Testimony by Peter Sprigg, Senior Fellow for Policy Studies, Family Research Council

Before the Advisory Committee on Blood and Tissue Safety and Availability (ACBTSA)
U.S. Department of Health and Human Services
Rockville, Maryland
December 5, 2013

Good afternoon.

My name is Peter Sprigg, and I am a Senior Fellow for Policy Studies at the Family Research Council in Washington, DC.

While FRC welcomes research regarding the blood donor policy for men who have sex with men, such as the research just reported, there are certain core principles we wish to reiterate as this committee continues its consideration of this issue.

There is no question that the use of donated blood tainted with HIV would be a threat to public safety. There is also no question that men who have sex with men are at a much greater risk of being infected with HIV. While there is also no question that we have made tremendous advances in the *treatment* of HIV infection, advances in the *prevention* of high-risk behaviors have lagged behind.

In September, the CDC reported that men who have sex with men

> " . . . are still at the center of the HIV epidemic in the United States. Just 2% of the U.S. population, they accounted for 63% of all new HIV infections in 2010 and 52% of people living with HIV infection in the United States in 2009. From 2008 to 2010, the estimated number of new HIV infections rose 12% among MSM overall and 22% among young MSM (aged 13 to 24 years)."

In fact, among adolescent and young adult males between the ages of 13 and 24, well over 90% of all new HIV infections in 2011 were as a result of "male-to-male sexual contact."

There is little evidence that a change in the lifetime deferral policy is needed to maintain an adequate blood supply. As the *Washington Times* reported this week, medical advances mean that the demand for donor blood is decreasing. Furthermore, only 0.4% of all blood donor deferrals are because of the exclusion of men who have sex with men.

The current policy should only be changed if *all* of the following conditions are met:

1) It can be shown that a change is *needed* to ensure an adequate blood supply.
2) It can be shown that the change would *result* in a significant increase in the blood supply.
3) It can be proven that a change would result in *no* added risk to the blood supply.
4) The change would add *no* additional costs for added or special screening procedures.

It seems unlikely that any revised policy would meet all four of these conditions.

Finally, let me point out that there is no "right" to donate blood. No reasonable concept of social justice requires expanding the pool of potential blood donors. On the contrary, social justice requires that *only* the needs of potential blood *recipients* be considered at all; and it requires that national policy ensure the maximum level of safety that is consistent with maintaining an adequate blood supply.