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Transition to a 1-year deferral for male blood donors who report sexual contact with men: Staff perspectives at one blood collection organization

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Abstract

BACKGROUND—Front-line staff at blood collection organizations (BCOs) play important roles in keeping the blood supply safe, yet research on their professional practice and perspectives on training needs is sparse. This qualitative study explored these topics with regard to the then-impending change in donor eligibility for men reporting sex with another man (MSM).

STUDY DESIGN AND METHODS—Semi-structured, individual interviews with BCO staff (N=13) in Northern California covered experiences of and opinions on: indefinite deferral, the revised one-year deferral, and anticipated potential challenges arising from the new policy. Transcripts were thematically coded, using deductive and inductive approaches. Analysis identified recurrent and divergent themes.

RESULTS—Interviewees reported strong values of professionalism and respect for donors, and supported the change to a one-year deferral for MSM donors. Nonetheless, nearly all voiced the need for more in-depth training to maximize the likelihood of successful implementation. Specific recommendations included the use of role play, provision of science-based talking points/FAQ, and empathy for donors and staff.

CONCLUSION—More than the usual training may be required to help BCO staff feel prepared to educate the public about changes to MSM-related deferrals, and communicate effectively with donors about potentially deferrable behavior. Overall, these findings suggest that, prior to future policy changes, BCO staff's opinions about, and role in implementing new donor eligibility screening procedures merit consideration.

Keywords

blood donation; blood center staff; MSM deferral; policy change; US

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INTRODUCTION

For over 30 years, men in the United States reporting any sexual contact with another male since 1977 were deferred indefinitely from blood donation (MSM77). In December of 2015, however, the Food and Drug Administration (FDA) issued Final Guidance to blood collection organizations (BCOs), shortening the deferral period to one year since last male-male oral or anal sex (MSM1YR). With this, the US became part of a growing list of countries that have shortened deferral periods to one year or less for MSM donors including Australia, Canada, France, the UK, and others. Despite some concerns about increased rates of HIV-positive donations in other countries that allowed MSM to donate based on interval since last sex, published findings suggest no increase in risk to blood recipients (1–3). Monitoring to assess changes in risk is currently also being conducted in the US, as part of the Transfusion Transmissible Infections Monitoring System (TTIMS)(4).

Blood center staff are instrumental contributors to the safety of the blood system, as they recruit donors, communicate about eligibility policies with the public, and assess donor eligibility. Health historians, in particular, play a vital role by reviewing individual donors' current health and responses to the donor history questionnaire (DHQ). The DHQ is used to record measured hemoglobin concentration, weight, blood pressure, pulse and temperature and contains questions assessing potential risk to the donor in donating (e.g., feeling healthy and well, pregnancy status) and potential risk to recipients, based on donor behaviors and potential exposures to transfusion-transmitted infections (TTIs) through, for example, travel, sexual history and previous disease. In terms of avoiding TTIs, the value of the DHQ depends mostly on donor disclosure, but also on the communication skills of health historians, who must inquire about behaviors which can be highly stigmatizing (i.e., MSM, sex work, injection drug use).

While the validity of DHQ questions has been assessed using cognitive interviewing,(5) research on the professional practice of BCO workers is sparse. Some early work indicated that the use of stigmatizing terms to describe deferrable behaviors may influence donors to disavow their risks (6), and poor treatment by staff may dissuade "safe" donors from returning to donate again (7). More recently, an evaluation of the clinical skills of a small group of health historians found staff performance generally "acceptable," (8) though the assessment did not include interactions with real donors. Front-line staff's own perspectives, particularly with regard to training needs and implementation of policies designed to keep the blood supply safe, are notably missing from the literature.

To address this gap, in accord with recommendations for inclusion of qualitative research in transfusion medicine,(9, 10) and heeding Goldman and O'Brien's (11) call for "transparency and involvement of [multiple] stakeholders" in discussion of MSM deferral policies, we conducted a qualitative pilot study with blood center staff in Northern California. This manuscript reports on BCO staff experiences of and opinions on the deferral policy in effect at the time of the research (MSM77), and their anticipated potential challenges arising from the implementation of MSM1YR.

