses* factsheet which describes risk of HIV transmission from an unknown source.

Table 2. Risk of HBV, HCV and HIV Transmission From a Known Positive Source

Exposure type	Known Positive Source Status		
	HBV+	HCV+	HIV+
Blood contact with broken skin, mouth or eyes ■ e.g. Punch from bleeding person to body causing break in skin ■ Large blood splash, e.g. arterial bleed ■ Blood contact to mouth from giving mouth-to-mouth resuscitation if no protective equipment used	moderate	low	low~
Needle stick injury and other penetrating injuries ■ e.g. Cut by a blade which recently penetrated another person ■ Recently used needle penetrating skin	very high#	high^	moderate*

In fact, the estimates on HIV transmission risk included in ASHM's factsheet over-estimate transmission risk as a result of the data being dated – pre-2012 – which was before our current knowledge of the effectiveness of HIV treatment was known. Therefore, it fails to differentiate risk depending on a range of intersecting factors, particularly the viral load of the person with HIV.

Although sharing of injecting equipment is a risk factor for HIV transmission, surveillance data reveals the limited role that the sharing of injecting equipment has played in Australia's HIV epidemic. The effect of low HIV prevalence among people who inject drugs is that the likelihood of coming into contact with a needle that has been used by someone with HIV is also low. Risk is further reduced because outside the body, HIV is relatively fragile and dies quickly. This means that a needlestick injury is unlikely to pose a significant risk of HIV transmission unless the needle had been used very close in time to the exposure.

Analysis of recent data provides far more moderate assessments of risk. For example, the Queensland Government's recent *Management of occupation exposure to blood and bodily fluids, 2017* states risk of HIV transmission from blood containing HIV to be 0.227% from a percutaneous injury, and less than 0.01% from a mucosal injury.³⁰ Notably, those estimates relate to blood from a source person who is not on antiretroviral treatments with a negligible or undetectable viral load. If the source individual was taking antiretroviral treatments and had an undetectable viral load, transmission risk would decrease (see 1.4 below).

1.6 The impact of HIV treatment on transmission risk

Soon after acquiring HIV, a person's viral load is very high but typically decreases over the first few weeks as their immune system responds. If a person does not commence treatment, their viral load remains fairly stable for some time, while the immune system is gradually depleted. In advanced HIV infection, viral load usually increases to higher levels again.

Antiretroviral therapy prevents HIV from replicating. This significantly reduces the viral load in a person's bodily fluids. When effective antiretroviral therapy is commenced, viral load usually drops to levels that are undetectable by current standard laboratory blood tests within a few weeks or months.

As well as producing significant, long-term health gains, decreases in viral load are associated with concomitant decreases in the likelihood of HIV transmission^{31 32 33 34} meaning that people with an undetectable viral load cannot transmit HIV. Much of that evidence is drawn from large-scale, double blind clinical trials considering transmission risk

as the result of sexual activity: acts that when considered without factoring the impact of treatment, include a significantly higher risk of HIV transmission than biting or wound exposure.

A mandatory HIV test conducted on a person with HIV on effective HIV treatment with an undetectable viral load (which is most people with HIV) would produce a positive result despite their being zero chance of HIV transmission. The motivation behind the proposed law is therefore flawed.

Scientific evidence that effective antiretroviral treatment precludes HIV transmission is now unequivocal based on two recent studies. The PARTNER and Opposites Attract studies found no HIV transmission from people with a viral load below 200 copies/mL after more than 75,000 acts of condomless vaginal or anal sex^{35 36 37}. A 2013 systematic review and meta-analysis also found no transmission where viral load fell below a threshold of between 50 and 500 copies/mL (depending on the study)³⁸.

1.6.1 Applying evidence on impact of HIV treatment in the Australian context

In 2014, the UN Programme on HIV/AIDS (UNAIDS) announced ambitious new global targets aiming to end the HIV epidemic by 2030. Those ‘Fast-Track’ targets are:

- 90 percent of people living with HIV will know their HIV status
- 90 percent of people diagnosed with HIV will receive antiretroviral treatment
- 90 percent of people on treatment will have suppressed viral loads.

Globally, NSW is tracking well, with NSW Ministry of Health data for January to March 2018 reporting the proportion of recently diagnosed people with HIV who are virally suppressed at 6-month follow up at 86%. The report also identified an increasing trend in the rapid uptake of HIV treatment, with 75% of those newly diagnosed between January and September 2017 having commenced treatment within six weeks, rising to 96% within six months of diagnosis³⁹.

Analysis of this data means that the likelihood of HIV transmission to NSW emergency services personnel through exposure to body fluids, which has not ever occurred before, is actually decreasing.

