



LGBT Network

Submission to the Petitions Committee
of the Scottish Parliament on PE1135 on behalf
of the LGBT Network

The LGBT Network is committed to enabling the fullest participation of all members of the community in influencing policy making, and achieving equity for LGBT citizens.

Introduction

We believe that the current policy of the SNBTS to permanently exclude all MSM (men who have sex with men) from being eligible to donate blood is not the correct policy to have. We have carefully studied all the available evidence, and have come to the conclusion that for the SNBTS to comply with the law both on blood products and equality legislation, and most importantly, to ensure that donated blood is safe and free of infection, it should change its current policy of excluding all those who have sex with men. Instead it should focus on donors who engage in high risk sexual practices, regardless of the gender of the prospective donors' partner. Our conclusions are based on evidence from practices and opinions of Blood Services around the world; on the opinions of some of the world's leading bio-ethicists and epidemiologists; on evidence that heterosexuals now account for more of the new HIV infections than MSM; on the current failings of the SNBTS' donor eligibility criteria; on the flawed analysis and flawed evidence that the Blood Services uses to defend its policy.

We fully accept and agree that this policy was correct when it was introduced at the height of the epidemic in the 1980's when MSM were at the epicentre of the outbreak. After 25 years the situation has however dramatically changed, and MSM no longer account for the greatest risk to the blood supply, nor does only focusing on excluding all MSM, protect the safety of the blood supply.

Current Donor Eligibility

A man, who has had unprotected sex with a prostitute can give blood after 12 months. A man who has unprotected sex with an intravenous drug user can give blood after 12 months. A man who has had unprotected sex abroad in a country which has high rates of HIV can give blood after 12 months. A man who has had unprotected sex with a woman he knew to be HIV positive can give blood after 12 months. A man who has unprotected sex with a different woman every night of the week, who may herself, have been one, or all of the above, can give blood tomorrow. However, a man who has only ever had protected sex with one other man is excluded from donating indefinitely.

The SNBTS do not allow MSM to give blood because they do not believe that protected gay sex prevents HIV transmission. This goes against all scientific, medical, statistical and historical evidence about the virus and the epidemic. Anne Mitchell, Associate Professor of the Australian Research Centre In Sex, Health and Society and Director of Gay and Lesbian Health Victoria crystallised the argument that safe sex does work. Speaking at the recent Anti-Discrimination Tribunal in Tasmania, which is currently looking at the blood ban, she said;

*"When safe sex was taken on by men who have sex with men (MSM) over the next few years [after the epidemic], the escalation in infection rates was pegged back. This made it immediately clear that the risk of HIV infection was not associated with male to male sex per se, rather it was associated with unsafe male to male sex. If safe sex was not effective in preventing HIV, we would still be experiencing rates of infection similar to those at the beginning of the epidemic."*¹

HIV Testing

HIV tests generally used in the UK do not test for the presence of the HIV virus in the body, instead testing for the presence of the antibody that the immune system creates to fight the virus. This results in having a window period of around three months. A procedure called Nucleic Acid Testing (NAT), which tests for the actual presence of the virus in the body, reduces that window period to around 8-11 days.² NAT is used by the SNBTS to test all donations for HIV. HIV is a non discriminating disease. There is no difference to what it does to your body or how long it takes to establish itself or show up in tests depending on how you were infected.

Discredited Analysis

Statistical analysis carried out on behalf of Health Protection Agency in England in 2003, by Soldan and Sinka, suggested that a full lifting of the ban increased the risk of HIV entering the blood stocks by 500%. A partial removal, excluding only men who had sex with men in the last 12 months, increased the risks by around 60%.³

However, this report has since been widely discredited as an inaccurate appraisal of the results of changing the policy on donor eligibility. For one, the study does not take into account the replacement of a blanket gay blood ban with a ban on potential donors who are engaging in high risk behaviour. Soldan and Sinka acknowledge themselves that this study has serious flaws; thus they significantly qualify their findings: *"Many assumptions were required to generate estimates of the risk of HIV infection entering the blood supply. The accuracy of the estimates is therefore uncertain and the probable ranges around the estimates were wide"*.⁴