METHODS

Our team partnered with Blood Centers of the Pacific (BCP), a blood collection organization (BCO) operating in both rural and urban parts of Northern California. This study focused on blood center staff perspectives to complement our previous research on MSM donor perspectives and opinions of MSM77 (12, 13). Data were collected from September–November 2015. All research procedures were approved by the Institutional Review Board at the University of California, San Francisco.

Recruitment

A member of the BCP executive team informed donor services staff about the study via email; the message included a weblink interested individuals could follow to obtain more information and give preliminary consent. A reminder email was sent two weeks after the initial message. Thirteen participants self-selected by using the link to provide their contact information for follow-up by the study team. Saturation of themes was reached with this small number, as can occur when semi-structured interviews are used to explore a limited domain with highly-expert participants.(14) Some details about participants (e.g., job title, length of tenure) have been omitted to protect confidentiality. One clarifying note: all use of the word “interviewees” below refers to the participants in this research, not to blood donors.

Data Collection and Analysis

Data were collected by two experienced qualitative researchers (SH, NS). All willing participants were interviewed individually by telephone, outside of work hours. The semi-structured interview guide covered experience deferring potential donors (including males reporting sex with another man), opinions about MSM77 and MSM1YR, and anticipated training needed to ensure successful implementation of MSM1YR. Interviews lasted between 30–60 minutes and were audio recorded for verbatim transcription. Interviewees received a $25 Amazon gift card.

Transcripts were imported to MAXQDA 12 Plus, a qualitative data analysis software package (15). Our analysis employed inductive and deductive approaches to identify recurrent themes across the interviews (16), and followed established procedures to create a codebook.(17) Transcripts were coded (by SH) and reviewed (by NS), with discrepancies resolved through discussion and consensus.

RESULTS

As described in Table 1, the 13 participants worked at various collection locations within the BCP network, and held diverse job titles with varying lengths of tenure.

Themes Identified

Experience with MSM77 deferrals—Despite the diversity noted above, there was a remarkable consistency to interviewees’ accounts of MSM-related deferrals. Virtually all interviewees had personally deferred a male donor with same-sex contact or interacted with donors who had been deferred. The others were able to share a detailed story about a

colleague's experience. Such deferrals were relatively rare; most participants estimated they confronted this once per year or less (some interviewees who worked in recruitment dealt with this issue more frequently). Blood drives at high schools were mentioned by several participants as times when MSM-related deferrals were slightly more likely, though they did not speculate on the reason for this. When review of a DHQ led staff to think deferral was called for, they often conferred with a supervisor (usually a nurse) to confirm their assessment. Sometimes the supervisor assumed the responsibility of informing the donor, sometimes the staff person did so.

Staff reported that would-be donors' reactions to deferral included acceptance, confusion, disappointment and anger. Interviewees shared stories of deferred men and their friends acting on disaffection with MSM77 by protesting at mobile drives or through subsequent communication with BCP. Most interviewees expressed empathy for the deferred, seeing in them the same motivations other donors have; as one participant explained, "The people that come in are wanting to donate. Often they're very dedicated people." Staff recounted feeling there was little they could do in deferral situations, especially for donors frustrated by perceived injustice. Common communication strategies for handling this included empathetic listening ("hearing [the donor] out,"), explaining the provenance of the deferral policy (i.e., BCP implemented deferrals as mandated by the FDA), and sharing information on how donors could "say [their] piece" (i.e., express their disagreement to the FDA) about the policy).

Transition to MSM1YR—In discussing the transition to the new deferral policy, most interviewees expressed enthusiastic support for the change, based on either the effectiveness of blood testing, questions about the risk presented by male donors reporting sex with men, or both. One interviewee put it succinctly, saying the "very accurate testing we have now" made MSM77 "archaic." Some of the staff also noted their sense that the variability of risk presented by MSM (depending on their sexual behavior), did not match the blanket deferral policy. One interviewee commented about MSM in monogamous relationships: "If they are truly, truly with one person or committed and if they're safe, and we could test their blood and everything, why can't they donate?" Another interviewee questioned whether MSM donors were necessarily "riskier" than some heterosexuals who were allowed to donate. She told a story about a recent heterosexual male donor to emphasize this point:

> We had a donor the other day actually discussing his very open relationship, very openly—made me think I'd be more worried about getting his blood than I would about getting a man's blood who's had sex with another man who's married to him or monogamous.