2. Decreasing HIV transmission risk through post-exposure treatment

Post-exposure prophylaxis (PEP) is a one-month course of anti-retroviral treatment available taken by an HIV-negative person after a possible exposure to HIV. If started within 72 hours of exposure and taken daily for 28 days, PEP is effective at preventing a person from becoming HIV positive because it can stop HIV from establishing itself in a person's immune cells even after the virus has entered a person's body^{40 41}. High rates of success have been reported over many years of PEP⁴².

Australia’s National Guidelines on *Post-Exposure Prophylaxis after Non-Occupational and Occupational exposure to HIV* suggest PEP may be recommended if a needle and syringe containing fresh blood ‘sufficiently’ penetrates the skin. Importantly, if a person is concerned they are at risk of HIV infection, PEP would need to be commenced regardless of

whether a ‘source’ person tested positive to HIV given the operation of the HIV testing window period renders single HIV tests inconclusive.

3. HIV is a chronic, manageable condition

HIV is a chronic condition requiring life-long treatment, however, studies now consistently show that antiretroviral therapies have radically increased life expectancy, that life expectancy has continued to improve over time, and that the long-term health and quality of life of people living with HIV has drastically improved.

Life expectancy for young people with HIV commencing antiretroviral therapy now approaches that of a young person in the general population^{43 44 45 46 47}. Furthermore, use of antiretroviral therapies has shifted cause of death of people living with HIV from traditional AIDS-defining illnesses to non-HIV-related causes^{48 49} similar to those affecting the general population⁵⁰.

An understanding of the current realities of living with HIV is vital because outdated notions of HIV contribute to the distress an incident can cause to an emergency services worker if they fear HIV infection may result. This can occur regardless of whether HIV transmission is even plausible given the incident. There have been numerous recent media reports of highly distressed emergency services workers in instances where the possibility of transmission was negligible to none (and transmission did not occur), suggesting the importance of effective support to affected personnel from trained health care workers.

4. A marked shift in legal principles

4.1 The right to bodily integrity

Options 3 and 4, which include mandatory testing, would represent a significant challenge to Australian legal principles. Taking blood from a person without their consent involves the criminal offence of assault as noted in the NSW Consent to Medical Treatment - Patient Information⁵¹ policy directive. HIV testing exceeds the legal boundaries of ‘examining’ a person, as it requires the subcutaneous drawing of blood: skin penetration constituting bodily harm. It is a marked infringement on an individual’s autonomy and control over their body, and a shift in legal principles that is not to be taken lightly. In particular, Option 4 – Senior police officer ordered testing following offence, is a cause of great concern as it would remove the safeguard provided by judicial oversight and make monitoring of the use of these powers extremely difficult.

Further, legislation that allows a senior police officer to detain and forcibly test individuals, without reference to the courts, may be used (or perceived to be used) as extra-judicial punishment. This has the potential to be harmful to the confidence that the public has in police and emergency services personnel.

4.2 Punishment for social undesirable behaviour and more serious offences

Spitting at emergency services staff, and other forms of assault, already constitute criminal offences which can be prosecuted before the courts.

4.3 Health processes to support people with HIV to avoid transmission

NSW has strong health infrastructure to support people with HIV to avoid transmission and this is more appropriate than focusing on legal or judicial processes.

5. Misdirection of resources

Operationalising mandatory testing will be expensive, diverting funds that would be more effectively spent on strategies to bring emergency services personnel up-to-date with HIV transmission risk, to support officers who are concerned they may have been exposed to HIV, and to support HIV prevention efforts more generally.

NAPWHA is currently considering a cost-benefit analysis of recently introduced, comparable mandatory testing laws in other states and territories as a component of the national audit of mandatory disease testing laws and would welcome the opportunity to provide the results for the NSW Government's consideration once completed.

6. The Australian HIV Response

The principles of voluntary testing, informed consent and confidentiality underpin high rates of HIV testing in Australia, and these principles remain central to the management of HIV.

Seventh National HIV Strategy 2014-2017

Australia has an internationally recognised response to the HIV epidemic built on a foundation of voluntary, consent-based HIV testing. At an individual level, a person who knows their HIV status is empowered to engage with appropriate health care as soon as possible to start anti-retroviral therapy, which increases health outcomes for the individual and eliminates the possibility of onward transmission. When a person has an undetectable viral load (typically as a result of treatment), HIV is untransmissible. Further, encouraging voluntary testing connects people with health services, regardless of HIV status, which provides opportunities for education about preventing transmission.

NSW has largely avoided criminal justice responses to HIV which have been shown internationally to push epidemics underground and contribute to their growth. The leadership and involvement of people with HIV is central to a successful response and this is made possible by enabling legal environments that respect and value individuals as full and valued members of society. Attempts to control or punish people with HIV through the justice system work against that. Legal responses that criminalise or stigmatise HIV create an environment in which people do not want to know their status (as knowledge of HIV status is an element of 'intent' or 'recklessness' in relation to HIV transmission). Further, in these environments people cannot talk openly with partners about HIV and its prevention. Thus, criminal justice responses to HIV *increase* the probability of future HIV transmissions and compromise the public health investment in testing and prevention services.

