

THE EVOLUTION OF THE **MSM** BLOOD DONATION POLICY IN CANADA

by

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ABSTRACT

In order to ensure the safety of the blood supply, potential blood donors in Canada are screened for eligibility prior to making a donation. This process includes answering a series of questions intended to identify those at higher risk of carrying transfusion-transmissible pathogens. Prior to 2013, male donors who had had sex with another man, even once, since 1977 were banned for life from donating blood. From 2013 onward, men who have sex with men (MSM) could donate blood provided that they had not had sex with another man for five years. This policy has been criticized, both before and after the policy change in 2013, as being discriminatory and not based on current scientific knowledge and practices.

This paper describes and analyzes the evolution of the MSM blood donation policy in Canada. The analysis shows that Canadian Blood Services, the organization in charge of the blood supply, prioritized blood safety and the perspectives of blood recipients above all others, which led them to take a particularly cautious approach in deciding when and how to change the policy. The analysis also reveals that the policy was finally able to change in 2013 because of the accumulation of research, the engagement of high-interest stakeholder groups, and shifts in the perceived costs and benefits of maintaining the status quo vs. changing the MSM blood donation policy. Examining the costs and benefits of a policy change for blood recipients and the MSM community suggests that what is needed for the policy to change in the future is more research into alternative screening criteria which can maintain the safety and adequacy of the blood supply.

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INTRODUCTION

There is a continuous need for blood and blood products in the Canadian health system. Whole blood, as well as its individual components, are essential in a variety of medical procedures including major surgeries and cancer treatment (CBS, 2015a). In Canada, blood and blood products are obtained through voluntary, non-remunerated donations from individuals and the health system must continuously acquire donations from both new and existing donors to maintain an adequate blood supply.

In order to ensure the safety of the blood supply, donors are screened for eligibility to donate and all donated units of blood are tested for markers of transfusion transmissible pathogens including hepatitis B, hepatitis C, human immunodeficiency virus (HIV) 1 and 2, human T-lymphotropic virus I and II, and syphilis (CBS, 2015a). During the screening stage, those who are considered to be at higher risk for carrying blood-borne pathogens which could be passed on to blood product recipients are either banned from donating blood or deferred for a set period of time before becoming eligible to donate. There is a wide variety of reasons why an individual may be deferred from donating blood in Canada, including intravenous drug use, having a recent tattoo or body piercing, or being a male who has had sex with another male.

The criterion pertaining to men who have sex with men (MSM) has been a point of controversy since it was introduced. Up until 2013, male potential donors were asked "Have you had sex with a man, even one time since 1977?" An affirmative answer resulted in an indefinite deferral, meaning that the person was banned for life from donating blood. In 2013, the screening question was changed to "In the last five years, have you had sex with a man, even once?" An affirmative answer to this question resulted in a temporary deferral, meaning that the potential donor was banned from donating blood until such time that they could answer "No" to this question. Both before and after the change in 2013, the MSM blood

donation policy has been criticized as being discriminatory and not based on current science (Germain & Sher, 2002; Smith, Fiddler, Walby, & Hier, 2011). Despite such criticisms, the policy has persisted.

The purpose of this paper is to review the history of the MSM blood donation policy in Canada in order to identify why it has evolved the way it has and predict possible future changes to the policy. This analysis may also inform discussions around the MSM blood donation policies in other countries and the literature around other controversial policy changes.

METHODS

The project included a review of academic databases, grey literature, and informal sources such as news articles and information from websites. The focus was on the MSM blood donation policy in Canada but the review also included sources covering MSM blood donation policies in other countries. Material selected for inclusion included:

- Studies and models assessing the theoretical or actual impact of a change to the MSM blood donation policy
- Pieces arguing for or against changes to the MSM blood donation policy
- Policy analyses of the MSM blood donation policy

Academic databases were searched using a combination of subject headings, for those databases which have them, and keyword searches. Initial searches combining the concepts of MSM, blood donation, *and* Canada resulted in relatively few results and so the search protocol was changed to only include the concepts of MSM and blood donation. The following databases were searched: BioMed Central, Canadian Public Policy Collection, Cochrane Database of Systematic Reviews, Cumulative Index to

Nursing and Allied Health Literature (CINAHL), Google Scholar, Health Source, HeinOnline, MEDLINE, PubMed, and Web of Science. See Appendix A for the search protocol for CINAHL, which is illustrative of the searches used in all databases. The titles and abstracts of the search results were reviewed for relevancy, and over 200 documents were downloaded for more detailed review. Informal sources were identified through the Google search engine, using keyword searches. Further sources were identified from the reference lists of relevant articles during the initial search.

During the analysis, more time and weight was devoted to the literature pulled from the academic database searches, as well as the Canadian Blood Services website. Informal sources from the Google searches were used primarily to contribute to the context and verify recent information which may not have been reflected yet in the academic literature due to time lags resulting from the publishing process (e.g. current status of MSM blood donation policies around the world).

Documents pulled from the literature search were categorized based on the country whose MSM blood donation policy they referred to. The most detailed reading and analysis was devoted to the documents specifically related to the Canadian MSM blood donation policy. However, many of the documents relating to the US MSM blood donation policy were considered relevant to the policy debate since both countries had the same policy prior to 2013, and so significant time was also spent reviewing these documents. Furthermore, some documents reviewed MSM blood donation policies for multiple countries, including Canada, and these were also reviewed in detail. Documents focusing entirely on MSM blood donation policies in countries other than Canada and the US, or covering tangentially related topics, were only read in detail where they appeared to be directly relevant to the Canadian MSM blood donation policy (e.g. an Australian review of the impact of changing to a 12-month deferral period, since the Australian experience has been cited by CBS).

