Evaluating the validity of restrictions on blood donation eligibility for men who have sex with men (MSM) in the United States, France, and Switzerland

Swathi Gorantla
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Evaluating the validity of restrictions on blood donation eligibility for men who have sex with men (MSM) in the United States, France, and Switzerland

By Swathi Gorantla

Spring 2022
Abstract

For the first time in a decade, the number of new human immunodeficiency virus (HIV) diagnoses is higher for heterosexual people compared to gay and bisexual men (Florêncio, 2022). Additionally, in the United States, the American Red Cross has declared a national blood crisis due to the nationwide shortage of donated blood. During this crisis, charged with the new information on HIV diagnosis rates, many advocates for the Lesbian, Gay, Bisexual, Transgender, Queer (LGBTQ+) community question why discriminatory policy surrounding gay and bisexual men donating still exist around the world. These policies are changing worldwide – several European countries have lifted bans on gay men donating blood, such as the France (however there are still conditions such as requiring a monogamous relationship). However, in the United States, only gay and bisexual men who have been sexually inactive for 90 days are able to donate blood. In Switzerland, they must be sexually inactive for one year. This study aims to explore how policy surrounding blood donation is developed to study how health-related policy in general is formulated. Because there is a discrepancy between the restrictions on blood donation and the true risk of HIV transmission in blood donations used for transfusions, there must be factors beyond pure science influencing policy. This paper observes the following factors as influences in health policy beyond pure science: historical context, technologies, and public perception.
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Introduction

Blood donation, today, is a vital procedure that is volunteer based. National blood donation schemes create a process that involves many actors. At the most basic level, there is a blood donor and there is a transfusion recipient. Donors are screened through questionnaires and medical experts to ensure safe blood is collected and disseminated. Further testing is done, again, for the purpose of recipient safety. The questionnaires for and general evaluation of the donor follow guidelines set by specific policy making entities. Blood donation policy falls into the category of health policy. The policy-making entities use a variety of resources to create recommendations and guidelines that claim to keep safety at the core of their decisions. As a general standard, the policy-making entities allegedly use scientific knowledge to make these guidelines and adjust guidelines in response to evolving science.

However, there are many other factors that influence policy. To investigate what kinds of factors have an impact on health policy, this paper aims to investigate how blood donation policy has changed regarding male donors who have sex with men in three countries where the current policy differs. In the United States, male donors who have sex with men are only eligible to donate if they have not had sexual contact with another man in the past 3 months. In France, this kind of “deferral” policy has been lifted, and restriction on blood donations are based on risk behavior rather than sexual orientation. Finally, in Switzerland, male donors who have sex with men are currently ineligible to donate blood if they have had sexual contact with another man in the past year.

The objective of this study is to analyze three factors that influence health policy and the impact they have, including what biases they hold. Historical context, receptions to technological growth, as well as public perceptions all have an impact on policy creation. This paper dives into
how these three factors have influenced blood donation policy for men who have sex with men in the United States, France, and Switzerland.

It is expected that health policy is created based on scientific evidence and without bias. Therefore, identifying factors beyond pure science that have an impact on policy and hold potential bias helps create a critical dialogue on how policy is created. Blood donation policy has effects beyond recipient safety. Of course, safety of the recipient should be considered the number one safety, but unnecessarily strict policy can harm communities. Policy creation, therefore, should be based on science rather than a reaction to public fears and demands.

**Research Methodology**

This research was developed through the combination of a review of the existing literature, current and prior guidelines regarding blood donation eligibility, as well as qualitative interviews with representatives from LGBTQ+ organizations. Overall, the research combines qualitative analyses from both the relevant sources and the interviews conducted.

The aim of the literature review was to identify key factors that could influence blood donation policy, and health policy. Three key factors were identified through analyzing current and past guidelines and recommendations released by the United States, French, and Swiss governments along with reactions to these guidelines. Press releases about policy changes were included in the study and provided meaningful insight into how governments and policy-making entities formulated any changes to policy. New sources, both from the past and recent times, regarding policy decisions were also analyzed, as they represent general reactions to blood donation policy and potential changes.

Furthermore, research on the policy making entities in each of the countries were included in this process to garner an understanding of their operations and where potential biases
could exist. Once the policy making entities were identified, it was critical to evaluate their mission statements as well as the relevant guidelines and recommendations they have published. Administrations of these organizations during relevant changes represent key stakeholders that may hold personal biases as well. Therefore, personal statements were identified through press releases, social media posts, and statements made to news sources.