This analysis was brought up in the Anti Discrimination Tribunal in Tasmania. Soldan and Sinkas' analytical approach was harshly criticised by Travis C. Porco, PHD; a Mathematical Epidemiologist. He concluded that: *"It is the concern of this*

¹ Anne mitchel testimony to tas tribunal 12/8/08

² Quinhealth info

³ Evaluation of the de-selection of men who have had sex with men from blood donation in England, K. Soldan & K Sinka, Vox Sanguinis 2003 84, p265-273

⁴ Ibid, p1

respondent (TCP) that deferment of donation from very low risk (long-term abstinent or exclusively monogamous in a seroconcordant relationship) MSMs provides at best illusory safety.⁵

Blood Safety and Quality Regulations 2005

There is a legal requirement on the Blood Service to defer those who engage in high risk behaviour. EU Directive 2004/33/EC, translated into UK law as the Blood Safety and Quality Regulations (2005) requires permanent deferral (i.e., lifetime exclusion from donation) for "Persons whose sexual behaviour puts them at high risk of acquiring severe infectious diseases that can be transmitted by blood" (Schedule, Part 3, paragraph 2.1).⁶

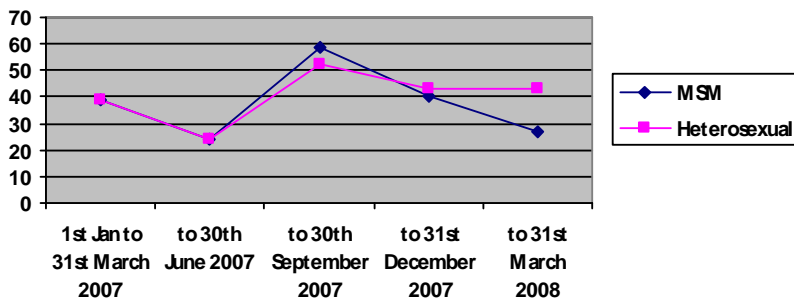
Temporary deferral is required for "Persons whose behaviour or activity places them at risk of acquiring infectious diseases that may be transmitted by blood".⁷ The length of the temporary deferral is specified: "Defer after cessation of risk behaviour for a period determined by the disease in question, and by the availability of appropriate tests". (Schedule, Part 3, paragraph 2.2.2).⁸

It is completely incompatible with the vast majority of scientific, medical, statistical and historical evidence on the transmission of HIV, and with current UK legislation, to suggest that a person who has had unprotected sex with an HIV positive person, is not at a high risk of contracting HIV, but the Blood Service let them donate after 12 months. It is again completely incompatible with the evidence to suggest that men who are having unprotected sex with a large selection of women, who themselves may be participating in unprotected sex (as in without a condom) with large numbers of men, are less of a risk than a gay or bisexual man who has only ever had protected sex.

HIV Transmission in Scotland

The SNBTS claim that 86% of new HIV infections in Scotland in 2007 occurred from MSM, Terrence Higgins Trust claim 87%. The figures from the Health Protection Agency Scotland, however, do not support that claim.

How HIV was probably acquired in Scotland – Health Protection Agency Scotland.⁹



History of the HIV Epidemic

People working in the blood service are highly skilled and experienced epidemiologists, who have been dealing with the HIV/Aids issue since this epidemic began. We now know that HIV spread so quickly through the gay population because in the 1980's there were the perfect conditions for the virus to spread through sexual networks. We know that HIV disproportionately affected MSM at the beginning of the epidemic because of factors like low use of condoms and multiple partnerism.¹⁰ High densities of gay and

bisexual men in urban areas, operating in a relatively close knit community, created that sexual network of men which caused the virus to spread. The virus could be in one person and be rapidly transmitted to many other people in the network. Condoms were of course found to prevent HIV transmission. Safe sex campaigns were begun in earnest, which were successful in bringing down the staggering number of new infections among gay and bisexual men. As being gay became more acceptable, people felt more welcome into society and were given legal protections that helped reduced the isolation and internal negativity that many gay and bisexual men felt, which increased self perception and the need for multiple partnerism subsided as men could find acceptance elsewhere and their relationships became recognised. Fantastic work by LGBT and HIV organisations helped make safe sex among gay and bisexual men an almost universally known and practiced fact, as well as better education in schools, thanks partly to the abolition of Section 28.