ORIGINS OF THE MSM BLOOD DONATION POLICY

The MSM blood donation policy in Canada originated as a result of the emergence of HIV and acquired immune deficiency syndrome (AIDS) in the early 1980's (Krever, 1997). When HIV/AIDS first emerged, it was originally associated with MSM activity since many of the first cases were young MSM (AVERT, 2014). However, shortly after the first reports of MSM contracting this new disease, a number of other people with no history of MSM activity also presented with similar symptoms. The primary groups of such people afflicted with the new disease were Haitians and intravenous drug users, but there were also cases appearing among hemophiliacs and people who had received blood transfusions (AVERT, 2014).

As time went on, there was increasingly convincing evidence that HIV was a transfusion-transmissible pathogen and that it could be transmitted even when an infected person did not exhibit any symptoms (Krever, 1997). In order to try and prevent the virus from entering the blood supply and infecting blood product recipients, the Canadian Red Cross (which was in charge of the blood system in Canada at the time) urged people at high risk of contracting HIV, including MSM, not to donate blood. Initially, this approach was based solely on voluntary self-exclusion but by 1988, potential donors who identified as having engaged in MSM activity were banned by blood services staff from donating blood (CBS, 2015a; Krever, 1997).

In spite of these precautions, hundreds of people were infected with HIV through the blood supply during this period. This tainted blood scandal resulted in a significant loss of trust in the national blood system and led to a Royal Commission of Inquiry into Canada's blood system led by Justice Horace Krever in order to examine how the blood supply became contaminated and how such an event could

be prevented in the future (Lapierre, 2015). The Krever Commission emphasized that the safety of the blood supply was paramount, and that in order to safeguard the blood supply going forward, a precautionary approach should be taken in the absence of complete knowledge (Krever, 1997). The history of the tainted blood scandal, and the emphasis on safety from the Krever Commission, have contributed to the persistence of the MSM blood donation policy in the face of opposition.

THE DEBATE: ARGUMENTS FOR AND AGAINST CHANGE

The MSM blood donation policy has been debated since the time it was introduced to the present day. There are two primary arguments used by those who advocate for change: (i) the policy is not based on current scientific knowledge and practice, and (ii) the policy discriminates against MSM.

Regarding the first argument, it is recognized that the policy may have been justified during the early years of AIDS in Canada when little was known about the disease and there was no way to test if someone had been infected with HIV. However, within a few years of the emergence of HIV/AIDS in Canada, a test had been developed which could detect the presence of antibodies to HIV within months of infection, and all units of blood collected in Canada from this point on were tested (Krever, 1997). By the early 2000's, a new test was introduced to the Canadian blood system which could detect HIV within weeks or days of infection (CBS, 2015a). Alongside these advances in testing, understanding of HIV/AIDS grew, including greater knowledge of its transmission and prevention. Given these advances in knowledge and testing, it has been argued that the MSM blood donation policy is overly stringent and could be changed without increasing the risk of transfusion-transmitted HIV (Wainberg, Shuldiner, Dahl, & Gilmore, 2010).

The other primary argument used by those advocating change is that the policy stereotypes and discriminates against MSM. For example, while MSM are deferred for five years (and previously, were deferred for life), a woman who has had sex with an MSM is only deferred for 12 months before becoming eligible to donate blood (Galarneau, 2010). Further, the policy treats all MSM as having the same high level of risk, ignoring differences such as whether the potential donor is in a monogamous relationship or has multiple sex partners, whether he uses condoms or not, and what types of sexual practices he engages in (e.g. anal sex vs. oral sex) (Lake, 2010; Wainberg et al., 2010). Conversely, the policy treats all non-MSM as having the same level of low risk. For example, with the current screening questions, a heterosexual man who frequently engages in unprotected sex with multiple partners would be allowed to donate blood (Vernillo, 2010).

Initially, it was primarily members of the MSM community who protested the policy but as time went on, members of the general public increasingly began to protest the policy as well. Student groups at universities across the country began to demonstrate against the policy and arranged boycotts of on-campus blood drives starting in the mid 2000's (CBS, 2012a) and health professionals also began to call for change (Wainberg et al., 2010).

Those who have defended maintaining longer deferral periods for MSM have argued that the safety of the blood supply is of utmost importance, and that allowing MSM to donate blood could jeopardize this safety. In particular, they point out that MSM account for the largest proportion of HIV infections in Canada (e.g., Public Health Agency of Canada, 2013) and even though all donated blood is tested for HIV, there is a concern of an infected unit entering the blood supply through failures in the screening process such as false negatives or administrative errors (Germain & Sher, 2002). There is also a fear that the MSM population may be at greater risk for as-yet-unknown emerging infectious diseases and that by

reducing the deferral period for MSM, there is the potential for another tainted blood scandal (Smith et al., 2011). The main stakeholder group that has argued for maintaining the policy consists of blood product recipients, such as members of The Canadian Hemophilia Society and Thalassemia Foundation of Canada (Goldman, Lapierre, Lemay, Devine, & Sher, 2014).