A few interviewees voiced reservations about the change to the 1-year deferral; however, they ultimately expressed trust in the system and presumed science supported the policy. One person said, "I'm kind of old school. I mean…. Man-woman is what I believe in. But…. I mean, this is America and you have - you know, you can love who you want to love. And so, I would just have to go with what BCP tells me to do." Another expressed a similar sentiment, saying, "I would put my trust in the scientific evidence of the one year. And that —I mean, they must have done lots of studies for infection rates and all that."

On the other hand, many indicated that while MSM1YR is a "change in the right direction," it did not go far enough. As one interviewee explained:

> It's still sort of discriminatory. You know, it's hard to tell someone, 'Okay, well, if you're a man and you haven't had sex with a man in a year, then you're okay to donate. But if you're a woman and if you've had sex with 12 different people in the last three days, no one's asked that question and it's perfectly okay.' ….. I mean, to me the policy almost seems ridiculous because you're saying, okay, it's okay as long as you just don't have sex for a year. And would you say that to a heterosexual person or a lesbian?

Professionalism—Regardless of their opinion about MSM1YR, the vast majority of interviewees' responses demonstrated strong values around professionalism and treating all donors with respect, and they expected their co-workers felt the same. As one interviewee passionately declared, "Not just BCP, but blood centers throughout the nation—we owe it to the patients we serve, we owe it to the donors who help us meet those needs, to make sure all staff…are completely comfortable talking about [deferral-related] issues." As part of their professional responsibility, participants commonly asserted they would follow whatever standard operating procedures (SOPs) were adopted in relation to blood donation by MSM. A participant explained, "As a blood bank there's multiple different reasons that an individual may be deferred, and we have to follow the rules that are set by the FDA, whether or not we agree with them or disagree with them."

Recommendations for training/reference materials

Few interviewees spontaneously voiced concerns about learning the new rules; they appeared to implicitly trust BCOs would provide what was needed to ensure successful implementation. As one participant said, "I would just have to do what they tell me to do." However, our previous research with MSM donors who were noncompliant with MSM77 had revealed particular objections and questions that could plausibly surface in new DHQ review procedures. In interviews, these participants had marshalled sophisticated understandings of blood screening and epidemiology to critique a 1-year deferral (merely a proposal at the time) for lacking a scientific basis, as well as discriminating against MSM with stable partners. Some (even current donors) also expressed confusion about what "counted" as "sex." We drew on these findings to create hypothetical scenarios in which donors challenged the justification for the new policy, or provided information that required the health historian to probe about same-sex sexual practices. When BCP staff were asked how prepared they felt to respond to such situations, they reported widely varying comfort levels. Virtually all interviewees identified challenges and expressed a desire for training, both to improve potential donors' experiences and to strengthen their own confidence in representing their agency well. We detail the two most common suggestions below.

More than a sign-off—All interviewees anticipated receiving revised versions of SOPs and being required to "sign-off" to acknowledge receiving them. Those in public-facing positions also hoped to receive "talking points" offering guidance about how to discuss the donor eligibility changes. After considering the hypothetical work scenarios, however, 12 of the 13 interviewees endorsed the idea of using role-play and/or interactive exercises as a

training modality. This occurred both as a spontaneous suggestion and in response to a direct question from the interviewer. In an example of the former, one woman suggested, “having a set-up of back-and-forth questions, kind of like acting it out…or even giving us a script.” The role-play technique was seen as a way to help staff avoid “fumbling, trying to come up with the words” to ask clarifying questions by themselves, since “it’s only when you [do something] that the questions come up. You learn something new, you don’t have questions…it won’t occur to you until you’re in the moment.” (each quote from different interviewees)

Importance of empathy—Interviewees stressed this in relation to multiple aspects of both MSM77 and MSM1YR deferrals. Talking about such a “sensitive, private subject” and then being deferred was understood to have always been troubling for donors. One interviewee with supervisory responsibilities noted that, while not the norm, “I’ve even had to counsel some staff on having a little bit more empathy—whether or not you have it then—to at least show it for good customer service in the history booth.” In relation to the revised eligibility criteria, several interviewees noted blood center staff’s relative lack of experience with MSM donors and their concern about such donors being offended or inadvertently “outed” in the screening process. They urged empathy for donors deferred pursuant to MSM1YR (due to misunderstandings about eligibility, for example).