The situation we are at now is one where incidences of unprotected sex with multiple partners is more likely to occur among heterosexuals. The scary fact is that knowledge and use of safer sexual practices and HIV prevention among heterosexuals is incredibly poor. In 2007, 79% of the UK population knew that HIV was transmitted through unprotected heterosexual sex.¹¹ Another survey said that three out of four young women do not believe they are at risk of HIV. Nine out of ten do not think a condom is essential to take on a night out and nearly half ignore condoms when talking about their sex life.¹² Compare that to gay bars and clubs where condoms and lubricants are easily available for free, and straight bars and clubs where there are generally no free condoms available.

⁵ proco

⁶ <http://www.opsi.gov.uk/si/si2005/20050050.htm>

⁷ ibid

⁸ ibid

⁹ <http://www.hps.scot.nhs.uk/bbvsti/surveillance.aspx>

¹⁰ Sexual Ecology: The Birth of AIDS and the Destiny of Gay Men, Gabriel Rotello, Dutton adult, 1997

¹¹ <http://www.nat.org.uk/HIV-Facts/Statistics/UK>

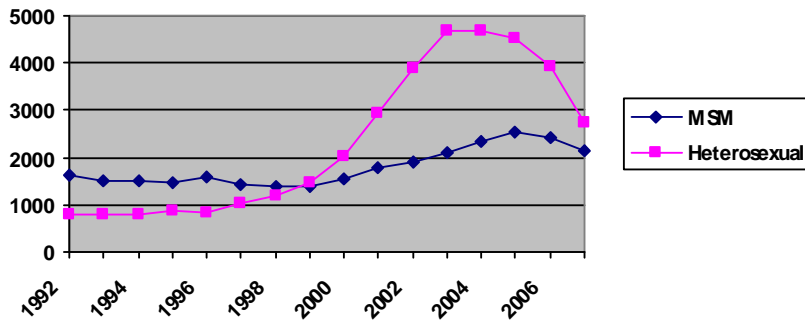
¹² http://www.metro.co.uk/news/article.html?in_article_id=34425&in_page_id=34&in_a_source=

HIV Infections in the UK

Looking at new HIV infections as a whole throughout the UK, we can clearly see the early benefits that safe sex message brought in the gay community as infections levelled off in the early 1990's. The subsequent rise in HIV infections in later years can be attributed to a new generation of gay and bisexual men having missed out on the HIV/Aids campaigns on the 1980's

The most worrying trend however is surely the massive increase in heterosexual infections, which since 1999 have been the majority of new infections throughout the entire UK.

How HIV infection was probably acquired in the UK – Health protection agency¹³



Ideas about HIV

Working in the epidemiology or blood service field during that time in the 1980's, one can see how professionals now would have good reason to have a healthy and reasonable distrust of gay and bisexual men due to past behaviours and its devastating results. Yet the situation has changed. We can no longer afford to think of HIV as just a 'gay' disease. It is scary for us to confront HIV. Many of us do not understand it, we don't want to have to think about changing our sexual behaviours to prevent it, we don't want to think of the risks associated with the

behaviours. If you understand how HIV works, and if you understand how knowing your status as early as possible will enable you to have a relatively normal life span, and the advances in Anti-Retroviral therapy can make HIV a chronic condition rather than a life threatening disease. The key is promotion of regular testing for everyone. 43% of HIV diagnoses in heterosexual men are diagnosed late.¹⁴ The British HIV Association says at least a quarter of deaths reported in HIV+ people in the UK between 2004 and 2005, may have been avoided if HIV had been diagnosed earlier.¹⁵

Some say that the key to promoting safe sex is fear. It is fear that motivates people to change their sexual behaviour. However we think the better option is for people to know all the facts, to make decisions based on these facts and to enjoy their sex lives in a safe manner, free of the fear of getting a disease and free of fear if they are unfortunate to contract one. HIV is no longer just the 'gay' disease and can no longer be treated as such, HIV can and will be passed on through high risk behaviours whatever the gender of your partner.