CANADIAN BLOOD SERVICES TAKES A CAUTIOUS APPROACH

In Canada, Canadian Blood Services (CBS) is responsible for maintaining the blood supply for all provinces and territories except for Québec, where the responsibility lies with Héma Québec (HQ). Health Canada maintains arms-length regulatory oversight of both of these organizations. Before any operational changes are made to the blood supply system, including donor screening policies, CBS and HQ must submit proposals to Health Canada, with supporting evidence that the proposed change would not endanger the blood supply (Health Canada, 2013).

As the organization in charge of the majority of the nation's blood supply, CBS found itself in the middle of the debate around the MSM blood donation policy. In deciding whether to change the policy, it appears from the literature that CBS gave priority to the safety of the blood supply above all else, leading to a very cautious approach. This emphasis on caution explains why the policy took as long as it did to change, and why the policy change in 2013 only reduced the deferral period to five years rather than a shorter period.

There were several reasons why CBS needed to be cautious in considering any change to the MSM blood donation policy. First, the history of the tainted blood scandal had understandably made blood users more sensitive to any change which could potentially increase the risk of transfusion-transmitted infection (Leiss, Tyshenko, & Krewski, 2008). A tragedy such as this can make it harder than usual to

change a policy, even when new knowledge and practices make the policy less justifiable (Wilson, Atkinson, & Keelan, 2014).

Second, although the blood recipient group eventually found themselves as the only voice arguing for the status quo against multiple other stakeholder groups, their voice had a disproportionately large influence because they were the group most likely to bear the consequences of any increase in the risk of transfusion-transmitted infections. Their tolerance for any additional risk arising from a change in the MSM blood donation policy, no matter how small, was very low for a number of reasons. Aside from the history of the tainted blood scandal, there is generally lower tolerance for risks which are perceived to be involuntarily imposed vs. voluntarily chosen, and also lower tolerance for risks which are considered to be human-made rather than natural (Leiss et al., 2008). From the perspective of blood recipients, any increase in risk from changing the MSM blood donation policy would be involuntarily imposed *and* human-made. Further, a change to the MSM blood donation policy could be seen as a transfer of costs from one stakeholder group to another (Leiss et al., 2008). That is, relaxing the deferral criterion would reduce the “costs” to the MSM community in terms of perceived discrimination, but would increase the “costs” of a potential increase in risk of transfusion-transmitted infection primarily among frequent blood users. Such a transfer of costs understandably meets with great resistance from the group who costs are being transferred to. This is illustrated in the following quote from a member of the Canadian Hemophilia Society during a conference in 2001 to discuss the MSM blood donation policy: “As bearers of 100% of the risk of infection, recipients have zero tolerance for avoidable risk” (Chiavetta et al., 2003). A zero-tolerance stance for increased risk makes policy change very difficult because, as CBS has recognized, “modelling studies will never show a zero increment in risk” (CBS, 2015b). The consensus statement from this same conference also stated that there was no right to donate blood, whereas

blood recipients could argue that they have a right not to be inflicted with disease or injury (King et al., 2002).

Third, any proposals for a policy change needed to be approved by Health Canada. Any proposed changes to the blood donation process are assigned into one of four categories, with category 1 being the lowest risk and category 4 being the highest risk (P. Loftus, CBS, personal communication, July 2012). The higher the risk category, the longer the review would take and the more information would be required by the reviewers to approve the change. The MSM blood donation policy was a category 4 risk and, as such, it is possible that CBS took longer than minimally necessary in order to ensure there was sufficiently strong evidence and support before submitting a proposal for change to Health Canada. In the media around this issue, CBS staff members have also mentioned that part of being able to change this policy is being able to convince both blood recipients and Health Canada that any change does not jeopardize the safety of the blood supply (Christopher, 2013; “Canadian Blood Services wants,” 2013).

CAUTION IN ACTION

For the reasons outlined above, CBS moved forward with the policy change in a deliberately cautious manner. This is evident in the time and resources that CBS devoted to the process before applying to change the policy, an emphasis on including all high-interest stakeholders throughout the process, and the change to a five-year deferral period in 2013 as a first step rather than a change to a shorter deferral period, such as one year.

One of the first signs of CBS’ engagement in the MSM blood donation policy debate was hosting a consensus conference in 2001. The conference, titled “Blood Borne HIV and Hepatitis-Optimizing the Donor Selection Process”, brought together representatives from various high-interest stakeholder

groups to establish principles that would guide the evaluation and revision of donor deferral criteria, and areas needing further research (King et al., 2002). Participant groups included the Canadian Federation of Students, Equality for Gays and Lesbians Everywhere, the Canadian AIDS Society, the Canadian Hemophilia Society, and the Thalassemia Foundation of Canada. There was little consensus, with the student and gay rights groups advocating a change to gender-neutral screening questions about risk behaviors, while the patient groups were opposed to any change, believing that any such change would adversely affect the safety of the blood supply (Goldman et al., 2014). The consensus statement that was produced from the conference (King et al., 2002) did not provide any direct recommendations for whether the MSM blood donation policy should be changed and so the status quo was maintained.

Several years later, CBS contracted the McLaughlin Centre for Population Health Risk Assessment, University of Ottawa to conduct a study examining the MSM deferral criterion using risk management principles (Goldman et al., 2014). The researchers considered the options of changing to a 10 year deferral, five year deferral, one year deferral, or no deferral and reviewed relevant studies in their analysis. They concluded that a five year deferral period would be acceptable, but not a one year deferral period (Leiss et al., 2008). When these results were presented to the high-interest stakeholder groups, there was still little agreement between the groups, with blood recipients reluctant to consider a policy change (Goldman et al., 2014). As a result, the CBS Board of Directors opted to err on the side of caution and maintain the indefinite deferral for MSM, while continuing to call for further research that could inform the discussion (Goldman et al., 2014).