But it wasn’t only donors that were seen as deserving empathy. Many noted that “It’s always going to be awkward to talk about sex with a stranger,” and stressed the training process should also include empathy for the employees going through it. In addition, one interviewee noted that staff have varied cultural backgrounds; discussing sexual practices with potential donors may present special challenges for some of them. In general, allowing ample time for training (including questions and discussion) was seen as key. Staff provided specific suggestions for facilitating a successful implementation of the policy change, as outlined in Table 2.

DISCUSSION

To summarize the findings from this qualitative, pilot study, BCO staff in Northern California reported personal experience with, or knowledge of, deferring MSM donors. Such deferrals were described as frequently upsetting to would-be donors, though all interviewees reported implementing them in accordance with regulations and BCO SOPs. Among participants in this study, attitudes about the shift from MSM77 to MSM1YR ranged from principled acceptance (based on a value of professionalism and presumption of scientific support) to enthusiasm. When probed about hypothetical scenarios involving the new deferral policy, most felt they needed more support and guidance than what would typically accompany a change in donor eligibility.

Given that these interviewees live and work in Northern California, where there is a large LGBTQI community, we expected many of them to have regular interactions with gay men and be relatively comfortable with the idea of MSM being allowed to donate blood. This was indeed the case. Yet despite this comfort, nearly all participants voiced the need for training that was more in-depth than that typically associated with donor eligibility policy changes.

What is clear from our findings is that, though BCO staff portrayed their professional responsibilities as taking priority over personal opinions about MSM1YR, even enthusiasm for the policy change did not necessarily translate to full confidence in the ability to apply it effectively with actual donors. For our interviewees, the novelty of certain questions potentially necessary for DHQ review with MSM donors led to some concern over inadvertent "outing", or inept (even offensive) phrasing of required probing. If BCO staff in other regions of the country have less experience (or different experiences) with gay men, their initial interactions with MSM as donors may be characterized by greater uncertainty, and hence, they may have a concomitant greater need for training.

As Doll and colleagues pointed out 25 years ago, the use of stigmatizing language can discourage donors from reporting sexual risk behaviors.(6) Training staff in open and non-judgmental communication may help them better identify both eligible and ineligible donors. Achieving this could enhance the effectiveness of the DHQ as well as potentially maximize the expansion of the donor pool resulting from the change in policy. As a follow-on effect, well-informed donors gain an accurate understanding of regulations, such that donors who become eligible to donate can return.(7)

We acknowledge the limitations of this small, qualitative study, conducted with staff from a single BCO. Readers should recall, however, that the number of interviews conducted was so limited precisely because theoretical saturation was reached quickly. In addition, though qualitative findings are not typically "generalizable" in the same way quantitative data can be, this does not preclude transferability of the findings.(18) That is, they may well have broader applicability—especially when differences between the context where data were collected and where the findings would be applied are critically considered. In this sense, it bears noting that 73% of those polled in the San Francisco Bay Area in 2013 supported same-sex marriage, compared to 61% in California,(19) and at a time 60% of a US national sample agreed that "society should accept homosexuality."(20) If such attitudes (despite interviewees' protestations to the contrary—and more on this below) do influence perspectives and training needs of BCO staff, we believe that having collected these data in Northern California is actually a strength of the study, as the location may constitute an "easiest-case scenario" in terms of implementation of MSM1YR. Knowing this, policymakers and administrators in other contexts can judge how closely their own jurisdiction approximates these conditions.