The policy-making entities included the national governments in the United States, France, and Switzerland. Specific sub-sections of the government play more of a role in creating policy for blood donation. Some of the organizations that were identified included the Food & Drug Administration and the Centers for Disease Control in the United States, the Ministry of Health and Santé publique France in France, and Blood Transfusion Service of the Swiss Red Cross Ltd and Swissmedic in Switzerland. Other organizations do not necessarily have the direct power to make decisions but have issued statements on their perspective on the issue. These organizations include the American Red Cross and the European Court of Justice. Once the organizations were identified, published recommendations and guidelines regarding blood donation by the respective organizations were able to be included in the literature review.

Ideally, to get a better understanding of how decisions are made behind closed doors, key stakeholders within the policy-making institutions would be interviewed. To obtain this perspective, representatives from the organizations were reached out to via contacts on the corresponding websites as well as through LinkedIn. An overwhelming majority were unable to complete the interview request, as instead referenced official documents and statements that were release in lieu of an interview. The rest of the contacts did not respond.

The lack of personal communication with key stakeholders in the policy-making entities led to relying on voices from other stakeholders within blood donation policy creation. LGBTQ+
communities have been harmed by the policies, claiming that they are not medically founded. To understand more about this claim, LGBTQ+ organizations and members of the LGBTQ+ community within the three countries were contacted for interviews. These interviews primarily aided in formulating the analysis on the impact that perception plays in policy creation. Additionally, some of the organizations have worked with policy-making entities and have insight into how those conversations are conducted.

The interviews quoted in this paper are from a representative from the Switzerland Pink Cross, the national umbrella organization for gay and bisexual men, and a member of the LGBTQ+ community in the United States. Roman Heggli is the managing director of the Pink Cross. After reaching out via email, Roman responded and an interview was set up for April 12, 2022. The interview took place over Zoom and verbal consent was retrieved before asking questions about his organization as well as his thoughts on the existing blood donation policy in Switzerland. John Smith is a member of the gay community and asked for his identity to be kept anonymous for the interview. The meeting took place on April 18, 2022 and verbal consent to record the interview was obtained before asking about the blood donation policy in the United States and his thoughts about the existing policy.

**Literature Review**

The identified factors that influence health policy are based on perspectives from existing literature, including theory about the influence of history, technology, and cultures/perspectives. Where there is a lack of sources that reference blood donation policy for the MSM population, there is significant information on the policy creation process and the factors that influence this process. In this section, the main literature focusing on theory used in this paper are described.
Literature on the Impact of History

History plays an influence role in creating policy. Its impact comes in many different forms, from policy makers trying to avoid past errors to public fear of history repeating. The literature on the relationship between history and health policy demonstrates that effect is not necessarily positive or negative, but merely demonstrates that it plays a role. History imparts “moral and ethical principles” on a population (Berridge, 2008). It helps form their perspective on certain conditions and standards. However, there is a concern that the value of history cannot be tested the same way you test the value of scientific discovery. It is not an influence that provides “yes” or “no” answers, rather, it allows for critical thinking and open dialogues. When considering history, it is relevant to consider the impact of past policy. The value of history diminishes if organizations are unable to admit prior errors and be willing to learn from them.

Berridge, in “History Matters? History’s role in Health Policy Making,” describes how politicians use history in debates and arguments. Within her paper, there are perspectives from both sides, one stating that history has a role in policy making and that it is a form of evidence, and the other stating that history has no formal role in the health policy sector. However, her findings support the fact that history is used in policy making. Some of the uses of history cited in her paper are ones that allow policy makers to be critical and learn from previous policies and their effect. On the other hand, there were also instances where policy makers were more inclined to “invoke history” over other significant evidence (Berridge 2008).

Part of the criticism of the role of history in policy making is that the influence of history is not made clear in official policy. This is, in part, because “when the works of historians have been used by policy makers, they are not cited” (Adu-Gyamfi et al., 2016). The existing literature argues that though history should not be neglected in policy creation, it should be used
in combination with relevant scientific information. Furthermore, history is “potentially valuable” but it should be “fairly recent” to include in policy-making decisions (Adu-Gyamfi et al., 2016).