In 2008, CBS conducted an anonymous survey of current blood donors, asking them about their opinions on the current screening practices and possible changes to the MSM criteria. The researchers found that

about half of the respondents felt the MSM criteria should be changed, with donors under the age of 50 being more likely to support a change in the policy (Goldman, Yi, Ye, Tessier, & O'Brien, 2011). The survey also included possible alternatives to the MSM question, but based on the responses to these questions, the authors concluded that using gender-neutral screening questions would lead to an unacceptably large donor loss and so was not a feasible alternative at the time.

The study by the McLaughlin Centre and the anonymous survey of CBS blood donors were key pieces of research for CBS, since much of the discussion and research at this time focused on the MSM blood donation policy in the United States rather than Canada. These pieces of research thus filled a gap in the evidence base to support any change to Canada's MSM blood donation policy. Another key piece of evidence which filled a critical knowledge gap was a 2009 supplement in *Transfusion* which reviewed some of the highest priority emerging infectious diseases (Stramer & Dodd, 2013). This was an important piece of work because most of the literature on the MSM blood donation policy relates to HIV/AIDS, which doesn't address blood recipients' fears of a new pathogen emerging in the MSM population. The research reported in the *Transfusion* supplement found that only one of the highest priority emerging infectious diseases at the time, human herpesvirus (HHV)-8, was associated with MSM activity (Stramer & Dodd, 2013). Many of the others were related to geographical risk. Further, although HHV-8 was associated with MSM activity, it was not a significant blood transfusion risk because it is not transmitted by the types of blood products used today (Vamvakas, 2009). This information provided support for the idea that the MSM deferral could be reduced while maintaining the safety of the blood supply.

Aside from commissioning, conducting, and referring to research to inform the policy debate, there were other signals that CBS had a willingness to consider changing the policy, but desired stronger

evidence and stakeholder engagement before applying for a policy change. For several years, CBS had jointly offered funding with the Canadian Institutes for Health Research in the area of blood supply risk and the MSM blood donation policy (CBS, 2015a). CBS also formed a Lesbian, Gay, Bisexual, Trans, Two-Spirit, Queer (LGBTQQ) Working Group in 2009, which was composed of members of patient groups and the LGBTQQ community. However, the group was disbanded shortly after forming primarily because of a confrontational environment due to an ongoing court case involving Kyle Freeman, a gay man who had been donating blood while lying about his status during the screening process (Goldman et al., 2014). The Freeman case may have also contributed to delays in applying for the policy change since it would not have been consistent with a cautious approach to apply for a policy change before the case was resolved. The court case concluded in 2010, with the presiding judge ruling in favor of CBS, although she did make a statement that the indefinite deferral period that was in place at the time was excessive (Symington, 2011).

In 2011, nearly a decade after the consensus conference in 2001, the CBS Board of Directors passed a resolution to change the MSM blood donation policy from an indefinite deferral to a temporary deferral between five and 10 years. In order to decide on the exact deferral period and obtain support from all stakeholders before submitting the policy change request to the regulator Health Canada, CBS underwent another round of consultations (Goldman et al., 2014). This included an online survey in early 2012 sent to nearly 6,000 members of the general public (a representative sample of the Canadian population by region, sex, and age), nearly 6,000 representative active blood donors, and members of the LGBTQQ and student communities. The survey gathered data on awareness and opinions about the MSM blood donation policy, as well as opinions about the proposed policy change and its expected impacts. The survey found strong support for a change to the policy (CBS, 2012b). This round of consultations also included face-to-face meetings, first with the National Liaison Committee that advises

the CBS Board of Directors, then patient groups, LGBTTTQ groups, and a meeting with both groups together (CBS, 2015a; Goldman et al., 2014). CBS also created a new MSM policy working group with equal representation from patient groups and LGBTTTQ advocacy groups (CBS, 2015b). Finally, they modeled the impact of a change to a five year deferral and estimated that in the worst case, this would only lead to one extra HIV-contaminated unit every 1,072 years (Germain, Robillard, Delage, & Goldman, 2014).

With this additional research and consultation completed, CBS and HQ submitted a request to Health Canada in 2012 to change the MSM deferral period from indefinite to five years, meaning that men who have not had sex with men in the previous five years would be eligible to donate blood. The request was backed by letters of support from 17 different stakeholder groups and on May 22, 2013, Health Canada approved the change, and the new deferral policy was implemented by CBS and HQ in July 2013 (CBS, 2015a).

Although the lifetime ban was removed, the policy debate did not end. The five-year deferral was still criticized as being discriminatory and not evidence-based (e.g., Carter, 2013; Picard, 2013), and CBS was still under pressure to change the policy. However, as the history of the policy to this point shows, CBS placed priority on blood safety and would not consider a policy change without both stakeholder buy-in and research showing that a policy change would be unlikely to reduce the safety of the blood supply. In keeping with this, CBS continued to monitor the impacts of the policy change on rates of transfusion-transmitted infections, call for research into the area of blood supply risk, keep up to date with what was happening in other countries that had changed their MSM policies, and conducted another public poll in late 2014 asking for people's opinions on further reducing the deferral period for MSM (Csanady, 2014).