We also note that, at the time of these interviews, BCP had not implemented MSM1YR. Hence, when asked about implementing the policy change, respondents were necessarily speculating. Whether this speculation proved accurate cannot be known from this dataset. Likewise, their responses were not produced in a vacuum. All interviewees understood there was controversy surrounding the 1-year deferral, but that it would soon become the new procedure. The degree to which this might have influenced their responses (via social desirability bias or otherwise) is unknown. Open-ended questioning was used to minimize this possibility. Finally, it may be that BCO staff who were uncomfortable discussing donation by MSM were less likely to self-select into our sample. This, however, seems merely to strengthen the "easiest-implementation scenario" argument made above. If discomfort with the interview topic led some BCO staff to passively decline participation in

our study, there is little reason to believe that they would require less training on MSM1YR implementation, or would benefit from less empathy around the need to discuss such matters than staff who were interviewed.

Limitations of this study notwithstanding, the implementation of MSM1YR raises a number of important new research questions. Most obviously, evaluation of the shift to MSM1YR is necessary to determine whether BCO staff encountered the challenges they predicted, as well as examine how MSM donors experience MSM1YR deferrals. Other avenues of investigation look to the future. Because some advocacy groups and members of Congress promote further revision to the deferral of MSM donors, data addressing potential alternate policies are urgently needed. One modeling study predicted a “worst-case scenario” of a four-fold increase in the risk of transfusion-transmitted HIV exposure in the US, were pre-donation risk assessment questions to be totally abandoned.(21) However, between MSM1YR and complete removal of any risk screening there are several potential policies which could be evaluated. Individual risk-based eligibility criteria is often raised as a possibility, though this would likely require BCO staff to lead in-depth discussions of sensitive topics with potential donors. Based on our findings, we would encourage any assessment of this option to consider both BCO staff’s opinions about, and role in implementing such an approach. Overall, these findings suggest that, regardless of whether or how eligibility criteria for MSM donors change in the future, feeling prepared to articulate the rationale behind policy change and communicate effectively with donors about potentially deferrable behavior could allow BCO staff to better address the goals of educating the public about the shift and fulfill their important role in ensuring the safety of the blood supply.

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Table 1

Selected characteristics of interviewees

Participant Gender	3 male, 10 female
Professional Role *	3 phlebotomists, 3 in recruitment, 4 RNs, 3 office-based other (3/13 had supervisory responsibilities)
Tenure at BCP (range)	1–20+ years
Regions represented	San Francisco, South Bay, Fairfield, Santa Rosa, Shasta

* categories designed to be informative without compromising confidentiality

Table 2

Staff suggestions for successful implementation of MSM1YR

Suggestions	Explanation	Quotes
Provide staff with role-play scenarios and FAQs	Include role-play opportunities in training on the policy change, so staff can try out language.	"*Do it by role play. So [pairs of blood center staff] get a little paragraph, this is what the donor is saying that they've done, and when they did it, and now you two role play."*
	Provide specific questions and answers to all staff likely to interface with the public on this issue.	*"If there were talking points prepared and given to me then I would feel comfortable answering [questions]*"
Focus on clear, simple, scientific explanations	Clarify justification for new policy to staff so they can explain it—both to deferred donors and concerned members of the public who feel anxious about the change.	*"I think there's going to be a lot of upset and confused people. I think what really is going to help… is knowing just the scientific reasons behind [the change]."*
		"It's part of my job is to be educated about it and to be able to explain to people what the rule is."
Engage with activists	Find common ground with the LGBT community/ activists between MSM1YR and deferred donors' desire to help. These groups might recruit "buddy donors" (eligible individuals who donate in place of deferred MSM), or work with BCO staff to help them become more comfortable with screening MSM donors, facilitating implementation of the new policy.	*"This isn't about shutting down a blood drive… This is just real people talking about blood, keeping blood in the public consciousness, everyone benefits… And then also it's about, 'Hey, I can't donate,' [but] getting friends who can donate to come out and donate."*
		Representatives from LGBT groups could *"humanize*" the new policy for BCO staff, help them understand "*what this change means to the community."*
Deal constructively with donors' reactions to being deferred, including accusations of homophobia in MSM1YR	Help donors process being deferred by engaging in empathetic listening and conversation (even though this goes beyond SOP). Provide information on how to communicate with the FDA about the donor's opinions about the policy and desire for change.	*"What I find works the best is to let a person share what their experience was, how they feel about it, and then I can address their concerns with the facts and give them the opportunity to … be part of the change."*
		"We have some handouts…on what people are doing and what BCP has also done. It's a petition [about changing the policy] basically."