Based on the existing literature on the relationship between history and policy, this paper attempts to analyze if the historical context used to justify blood donation restrictions is valid and supported by scientific knowledge. Based on the theory presented by the existing literature, history can be used out of context to support political gain rather than for keeping the health of a nation at the core of decisions. Therefore, there may be biases when using history to make health policy decisions.

Literature on the Impact of New Technology

Ideally, innovation and policy would go hand in hand. As scientific knowledge grows and relevant technology is invented, policy can be changed as risks change. Naturally, there is a delay in between innovation and policy as evidence is gathered. Therefore, the existing literature regarding innovation and policy is focused on what this delay looks like. There is no specific timeline, as new technology varies quite a bit, but the time difference between available technology and consequent policy implementation can be analyzed to be necessary or not.

British scientist, CP Snow, identified the disconnect between science and the humanities in his 1959 essay, “The Two Cultures.” He identifies the split as detrimental and calls for more communication between these two seemingly separate worlds. The impact of the disconnect is that “articulation with public policies at the national level are not adequately resolved, therefore local capabilities remain hidden, and the technologies developed encapsulated” (Bianchi, 2013).

Furthermore, unwarranted delays in the use of technology can be harmful. For instance, regarding energy innovation, the lack of funds to support new sustainable technology is causing
negative effects on the environment. The evidence that a problem exists is available and the technology to present a solution to the problem is similarly available. Schiener (2019) argues that bridging the gap between technology and policy making, therefore, is vital. Prior health crises have demonstrated how policy makers have excluded medical experts in their decision-making process and today the exclusion is with technologists. The reality is that technologists and policymakers rely on one another regardless of the lack of a formal relationship (Chavern, 2019). Policymakers must stay informed and act accordingly in response to new technology. While a slight delay is understandable if one is to rely on scientific evidence before making changes, longer periods are unacceptable.

Regarding this paper, literature on the development of new technologies for blood screening and disease prevention and treatment were also analyzed. The literature on this topic was objective and focused on the scientific findings. The most relevant part for this paper was the date of publishing and the validity of the research methodology. Using the existing literature on the relationship between technology and policy, the difference in time between evident scientific knowledge and policy change were evaluated for any evidence of biases.

**Literature on the Impact of Perception**

The main concepts to understand the impact of perception on policy creation is from “The Role of National Culture in Shaping Public Policy” by Dr. Katherine Danielle. In this analysis, Danielle provides examples of how policy has been impacted by national culture. It provides a background understanding for why policy can vary between countries when the scientific knowledge stays consistent. She argues that a “typical narrative” can influence the course of policy creation (Danielle, 2014). Throughout the paper, there are case studies of the
role that culture has played in policy creation, providing background context of the role culture plays. She does not attempt to support or reject the influence.

While Danielle provides an objective lens on how culture impact policy, Muers (2019) discusses how culture should be kept at the heart of policy making decisions in “Culture, Values, and Public Policy.” While this makes sense for social policy decisions, it may not be the most reliable factor for policies in the health sector. Muers concedes that the central role of culture should be “nuanced or altered for particular contexts” (Muers, 2019). Policymakers are regarded to be reactionary, then, as they create policy that reflects existing ideologies. Pre-dominant cultural attitudes may be backwards in nature, however, and relying on general perception can, therefore, be harmful. Additionally, cases in which fear of public reaction drives policy creation over general scientific knowledge undermines the position of policy-making entities and the objective position from which they stand.

The existing literature demonstrated that culture has an impact on many other aspects of society that can, in turn, influence policy. For example, the media plays a role in how people react to policy (Berridge, 2008). Media is considered a reflection of the audience’s perception as content creators mainly focus on retaining viewers. Overall, the existing literature on the connection between public policy and culture or public perception demonstrates that there is a significant impact of perception in policy. This paper, then, aims to evaluate whether the impact of perception for policy regarding MSM blood donations is valid in the United States, France, and Switzerland.

Analysis

Historical Context
The first transfusion of human blood occurred in London in 1818 by James Blundell. Afterwards, the first blood bank, a systematic collection of blood, was established in 1932 in Leningrad. Blood donation, in a systematic fashion, is crucial in the medical world. It helps patients survive surgeries, cancer treatment, chronic illnesses, and traumatic injuries. The systematic aspect is essential as it is important to use correct matches for blood transfusion and blood must be tested for transmittable diseases. Safety, primarily of the recipient of blood transfusions, has been the core of creating policy around blood donation. Therefore, the emergence of the global AIDS (acquired immunodeficiency syndrome) epidemic in the 1980s represented a shift in blood donation criteria.