Introducing mandatory HIV testing will make the goal of the *NSW HIV Strategy 2016-2020* to virtually eliminate HIV transmission in NSW by 2020 more difficult⁵². It is vital that new legislation does not undermine NSW's highly

respected public health system, which is increasingly making inroads to reduce the incidence of HIV transmission and which has long been successful at managing the very few individual people living with HIV who may put others at risk.

One of the hallmarks of Australia's HIV response has been community-led strategy operating in partnership with researchers, healthcare professionals and government. The rejection of mandatory HIV testing by AFAO and NAWPHA is not based on a theoretical stance but on a pragmatic understanding of the way that HIV-related laws and their implementation are understood by, and impact on, communities affected by and living with HIV. The introduction of mandatory testing of people who are suspected of living with HIV or another blood borne virus has the potential to erode our HIV response.

The Options

Options	Comments and Recommendations
Option 1 Improve policy and practice for assessment, counselling and management	<p>Option 1 is the most appropriate and evidence-based response to allay concerns and anxiety among emergency services personnel. The risk of transmission of BBVs in most circumstances is negligible to none and is being appropriately managed through existing policies and practice.</p> <p>In implementing this option, services must be appropriately resourced to both proactively provide education and respond to situations that may arise.</p> <p><u>Recommendations</u></p> <ul style="list-style-type: none"> - Implement this option - Provide emergency services with appropriate resourcing to increase the knowledge of their members - Liaise with HIV and viral hepatitis specialist and peer-based services to ensure that the information is up to date and relevant to the situations that may be encountered
Option 2 Source person tested only with their consent	<p>Option 2 is an unnecessary intervention that has the potential to increase anxiety among community members and emergency services personnel and to consume valuable health care resources for little benefit.</p> <p><u>Recommendation – Reject this option</u></p>
Option 3 Mandatory testing with a court order	<p>While the requirement for a court order would assist in lessening the frequency of inappropriate or unnecessary requests, the overall concerns about mandatory tests remain.</p> <p>The rationale for forcibly testing a third party for HIV is misconceived. Even if a positive HIV result is returned, it cannot establish whether transmission has occurred. Conversely, as there is a window period for HIV tests, a negative</p>

	<p>test result from a third party is not conclusive. This will likely fuel unnecessary anxiety for some, while creating a false sense of security for others.</p> <p><u>Recommendation – Reject this option</u></p>
Option 4 Mandatory testing ordered by police	<p>Option 4 is the most problematic, particularly if a police officer is tasked with making such determinations. Police are not health professionals and may not have a good understanding of what constitutes risk. They may also be influenced by a (perhaps understandable) desire to support their colleagues and implement mandatory testing when it is not necessary or useful.</p> <p>The rationale for forcibly testing a third party for HIV is misconceived. Even if a positive HIV result is returned, it cannot establish whether transmission has occurred. Conversely, as there is a window period for HIV tests, a negative test result from a third party is not conclusive. This will likely fuel unnecessary anxiety for some, while creating a false sense of security for others.</p> <p><u>Recommendation – Reject this option</u></p>

Finally, should the Government consider any options other than Option 1, the following safeguards are required:

- If any other option is implemented, it should be implemented alongside Option 1
- Legislation related to testing must be implemented only where there is scientific consensus that there is a real risk of HIV transmission. That is, the legislation must specify that exposure to saliva or when other bodily fluids come into contact with unbroken skin is not a cause for testing
- Assessment of risk must be conducted by a health care professional
- Information regarding the use of testing options must be accessible through a Freedom of Information request in order to understand and monitor use of the new law or policy
- Results of testing must not be used for a purpose other than the stated aim of relieving anxiety of the individual emergency service worker and must be not be retained

¹ https://www1.health.nsw.gov.au/PDS/pages/doc.aspx?dn=PD2005_406

² https://www1.health.nsw.gov.au/PDS/pages/doc.aspx?dn=PD2011_022

³ Vandamme A-M, Van Laethem K, Schmit J-C, Van Wijngaerden E, Reynders M, Debyser Z, *et al* Long-term stability of human immunodeficiency virus viral load and infectivity in whole blood. Eur J Clin Invest. 1999;29:445–52.

⁴ NSW Health's 2017 Policy Directive HIV, Hepatitis B and Hepatitis C – Management of Health Care Workers Potentially Exposed

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- ⁵ The Expert Consensus Statement was endorsed by more than 70 leading scientists from 46 countries as well as by the International AIDS Society (IAS), the International Association of Providers of AIDS Care (IAPAC) and the Joint United Nations Programme on HIV/AIDS (UNAIDS).
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