CONCENTRATED VS. DIFFUSE COSTS AND BENEFITS

The story of the evolution of Canada's MSM blood donation policy is a story of prudence. The MSM blood donation policy in Canada has changed, and continues to change, on a timeline which some may consider too slow, but one which is consistent with a cautious approach.

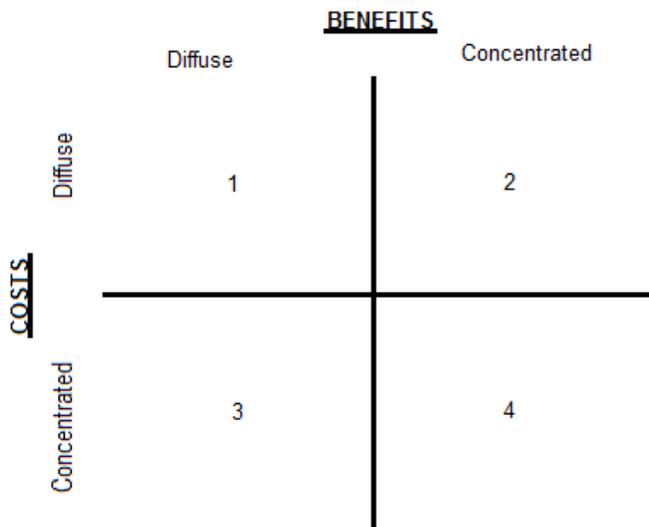
One tool that can be used to analyze political battles and help explain why the MSM blood donation policy has taken as long as it has to change, is to apply the ideas of concentrated vs. diffuse costs and benefits (Stone, 2002). Costs or benefits of a particular policy are considered concentrated if they are considered very important or have a large impact on the lives of those affected, or if they affect a smaller group of people (since this can make it easier to mobilize as a group). Costs or benefits are considered diffuse if they are considered peripheral to a person's life, or are spread out over a large number of people. In political battles, concentrated interests tend to win out over diffuse ones.

Over the history of the MSM blood donation policy, the perceived cost to the blood recipients of any policy change was strongly concentrated. There was little, if any, tolerance for even minute increases in risk because for blood recipients, the policy was a matter of life or death. Under the status quo, the MSM community was the group bearing the costs, in terms of being denied the opportunity to donate blood and experiencing discrimination. However, these costs were more diffuse than the costs to blood recipients and consequently, it is not surprising that CBS placed greater weight on the concerns of blood recipients. Furthermore, Stone (2002) points out that people tend to respond to losses and gains differently, and that they are far more likely to mobilize to avoid a loss than they are to mobilize around a potential gain. Changing the MSM blood donation policy from an indefinite deferral period to a time-

limited deferral period has often been framed as a potential loss to blood recipients (a perceived loss in safety relative to the existing condition) and a gain for the MSM community.

Another way to apply the idea of concentrated costs and benefits is to examine where stakeholder groups fall on a grid like Figure 1 below under the current policy vs. a proposed future policy. While Stone (2002) uses this grid to distinguish between only four categories defined by the quadrants, one can imagine instead that the grid lines are continuous, so that there are an infinite number of possible positions even within a single quadrant, depending on the magnitude of the costs and benefits. The relative positions of the stakeholder groups can help predict the outcomes of such political battles.

Figure 1: Concentrated vs. diffuse costs and benefits

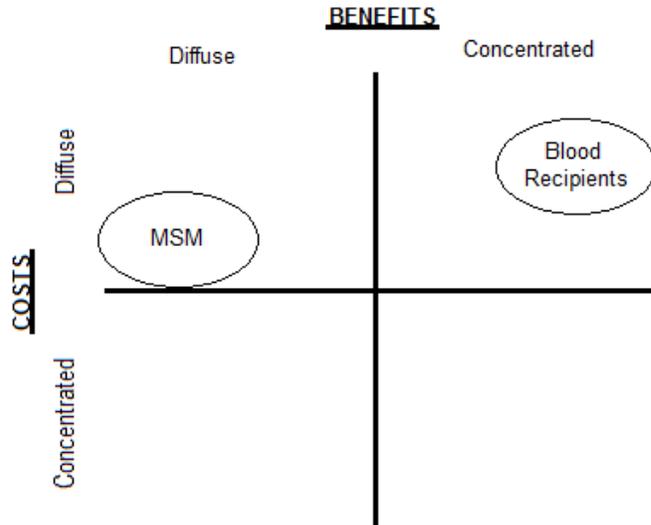


This analysis will focus on blood recipients and the MSM community only, even though there are other stakeholder groups who are impacted by this policy such as the general public, current non-MSM donors, and future non-MSM donors. However, the blood recipient group and the MSM group arguably have the most concentrated interests in this debate, both in terms of how strongly the MSM blood

donation policy impacts them and in terms of being relatively small compared to other stakeholder groups, which may make it easier for them to mobilize and advocate for their positions to CBS.