The fear of the condition along with the primary affected demographic during this time, men who have sex with men (MSM), led to a permanent ban on MSM from donating blood in many countries, including all three included in this study. At the time, “these precautions were deemed necessary due to the lack of testing for the AIDS pathogen” (Beattie & Mucklow, 2018). However, by 1984, French and American scientists identified human immunodeficiency virus (HIV) as the cause of AIDS. With this discovery, scientists were able to develop tests quickly. The early tested used the enzyme-linked immunosorbent assay (ELISA) method which focused on identifying antibodies to detect HIV.

The ELISA method had a window period, the time after infection and before seroconversion, that could be three to six months (Alexander, 2016). The delay in identifying the infection could be reason for deferral periods. However, the shift from a permanent ban to 12-month deferrals (which the United States, France, and Switzerland all shifted to) happened much after the early tests were developed. The tests were developed in 1985 and have consistently
been improving since then. The permanent ban was lifted, in all three countries, well into the 21st century.

**Policy Creation Entities**

Understanding the entities that create policy provides valuable insight to the biases that can exist in policy making. Furthermore, the evolution of the organization and actors involved in blood donation policy creation provides additional insight into the historical context for blood donation policy.

**United States**

In 1940, the United States government established a national blood collection program. It originally grew as the Red Cross created programs to collect blood for the US military, but the Red Cross began blood programs for civilians in 1948. By 1972, the Red Cross had called for a national blood policy and in the same year, the Food & Drug Administration (FDA) began regulating all existing blood and plasma centers. Blood supply safety is a responsibility shared by many actors but the FDA has regulatory authority over all blood products. The Centers for Disease Control and Prevention (CDC), on the other hand, is tasked with surveillance of health risks within the blood supply. The National Institutes of Health (NIH) provides support for the national blood system through research.

At the beginning of the AIDS epidemic, the FDA-approved changes to ensuring safe blood collection did not include questions about sexual practices, there was still a level of uncertainty and a lack of consensus about the magnitude of threat certain sexual practices involved. Overall, there was a general blind acceptance that the risk of AIDS was low in terms of blood transfusion.
Before there was a federal policy codified by the FDA, organizations had already implemented donor screening measures and excluded those who were considered high risk, which was primarily MSM in the 1980s. Organizations such as the CDC and the American Association of Blood Banks had issued statements with deferral recommendations. They also recommended surrogate testing, which was not as intensely followed by collection agencies. The FDA released guidelines asking men who has sex with multiple male partners to refrain from donating blood in 1983. In 1986, the guidelines became mandatory exclusions of men who have had sex with men in the past ten years. The FDA finally recommended the lifetime ban in 1992.

The FDA recommendations did not follow the progression of scientific knowledge nor available technology. The initial recommendation can be seen as a reactionary decision made when there was still very little knowledge about HIV. However, both the initial ban and the lifetime ban came after testing technology had been developed. The FDA was highly criticized at the onset of the epidemic for failure to take action to protect the blood supply, leading to individuals with hemophilia contracting AIDS and spreading it to their family members (Harmon, 2022). “Innocent” people who relied on proper safety measures for blood reception were harmed, and the FDA was to blame as the primary holder of responsibility in terms of blood products. The intensity at which they created policy meant to protect the blood supply from HIV may have been a political move to demonstrate the authority and reliability the FDA possessed, a move to reinstate their position in US health policy and regain public trust.

There are a variety of voices that are contributing to changes in blood donation policy in the United States. For example, the American Red Cross states officially on their website that they recognize “the hurt [the MSM] policy has caused to many in the LGBTQ+ community” and are committed to working with relevant partners to create blood donation criteria that is not
determined by sexual orientation (The American National Red Cross, 2022). The CDC has also stated that the FDA’s policies do not match with the existing technology (Centers for Disease Control, 2019). However, all blood collection organizations are regulated by the FDA in the United States, making the final say theirs.

