Blood Donation Deferral Policy

Background

The Australian Medical Students’ Association (AMSA) is the peak representative body for medical students in Australia. AMSA believes that all patients should have the right to the best attainable healthcare. Accordingly, AMSA advocates on issues that may impact health outcomes.

In Australia the supply and transfusion of blood products is an important service provided by the Australian Red Cross Blood Service (ARCBS). Every week 27,000 Australians need blood donations, with the main supply of blood products coming from volunteers in the general public [1]. As such, AMSA encourages medical students nationally to donate blood and incentivises this practice through the “Vampire Cup”, a competition between the university medical societies.

The safety of the blood products is paramount to the success of the service and as laboratory testing has become available the ARCBS has tested all donations for blood borne infections (BBI) [2]. Donor health questionnaires (DHQ), implemented in the 1980s are used in conjunction with laboratory testing to reduce the likelihood of transfusion-transmitted infections (TTI). The DHQ is designed to exclude those individuals who pose a disproportionate risk to the safety of the blood or their own safety, based upon their behaviour or health. If an individual is deemed a disproportionate risk for donation a deferral period is imposed [3].

This policy focuses primarily on the current 12-month deferral period imposed on men who have sex with men. The questions, relating to this focus, within the DHQ read:

“Within the last 12 months have you:
• Had male to male sex (that is, oral or anal sex) with or without a condom?
• Had sex (with or without a condom) with a male who you think may have had oral or anal sex (with or without a condom) with another man?” [4]

These questions reflect a population bias of Human Immunodeficiency Virus (HIV) infections in Australia. The Kirby Institute (2013) recorded 1253 new HIV diagnoses in 2012 and estimates approximately 28,000 to 34,000 individuals are living with HIV in Australia. In the period of 2008-2012 67% of new HIV diagnoses were attributed to MSM and 25% were attributed to heterosexual contact [5]. While the majority of HIV transmission continues to occur between MSM there remains a significant proportion of diagnoses, which can be attributed to heterosexual contact. Other BBIs such as Hepatitis B and C (HBV and HCV, respectively) are primarily transmitted through the use of intravenous drugs. 11% of all HBV transmissions between 2008-2012 attributed to sexual contact, of these 75% were attributed to
heterosexual contact and 15% to MSM. Of all HCV transmissions between 2008-2012 3% were attributed to sexual contact, however, data does not differentiate further based on sexual practice [5].

The transmission of BBI via sexual contact is based primarily on the type of sexual behaviour. Anal sex carries a higher risk of transmission of all BBI due to the nature of the membrane within the anal canal, compared to the vagina and the mouth, which have higher immunologic defences [2]. The practice of anal sex, however, is not restricted to the MSM population, and as such a similar risk of BBI transmission exists between heterosexuals who practice anal sex. The practice of anal sex, however, is not restricted to the MSM population and as such heterosexual couples that engage in anal sex carry a similar risk of BBI transmission should one of the individuals carry a BBI.

Condoms remain the most effective means by which to reduce the transmission of sexually transmitted infections, including HIV [6]. Despite this, their use in the community varies between groups. A cross-sectional study in the United States demonstrated that amongst the heterosexual population condom use was approximately 20% and 15% for vaginal and anal sex, respectively [7]. Condom use in the New Zealand MSM community, comparatively, has been reported as 80.6% in 2011 between casual partners engaging in anal sex [8].

There is currently a call to change the DHQ to a behaviour based questionnaire which does not target specific populations within the community, but rather performs an individual risk assessment based on the risk behaviour of the applicant donor [9]. Kesby (2014) states that DHQs allow population-level statistics to obscure within-group diversity. The basis of population-level screening can also be viewed to imply that all MSM are HIV positive and all heterosexuals are risk free [10].

In recent years there has been growing controversy surrounding the 12-month deferral period for MSM, and calls for a reduction or removal of the deferral period have been made [11]. In 2012, the ARCBS completed its own independent review suggesting that the deferral period should be lowered to 6 months, and cited that the 6-month period proposed was due to the testing window period for the Hepatitis C Virus (HCV) [2]. As evidenced by Kirby Institute statistics, HBV and HCV occur in significant proportions in the heterosexual community and have low levels of sexual transmission [5]. The current window period for HIV testing is approximately 20 days, and therefore the empirical deferral period for this test would be 6 weeks [12].

Internationally, Italy and Spain have changed from population-based fixed deferral periods to individualised risk assessments based on behaviour [13]. A review of the HIV positive donated blood in Italy demonstrated no statistically significant difference pre- and post change in risk assessment approach [14]. Such approaches to pre-donation screening remove stigmatism surrounding sexual orientation and instead focus on a person’s behaviour as a basis for assessing if the individual poses a disproportionate risk [13].

**Position Statement**

AMSA believes that the safety of donated blood should be maintained to the upmost quality. AMSA also believes that current deferral policies of the ARCBS do not reflect best practice risk assessment. Consequently, AMSA believes that the donation of blood should be open to those who pose a low risk based on an individual risk assessment of behaviour rather than broad ranging population-level targeting which does not reflect within-group diversity.

**Policy**

AMSA calls upon:
1. The ARCBS to:
   a. adjust their deferral period to reflect the true risk associated with an individual’s behaviour, removing any population-level bias;
2. Medical student societies of Australian medical schools to:
   a. circulate information to students, including those involved in the AMSA Vampire Cup that:
      i. informs on the risks associated with sexual behaviours;
      ii. combats the stigmatising inferences made by the ARCBS DHQ, particularly in relation to the risk of BBI and MSM.

References

9. Cascio MA, Yomtovian R. Sex, risk, and education in donor educational materials: review and critique. 2012(1532-9496 (Electronic)).
**Policy Details**

**Name:** Blood Donation Deferral Policy  
**Category:** F - Medicine in Australia  
**History:** Adopted, First Council 2014