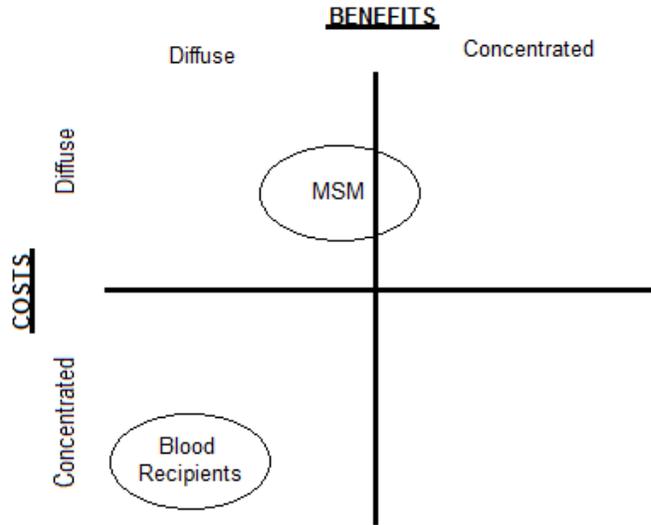
Prior to CBS deciding to change the policy from a lifetime ban, the blood recipient group would arguably fall somewhere in cell 2. The perception was that they had a blood supply that was as safe as possible, and therefore they enjoyed concentrated benefits under a stringent MSM donation policy. Since the receipt of blood products has potentially life-and-death implications, having a maximally safe blood supply represents an extremely concentrated benefit. Any costs to this group of maintaining the policy, such as accusations of discriminating against MSM, were diffuse by contrast, in large part because such accusations have typically been targeted at CBS rather than blood recipients. Although an additional consequence of a lengthy MSM deferral was a reduction in the number of donors contributing to the blood supply, these numbers were perceived to be small enough that they did not represent a significant cost either. The MSM group under the status quo experienced costs, but as discussed, these were diffuse. This group also did not enjoy any real benefits under the lengthy deferrals, and so they fall in the bottom left corner of cell 1, producing a grid that looks similar to Figure 2, below.

Figure 2: Pre-2011 stakeholder positions of actual MSM lifetime ban



Relaxing the deferral for MSM was perceived by the blood recipient group to result in a potential increased risk of transfusion-transmitted infection. As discussed, this would be a concentrated cost for this group, and any increase in the number of donors under a relaxed MSM blood donation policy would be considered relatively small compared to the existing donor pool, representing diffuse benefits. The MSM group would enjoy the benefit of being able to donate blood and having the policy be more consistent with the ideas of equality and gay rights, but these benefits would not be as concentrated as the feeling of having a maximally safe blood supply. Therefore, although the MSM group would move closer to the top-right quadrant, they would not fall entirely within it since these benefits are not strongly concentrated. The diagram under a relaxed MSM deferral policy would therefore look something like Figure 3 below:

Figure 3: Pre-2011 stakeholder positions expected after hypothetical change from MSM lifetime ban to a relaxed MSM deferral period

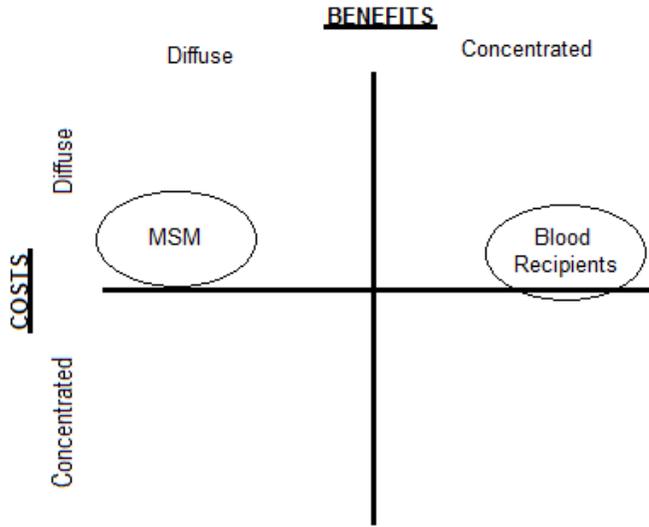


Examining these diagrams can help further explain why CBS privileged the voices of the blood recipients over other groups, and why they were so cautious in approaching a policy change. The proposed change would have shifted the MSM group within one cell of the grid, but the perceived costs or benefits of a policy change for them would not have shifted as much as for the blood recipient group. In contrast, a policy change was viewed as having the potential to result in the blood recipient group shifting from the optimal cell in the grid (concentrated benefits and diffuse costs) to the least desirable cell in the grid (concentrated costs and diffuse benefits). It is therefore understandable why the blood recipient group resisted a policy change so strongly and why CBS prioritized their perspectives.

In spite of this, the CBS Board of Directors passed a resolution to change the MSM blood donation policy in 2011. There are a few reasons for this. First and foremost, by the time CBS and HQ applied for the policy change, there was more research which suggested that a move to a five-year deferral period would not decrease the safety of the blood supply (e.g. Leiss et al., 2008; Seed, Kiely, Law, & Keller, 2010). This could have made the perceived costs to blood recipients more diffuse. Second, these studies