France

Much like the United States, the French government instituted a total ban on MSM giving blood in 1983 in response to the AIDS epidemic. Additionally, it came after hundreds of people died in the 1980s after receiving blood with HIV from the national blood transfusion center. The 1983 mandate was further reinforced by successive texts from 1993 and 1997. The decree was formalized in 2009. The reaffirmations were justified by the increased risk of HIV seen in MSM compared to other sexual relationships. The ban was lifted in 2016, a response to the years of campaigning by LGBTQ+ rights activists.

The Ministry of Health in France is the body that makes decisions pertaining to blood donation policy. The Santé publique France (SpF) is the French public health authority and conducts studies used to make decisions for public health. The SpF carried out numerous studies after the 2016 12-month deferral was instated, demonstrating that including MSM donors did not increase the risk of HIV infection. Back in 2012, Marisol Touraine pledges to life the ban on blood donation for MSM (Solidarites-Sante, 2015). However, to respect safety of recipient, France’s introduction of MSM blood into the national supply was done in stages. The goal was to introduce the 12-month deferral and study the changes to the blood supply. This scientific process was adopted in a bill to modernize the French health care system and was voted unanimously in the National Assembly.
The Ministry relied on recommendations from the National Agency of the Safety of Medicines and Health Products as well as the Institute for Health Surveillance in response to the decision made by the European Court of Justice. The European Court of Justice, based in Luxembourg, ruled that governments had the right to ban (or restrict) MSM blood donors given that they could provide evidence that it was the best way to limit the risk of HIV infection (Solidarites-Sante, 2015). Special projects were mandated to gather scientific evidence on if MSM bans were, in fact, the best way to limit the risk of HIV in blood.

The French government, since 2015, has had the mandate to end the exclusion of MSM from donating blood while considering recipient safety. The integration of a 12-month deferral was a move mirroring other western countries but was instated with the intent to observe changes and act according to findings. In stating so, the French government demonstrated a commitment to scientific knowledge as the backing behind health policy decisions. Though continuing with a deferral based on sexual orientation is a product of historical precedent, it was done this way to observe differences in risk with a scientific basis for further change.

**Switzerland**

In Switzerland, the original guideline that barred MSM from donating states that any man who has sex with a man cannot donate. This ban was implemented in 1977, and officially made law in 1988, prior to the discovery of HIV, and was finally lifted after 40 years on July 1, 2017. Instead, an abstinent period of 12-months was introduced for MSM and is currently in place. Compared to the United States and France, this change in policy came much later.

Policy around blood donation is created through the interaction of a variety of actors. Swiss transfusion medicine is managed under the Blood Transfusion Service of the Swiss Red Cross Ltd (BTS SRC). BTS SRC publishes mandatory guidelines for all regional blood
transfusion services. Swissmedic covers all aspects of transfusion medicine, from donor selection to blood transfusion. Additionally, all blood components are considered drugs and, therefore, must also follow all legal requirements, giving Parliament a say in creating the policy as well.

In 1949, the Swiss Red Cross (SRC) set up a central location for preparing blood products and in 1951 the Swiss government mandated the SRC to supply the population with blood products both in normal and war situations. In 1994, the government consolidated the blood transfusion centers and they were led and mandated by the SRC and the mandatory guidelines they create. In 2002, the Law of Therapeutic Products defined criteria for donor selection, mandatory tests, and record keeping. It also set up the federal drug regulatory agency, Swissmedic.

Swissmedic, in the past, has vetoed multiple attempts to discuss the issue of the blood donation ban. This use of power has prevented key voices from even having a say in the policy. At the same time, prior to moving to the 12-month deferral, in 2016, the director of the BTS SRC, Rudolf Schwabe, made statements supporting creating policy that is based on habits rather than sexual orientation (Romy, 2017). The difference in positionality of Swissmedic and BTS SRC raises questions about the basis of Swissmedic’s policy. Both organizations have similar interests, a safe blood supply, yet different approaches to this safety.

Impact of History

Though the fear of HIV contaminating the available blood supply was justifiable according to the existing literature reviewed in this paper, the fear was not abated despite the changes to prevention and treatment of AIDS/HIV. Though there were scientific advancements that could have allowed MSM to donate blood and contribute to national supplies, there was no revisions to existing policy.
At the beginning of the AIDS epidemic, diagnoses were predominantly in MSM, individuals from Sub-Saharan Africa, and non-medical intravenous drug users. This affected the perception of the disease, equating certain marginalized groups with AIDS/HIV. Additionally, these groups continued to have higher rates of HIV diagnoses for years. Furthermore, proportionally, rates are higher in MSM populations compared to many other groups still today. Because this connection, the general view that MSM means accepting the risk of HIV contraction, has been persistent, history creates barriers in amending policy.