The International Situation

In July 2006, French Health Minister Xavier Bertrand stated as he lifted the blanket ban: "*I want us to speak in the future not of 'populations at risk' but of 'sexual practices at risk. It isn't a question so much of ignoring a very troublesome situation—the regrowth of the HIV epidemic among male homosexuals; on the contrary it's a matter of remembering the danger of at-risk practices whether they be homosexual or heterosexual.*"¹⁶

In January 2001, the Italian Health Ministry repealed the blanket ban on all gay and bisexual men giving blood, and instead now permanently excludes those who have had "sexual intercourse with a high transmission of STI's" and enforces a one year deferral on those who have had "occasional sexual intercourse with a risk of transmission of STI's." As a result, the number of people infected by HIV through blood transfusions dropped by two thirds.¹⁷

In Spain, the policy on donor eligibility was changed to allow MSM who practice safe sex to donate in 2003, and again the number of infections from blood transfusions was reduced to one sixth of what it was previously.¹⁸

"*Only a small minority of homosexual men are at risk; the notion that all gay men are uniformly at risk is as offensive as a similar statement would be for exclusively heterosexual men. The policy is blatantly discriminatory on grounds of gender preference and it diminishes men who have sex with men by preventing them from full participation in the community.*" So said Dr William Murphy, the National Medical Director for the Irish Blood Transfusion Service.¹⁹

¹³ http://www.hpa.org.uk/web/HPAweb&HPAwebStandard/HPAweb_C/1203084373037

¹⁴ http://data.unaids.org/pub/Report/2008/uk_2008_country_progress_report_en.pdf

¹⁵ <http://www.aidsmap.com/en/news/DBD2459C-6C54-4169-9F35-CB53F25944FC.asp>

¹⁶ <http://resource.nusonline.co.uk/media/resource/Around%20the%20World.doc>

¹⁷ Aggiornamento dei casi di AIDS notificati in Italia e delle nuove diagnosi di infezione da HIV, Table 7, Ministero della Salute, December, 2004.

¹⁸ HIV/AIDS Epidemiological Surveillance in Spain: National Register of AIDS cases, Table 3, Ministerio de Sanidad y Consumo, June 2005.

¹⁹ <http://www.irishtimes.com/newspaper/opinion/2006/0914/1158001545752.html>

The Swedish Prime Minister Goeran Persson spoke out against the ban, and new rules to focus on all high risk behaviours will be implemented in Sweden in November.²⁰

Jose de Almeida Goncalves, Head of the Portuguese National Blood Institute lifted the ban in March 2006, stating: "The current trend is towards equality of criteria for all regardless of their sexual orientation."²¹

In Russia, the Ministry of Health said "The General Prosecutor recognised that there is nothing in the law which prevent gays to donate their blood."²²

In the US, the Blood Products Advisory Committee of the Food and Drug Administration in 2001 narrowly voted, by 7-6 to keep the ban they have now. However that policy is now in spite of the very strong objections to the ban by the American Red Cross, the American Association of Blood Banks and America's Blood Service. They wrote to the FDA saying: "*It does not appear rational to broadly differentiate sexual transmission via male-to-male sexual activity from that via heterosexual activity on scientific grounds... To many, this differentiation (between homosexual and heterosexual) is unfair and discriminatory, resulting in negative attitudes to blood donor eligibility criteria.*"²³

Australia and the Tasmanian Anti-Discrimination Tribunal

In 2006, a complaint was made to the Tasmanian Anti Discrimination Tribunal by a gay man called Michael Cain, who was denied by the Australian Red Cross the opportunity to donate blood. Australia, where the UK blood service imports blood products from, has a one year deferral for MSM. The tribunal began this summer and will likely continue hearing from witnesses until November.