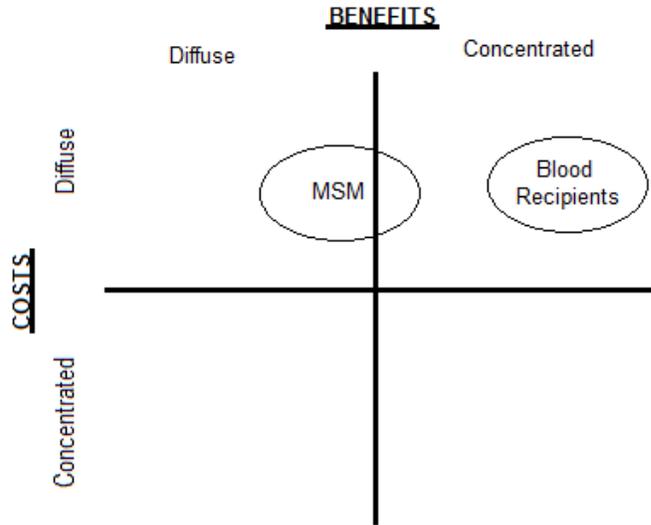
and events were taking place within the broader context of increasing recognition and acceptance of LGBTTTQ rights, which have changed significantly in the decades since the MSM blood donation policy was introduced. As acceptance of LGBTTTQ rights has grown, the policy likely became increasingly difficult to justify without seeming discriminatory, and therefore, the costs of maintaining the policy also grew. Perceptions of the fairness of CBS' policies has real implications for CBS' operations; for example, while boycotts of blood drives on campuses resulted in only a small reduction in the number of donations, they may have reflected broader disengagement of young people with CBS. This would be problematic since ensuring an adequate blood supply requires the involvement of large numbers of new young donors (CBS, 2015b). Finally, there is a concern that the need for blood and blood products will only increase in the future as Canada's population ages (CBS, 2015b; Saberton, Paez, Newbold, and Heddle, 2009). Any loss of potential donors resulting from maintaining lengthy MSM deferrals increases the costs of this option. This can result both from prohibiting MSM from being blood donors and losing potential non-MSM blood donors who refuse to donate blood in protest of the policy. The potential threat of an inadequate blood supply due to increasing dissatisfaction with the MSM policy and increasing demand for blood products would have changed the pre-2011 positions of the stakeholder groups to look more like Figure 4 below, with blood recipients shifting more towards concentrated costs.

Figure 4: Circa 2011 stakeholder positions shortly before actual change from MSM lifetime ban to a 5-year MSM deferral period



With sufficient research to convince blood recipients that the safety of the blood supply would not be jeopardized with a five-year deferral period, the post-2011 positions of the stakeholder groups would look like Figure 5. Comparing Figures 4 and 5, it can be seen that both the MSM group and the blood recipient group move into a more favorable position through changing the policy from a lifetime deferral to a five-year deferral. This helps explain why the policy was finally able to change, as a result of shifts in the perceived costs and benefits to the blood recipient group.

Figure 5: Circa 2011 stakeholder positions expected after actual change from MSM lifetime ban to a 5-year MSM deferral period



CURRENT DAY AND PREDICTIONS FOR THE FUTURE

At the time of writing, MSM potential donors faced a five year deferral period before being eligible to donate. However, a CBS report released in June 2015 stated that CBS and HQ will be applying to Health Canada for approval to change this to a one year deferral after monitoring has shown that there were no negative impacts resulting from the change to a five-year deferral period on HIV prevalence in donors, donor compliance, or trust in the blood system, (CBS, 2015b). CBS has also cited the experience of other countries which have reduced their MSM deferrals to 12 months and seen no increases in risk to the blood supply as a result, such as Australia, the UK, and Sweden (CBS, 2015b; Seed et al., 2010).

However, if the policy change to a one-year deferral period is approved, it is likely that the debates will still continue. The evolution of the MSM blood donation policy in Canada so far has centered around determining the appropriate length of time to defer MSM donors, but there are those who feel this is inadequate and advocate for a system of gender-neutral screening for specific high-risk behaviors. There

are a few countries which don't have deferral policies specifically for MSM and therefore conduct their screening in a gender-neutral manner, including Italy, Spain, and most recently, Mexico (McAdam & Parker, 2014).

The idea of concentrated vs. diffuse costs and benefits can again be applied to predict how this debate may play out in the future and how people can better advocate for change. There are a couple of concerns which have been raised about why a gender-neutral screening policy would not be feasible for CBS at the current time. There is the concern that such a change would result an unacceptable loss of existing donors. This is based largely on the survey of existing donors by Goldman et al. (2011) which included possible alternate gender-neutral screening questions asking about number of sexual partners in one's lifetime and in the past 12 months. Since many donors reported multiple partners for both questions, deferrals based solely on these criteria were considered infeasible. It has also been pointed out that there are important differences between Canada and countries which use gender-neutral screening such as Spain and Italy. Cited differences include the fact that donor eligibility assessments in Italy are done by specially trained physicians in face-to-face interviews, rather than clinic staff using a standardized questionnaire and manual, and the fact that the epidemiology of HIV is different in those countries (CBS, 2015b). In the absence of new research or arguments to address these concerns, the perceived costs of changing to a gender-neutral screening system will not change, which makes it unlikely that CBS would move to gender-neutral screening. Further, if the one-year deferral is approved, then whether CBS would consider moving to gender-neutral screening would likely depend heavily on whether rates of transfusion-transmitted infections change after implementing the one-year deferral.

As mentioned, the relative costs and benefits of a particular policy are not fixed. They can shift as a result of changing knowledge and practices, or changes in the ways that costs and benefits are

perceived. This is what has happened in the evolution of the MSM blood policy in Canada, and what has allowed the policy to change even with CBS being as cautious as it has been. To make it more likely that CBS would consider changing to a gender-neutral screening approach, the perceived relative costs and benefits to high-interest stakeholder groups like MSM and blood recipients need to be shifted. One way to do this would be to add to the research on alternate screening criteria. For example, while the Goldman et al. (2011) survey of donors asked about the number of sexual partners, the survey did not explore other ways of differentiating high-risk from low-risk donors such as asking about sexual practices (e.g. anal vs. oral sex, or protected vs. unprotected sex). Such research could also help assess claims that this level of questioning may be considered too personal by potential donors (Go et al., 2011), and that this type of risk screening can only be adequately done by physicians. Another potentially fruitful area of research would be to identify and better understand low-risk groups within the MSM community. In keeping with CBS' cautious and staged approach with this policy, an intermediary step between a one-year deferral and gender-neutral screening for all donors might be to conduct a pilot screening for high risk sex practices among MSM only. Conversely, instead of focusing on identifying low-risk MSM, research and debate could instead focus on the idea that some high-risk non-MSM might currently be donating and that gender-neutral screening would remove such people from the donor pool, making the blood supply safer.

