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VIEWS & REVIEWS

PERSONAL VIEW

The blood service should ask donors about practice, not just partners

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[Image: ROB WHITE]

Richard Titmuss's seminal study of blood donation systems, *The Gift Relationship*, concludes that the central question for ensuring the safety of the blood supply is, "What particular set of conditions and arrangements permits and encourages maximum truthfulness on the part of donors?" (see *BMJ* 2011;342:d2078, doi:10.1136/bmj.d2078).

Notwithstanding advances in the epidemiological modelling of risk and the screening of blood, truth telling and trust remain pivotal. Screening is imperfect, and laboratory facilities are overstretched. So the UK National Blood Service uses a "donor health check" questionnaire to identify would-be donors whose "lifestyle and medical history" puts them at greater risk of having contracted a transfusion transmittable viral infection (www.blood.co.uk/can-i-give-blood/donor-health-check). This triage of potential donors is designed to limit the volume of infected blood entering this fallible system.

Donors are trusted to answer a range of questions, including whether they have recently had a tattoo, travelled from a region of high HIV prevalence, or had sex with someone known to have HIV. They are also asked, "Are you a man who has ever had oral or anal sex, whether or not a condom was used, with another man [hereafter MSM]?" Answering "yes" to these questions currently results in a six month, 12 month, or lifetime deferral.

Permanent deferral of MSM is controversial, and the government has just announced a change to 12 month deferment. Notwithstanding this important change, the donor health check will probably continue to function as before.

The blood service presents the questionnaire as gauging donor behaviour, but its principal function is to sort people into groups with epidemiologically defined risk profiles. The questionnaire elides relevant sexual practices: it is not the "lifestyle" of the donor but rather the donor's contextual association with an aggregate high or low risk profile that determines whether or not his or her blood is accepted.

A recent report from the US Department of Health and Human Services identified this approach of using generalised risk profiles as "suboptimal" because it prevents donations from MSM at low risk while permitting donations from heterosexual people at high risk (www.hhs.gov/ophs/bloodsafety/advisorycommittee/recommendations/06112010_recommendations.pdf).

We concur, and suggest that the 12 month deferral of MSM (effectively still a lifetime deferral for sexually active MSM) does little to tackle over-reliance on the logic of risk group profiles. To illustrate, compare the deferment periods for three subsections of the UK population with different HIV rates, as given by the Health Protection Agency—MSM (5.3%), black African people (3.7%), and the general heterosexual population (0.09%).

Although deferment for MSM and black African people is now ostensibly the same, MSM must be abstinent for 12 months, whereas African migrants who have been resident for 12 months can be sexually active as long as their partners have been similarly resident.

This continued asymmetry in deferral is explained by the role played by context, rather than specific practice, in the way risk is calculated. For MSM, risk is imagined as endemic and proximate, with 82% of HIV transmissions estimated to occur within the UK and most assumed to be recent. Because MSM draw partners from within a population category of high prevalence, they are calculated as always at disproportionate risk—regardless of their practice.

The long standing calculation that a 12 month deferral is sufficient to avoid donations during the "window period" in African migrants is not based on any effect that assimilation

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may have on sexual practices. Because 68% of HIV transmission among black African people occurs abroad and is predominately historical, HIV among black Africans in the UK is imagined to be primarily imported. After 12 months, migrants can donate if they draw partners only from the low risk "general" UK population category.

We worry that substantial levels of transmission within the UK are de-emphasised, partner chains are imagined to only one degree of separation, and so complex sexual networks within and between segregated communities are overlooked.

Despite recent changes, the logic of deferral remains flawed because of its focus on population level risk groups and not practice. Current donor selection criteria trust that domestic heterosexuality is a protected context in which to harvest blood, even while heterosexual people represent the greatest absolute number of individuals living with transfusion transmittable viral infections in the UK. Risk is diluted by inadequately differentiated surveillance data that amalgamate subpopulations associated with higher risk of such infections—for example, people who live with deprivation (www.nwpho.org.uk/10yearhiv/HIV_10years.pdf), have low educational attainment (*Sex Transm Infect* 2010;86(suppl 3):S45-51, doi:10.1136/sti.2010.042283), have alcohol problems (*Int J STD AIDS* 2007;18:810-3, doi:10.1258/095646207782717027), or are migrants with 12 months' residency. The failure to assess actual sexual practice compounds the problem by obscuring multifarious high risk behaviours within the heterosexual population: multiple partnering and casual, anal, and unprotected sex (*J Sex Res* 2010;47:123-6, doi:10.1080/00224490903402538; *Sex Transm Dis* 2010;37:369-76, doi:10.1097/OLQ.0b013e3181cbf77d; *Sex Transm Dis* 2010;37:425-31, doi:10.1097/OLQ.0b013e3181d13ed8).

The recent change in deferral for MSM does nothing to challenge these inadequacies of trusting in generalised risk profiles instead of honest self reporting of risky practices. Heterosexual people who practise unprotected anal sex with multiple partners can still donate immediately—without question.

This is not a call for more subtle epidemiological profiling but rather an attempt to highlight the limits of using population based epidemiological categories as the primary means to determine donor selection. Risk profiles are a function of mapping of surveillance data, not an accurate description of actual sexual practice or the risk presented by an individual donor. Subsuming most donors within the aggregate heterosexual "low risk group" fails Titmuss's concern about encouraging maximum truthfulness and drives a wedge between blood collection and sexual health education.

If the National Blood Service is to do all it can to ensure the safety of blood it must develop a more rigorous predonation questionnaire that focuses on actual practices. Such a change of emphasis presents challenges but because donors are also potential recipients, they should understand the need to focus on practices directly related to risk.

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bmj.com/archive News: UK lifts lifetime ban on gay men giving blood (*BMJ* 2011;343:d5765, doi:10.1136/bmj.d5765); Research: Views and experiences of men who have sex with men on the ban on blood donation (*BMJ* 2011;343:d5604, doi:10.1136/bmj.d5604); Feature: Bad blood: gay men and blood donation (*BMJ* 2009;338:b779, doi:10.1136/bmj.b779); Head to Head: Should men who have ever had sex with men be allowed to give blood? (*BMJ* 2009;338:b311 and b318, doi:10.1136/bmj.b311 and doi:10.1136/bmj.b318)

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