Dr Scott Halpern is an internationally recognised bio-ethicist and epidemiologist at the University of Pennsylvania, and a consultant to the US Centre for Disease Control and the US Food and Drug Administration. In his expert testimony to the Tasmanian Anti-Discrimination Tribunal, he states

"Any effort to bar a specific group of citizens from donating must have sound reasoning behind it, and indeed, the burden of proof must always rest with those who wish to bar a particular group from donating (rather than with those who support equal access to donation). This means that from an ethical perspective, a specific group of citizens should not be barred from donating unless or until the preponderance of evidence suggests that barring donation from this group serves a broader societal goal (such as safety of the blood supply)."

*"If there is compelling evidence that the risks are primarily associated with the safety of the sexual practice and not with the sex of the partner, then it would be extremely difficult to justify a policy of excluding men on the basis of the sex of their partners. To do so would be unduly discriminatory"*²⁴

According to a report by Vincent Baron Reinhart et al, referenced by Dr Halpern in his testimony to the tribunal, the mean age of blood transfusion products in Western Europe was 16 days, in the United States it was 21 days. Dr Halpern said that blood older than 14 days is far more dangerous than blood from gay donors, in his testimony he states: "*Transfusion of older blood is ineffective at increasing tissue oxygen delivery, and may be associated with increased morbidity or mortality when compared with the transfusion of newer blood products.*"²⁵

During questioning at the tribunal, Dr Halpern states: "*I think we're talking about one in 100 risk of death on the one hand with using old blood, and about a one in a million risk of HIV on the other [using blood donated by MSM]; much rarer than getting struck by lightning.*"²⁶

Australian HIV/Aids expert Bill Bowtell, currently Director of the HIV/AIDS Project at the Lowy Institute for International Policy in Sydney, a former senior advisor to the Australian Minister of Health during the outbreak of the HIV epidemic, and a former senior advisor to Prime Minister Keating, stated in his testimony:

*"This blanket proscription no longer seems to serve any particular purpose in terms of protecting the blood supply from contamination with HIV. Highly effective testing, blood treatment and procedures are now well-established. These measures give the public the highest possible level of confidence in the integrity of the blood supply arrangements. In these circumstances, I do not consider any public purpose is served by maintaining a general prohibition on homosexually active men who are free of blood borne diseases from donating blood in the usual way and subject to the rules and procedures that apply to all donors."*²⁷

The fact that there is an incredible amount of evidence from highly respected professionals against the current policy of total exclusion for MSM, much, much more than can be discussed in 4 pages, and certainly warrants further, transparent examination. Evidence from the Tasmanian Anti-Discrimination Tribunal on the gay blood ban runs to thousands of pages alone. Not only that, but evidence that the SNBTS are currently using to support their arguments is not robust enough, and has major qualifications that do not justify using such evidence.

²⁰ <http://www.gaycork.com/forum/showthread.php?t=2580>

²¹ <http://www.thebody.com/content/art23460.html>

²² <http://www.pinknews.co.uk/news/articles/2005-1975.html>

²³ <http://resource.nusonline.co.uk/media/resource/Around%20the%20World.doc>

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²⁷ bowtell

The evidence we have presented strongly supports our opinion that you cannot accurately judge someone's risk of contracting HIV based on the gender of their partner. Instead the safest option, as already proven with the evidence from Italy and Spain, is to base donor selection criteria on the risk of behaviour that people engage in. At the very least, we have presented a wide range of epidemiological opinions and evidence that warrants a far more detailed review of the current policy. Any review must be transparent, be public and must communicate with and be open to participation of the gay community for its findings to be accepted by all concerned.

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