If the next big debate about the MSM blood donation policy is around gender-neutral screening, then this could potentially activate another high-interest stakeholder group: current donors who would be excluded under a new gender-neutral screening process. In that case, the costs and benefits of policy change for this group would also need to be considered. However, the composition of this group and the specific costs and benefits to them would depend on the details of any proposed gender-neutral

screening system, and so it may be too early to speculate on the nature of a political battle which includes this group as well.

DISCUSSION AND IMPLICATIONS

This review suggests that CBS took a very cautious approach when making decisions regarding changes to the MSM blood donation policy which resulted in the policy persisting for years, even in the face of criticism. They recognized that the MSM blood donation policy was viewed by some people as being unfair (CBS, 2015a), but they placed priority on the safety of the blood supply and the perspectives of blood recipients over other groups. In practice, the policy discriminates against MSM, but this appears to simply be an unfortunate by-product of a cautious approach. Faced with the difficult choice between being perceived as discriminating against one group or being perceived as disregarding the other group's concerns over safety, CBS chose the former. But over the years of the debate, CBS has shown a willingness to engage with high-interest stakeholder groups to try and achieve a consensus or compromise, as well as a willingness to regularly review and change the policy in light of new evidence.

The evolution of the MSM blood donation policy in Canada also illustrates how the nature of costs and benefits can lead a decision-maker (e.g. CBS) to privilege the voices of one stakeholder group over another, which can make the latter group perceive that they are being treated unfairly. This case is also illustrative of how such costs and benefits can shift over time, as a result of changing evidence and changing contexts. Understanding the nature of costs and benefits for high interest stakeholder groups under the status quo and a proposed policy change can help one predict the outcome of a political battle and identify potential actions which can help move the policy debate in a given direction.

The implications of this for the future of the MSM blood donation policy are that changes will only be possible if there is sufficient buy-in from the blood recipient group, there is sufficient evidence that any proposed changes will not jeopardize the safety of the blood supply, or the costs of maintaining the policy become too great. Given CBS' cautious approach, it seems likely that what is most needed to change the policy at this point in time is more research on the potential impacts of proposed changes. As discussed earlier, this could include research on alternative screening questions other than the ones used in Goldman et al. (2011) and Go et al. (2011), including assessments of the acceptability of such questioning for potential donors, the ability of such questions to correctly identify high-risk donors (i.e. epidemiologic sensitivity), and the impacts of such questioning on the number of eligible donors. This could also include more research to identify sub-groups with different risk profiles within the broader MSM population.

CRITICAL REFLECTION

It was around 10 years ago that I first had the idea of donating blood and discovered that, as a gay man, I was banned for life from doing so. I am gratified to see that the MSM policy has since changed to a five year deferral period, with a possibility of being further reduced to a one year deferral period. However, I also believe that a gender neutral screening system is the ideal, provided that it can be feasibly implemented without jeopardizing the safety or the volume of the blood supply.

Through working on this project, I have come to understand the immense effort and sensitivity it takes to change a controversial policy such as this and appreciate that CBS has taken such a collaborative approach since ultimately, we all want the same thing: the most effective blood supply system possible. I also believe that I better understand what is needed for CBS to consider changing the policy in the future; namely, more research into alternative screening methods such as gender-neutral questioning.

As a public health practitioner, I could see a potential role for myself in relation to this issue by becoming involved in such research in the future. I also see a more informal role for myself in contributing to discussions around the policy. I regularly see ads and articles about blood donation, and inevitably, I see many people making comments (in comments sections or through social media) that CBS is discriminatory and homophobic. I understand their frustration but feel there is more potential for progress if all high-interest stakeholders are able to work collaboratively. By contributing to such discussions when I see them in the future, I can potentially introduce viewpoints or suggest actions which focus less on painting CBS as the “bad guy” and more on what can be done to move the policy debate forward.

I believe that work on this project could also help me have a greater impact in public health in the future, even outside of this particular topic. I acquired a greater understanding of how to analyze a policy debate, including identifying the interests, understanding factors which contribute to their respective stances, and identifying potential points where intervention can help shift the debate. I feel these are skills which could be applicable to a wide range of public health issues.

I am grateful to have been given the opportunity through the Master of Public Health program to explore this topic in depth, strengthen my policy analysis skills, and perhaps be in a better position to contribute to further changes in this policy, or similar policies, in the future.

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APPENDIX A: SEARCH PROTOCOL FOR CINAHL

The following search conducted in the Cumulative Index to Nursing and Allied Health Literature (CINAHL) is illustrative of the searches used in all databases for this literature review:

1. MH "Blood Donors"
2. blood N2 don*
3. 1 OR 2
4. MH "Homosexuals, male"
5. "men who have sex with men"
6. msm
7. gay m?n
8. gay male*
9. OR (4-8)
10. 3 AND 9