In general, policies are easier to create than to withdraw. Support must be collected, and the policy must be justified in one way or another to be implemented. On the other hand, withdrawing policy involves admitting fault and rejecting prior support. In other words, it can be seen as accepting a certain kind of defeat and supporting for change, a concept that is quite difficult in the political world. Therefore, “the introduction of new technologies and the evolution of scientific consensus on both biological and social harm outpace policy change in many instance” (Wilson et al., 2014). For example, in France, collecting evidence that MSM donors do not pose a significant threat to the national blood supply was not the last step, the 2009 decree had to first be amended, which required the contributions of the scientific community as well as political backing.

The pain felt during the AIDS epidemic only adds to the hesitancy in bringing change to policy. Tragic history creates a narrative that harms the ability to change policy despite the emergence of new evidence and scientific knowledge. A simplified understanding of national blood supplies can be stated as follows: AIDS/HIV contaminated the existing blood supply during the epidemic, precautionary policy was created to protect recipients, the risk was eliminated. With a successful policy implementation, it is easy to reject the fight for change and
rely on precautionary policy rather than risk management. However, though it is understandable, it fosters biases, and the health system is not one that should be biased. Historical context should be considered in creating policy, but one cannot rely on the past to create policy of the future.

At the height of the epidemic, it made more sense to have a blanket policy that prevented the population at risk from donating. With a lack of understanding of the cause behind AIDS and without reliable testing, precautionary policy was the only option. Even then, however, there was backlash from the MSM community, citing discrimination. But, to many health professionals, the resulting stigma and discrimination was a necessary cost to protect the blood supply. Once there was a better understanding of AIDS/HIV, advocates argue that there could have been a switch to criteria for risk behavior, i.e. sexual contact with multiple partners regardless of sexuality, rather than specific populations. Again, though, equating MSM, and other specific groups, to HIV, an idea persisting from the 1980s, prevents this change in many countries, including the countries included in this study.

New Technologies

If HIV and AIDS were still understood and treated the same way they were in the 1980s, MSM donors could still be considered a threat to national blood supplies. However, much has changed since the onset of the epidemic. Specifically, scientific discoveries and technological growth have changed the way blood is tested and the accuracy at which is tested. Additionally, thanks to advancements in preventative care, HIV diagnoses can be prevented.

Testing technology

The first HIV antibody test was developed in 1985. It was able to show positives 6 to 12 weeks post infection but there was a high rate of false positives. Because the test was designed to screen blood products, high false positives reflect the interests of protecting the blood supply
where a “better safe than sorry” mindset prevailed. Second- and third-generation HIV tests reduced the testing window to about 3 weeks post infection. At this time, many nations, including the United States, France, and Switzerland, continued requiring a complete ban of MSM donors and continued for at least another decade. Early tests only screened for one of two HIV agents, but, by 1992, antibody tests could identify the second HIV agent as well (Fabry, 2016).

By the late 1990s, testing began to combine antibody and antigen detection, resulting in a reduced test-window (two weeks) and had 100% sensitivity and >99.9% specificity. At this time, a duplex nucleic acid test (NAT) was developed and implement in most developed countries by the early 2000s. These newer tests look for the virus itself, rather than the development of antibodies. NAT closes the window period between infection and antibody detection, resulting in a window period of 7 to 10 days. Because of the high sensitivity provided by ELISA, many countries continue to use the anti-body method or some combination of the available tests.

The progress in testing clearly does not align with the timeline relating to easing restrictions for MSM blood donation. The argument for exclusionary practices was because of higher rates of HIV diagnoses within the MSM population. However, testing is widely accessible to the MSM population, allowing individuals to monitor their own status in a timely manner. Furthermore, because every donation is tested, more than once in some countries, for HIV, restrictions on MSM do not reflect the state of technology today, or the state of technology available two decades ago. Interestingly, there is a surety demonstrated at the national level about these tests and the technology developed yet bans persisted. The misalignment of the trust in the test and the ability of MSM to donate demonstrates that the policy did not rely on testing ability. Furthermore, France’s removal of the ban does not align with any key change in the
available testing technology. The change from the 12-month deferral in the United States to the 3-month deferral also does not match up with any clear change in testing requirements. These decisions were made separate from scientific advancements.

In the United States, the FDA has established, after “careful evaluation of the available data, including data regarding detection characteristics of [NAT],” that testing is sufficient to allow MSM donors after 3-month abstinence period (US Food & Drug Administration, 2020). This statement was part of the FDA’s revised recommendation released in 2020 as a reaction to the demand for blood during the onset of the Coronavirus disease pandemic. However, data on NAT did not change specifically during 2020, the safety and testing ability has consistently been high for the past decade. The FDA did not create new policy recommendations after the release of new, sufficient data. The data already existed, it was just accepted in 2020 because of the demand, demonstrating how technology is not the driver behind changes to blood donation policy.

It is important to note that testing is important for blood supply safety regardless of who is donating. Though HIV was originally thought to effect only certain populations, the reality is that there is a certain level of risk for everyone. In 2003, in New Zealand, a non-MSM donor was identified as HIV positive and all previous blood donations by this individual were recalled (despite prior negative results). This resulted in a financial loss of $4 million and surgery in people with hemophilia was postponed (Bayor, 2015). As mentioned above, detection technology has improved since 2003, but the fact remains that excluding MSM donors does not definitely protect the blood supply and that testing is increasingly the best way to protect the blood supply. Additionally, between 2002 and 2010 in Switzerland, there was one HIV-positive donor of about 3,100,000 blood donations (again during a time with a permanent ban on MSM).
Despite the low rate of HIV infected blood donors in Switzerland, this case proved that the immense cost of testing is necessary.

**Preventative Care**

With a better understanding of HIV, there are clear ways to stay safe and take action to prevent HIV. Abstinence is a main prevention strategy, which is reflected in the deferrals used in blood donation policy. However, there are many other ways to prevent transmission. Proper use of condoms and HIV prevention medicines such as pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP) are widely used. Practicing safe-sex and getting tested regularly are important for HIV prevention. Additionally, if an individual is HIV-positive, there are many actions that can help prevent transmitting the disease to others (Girard, 2014).

The widespread accessibility of preventative measures renders abstinence-based deferrals contradictory. For instance, homosexuals who do not take PrEP but have been abstinent for three months can give blood while those who do take it (and therefore have the least risk of contraction) are unable to. However, taking medication to prevent HIV is currently a conditional leading to deferrals for blood donation. Because testing looks for the presence of antibodies, the use of PrEP may interfere with testing for HIV by delaying the presence of antibodies or resulting in inconclusive results. However, by making this a condition, pre-donation questionnaires are capturing part of the risk of HIV contamination without targeting specific sexual orientation. A similar strategy could be used to evaluate other risky behavior.

PrEP and other preventative care has also reduced the threat of HIV transmission. Therefore, with proper preventative care, long-term monogamous MSM relationships are at similar levels of risk as another other monogamous relationships. With the widespread access to preventative care and routine testing, the risk of HIV in the MSM population has had a severe
decline. Though HIV is still a major public health concern, more and more studies demonstrate that risk is more associated with sexual behavior rather than sexual orientation.

Basing blood donation policy on the current technology does not lend itself to differentiating by sexual orientation. Even if MSM are still considered a threat to blood supplies because of higher rates of HIV, the window period is much less than the deferral periods in the United States and Switzerland. The international standard for detention of infectious disease is double the window period, following an ultra-cautious model meant to respect the safety of blood transfusion recipients (Steele, 2020). Double the window period of the test used by the United States, France, and Switzerland is still less than a month, rendering very little explanation for a 3-month deferral in the United States and even less in Switzerland.

Perception

According to Katherine Daniell’s 2014 literature review for the Australian Nations University, national culture plays a significant role in shaping public policy. In terms of health policy, which, in its purest form, would be based on scientific knowledge and medically valid, there she mentions how culture plays a role as well. This influence, in part, can help explain how different countries vary in terms of policy.

An increasingly globalized world means that scientific knowledge is widely accessible and is reviewed on a global scale. Additionally, political relationships between the United States, France, and Switzerland are ones that foster healthy academic dialogue. However, the fact remains that the policy around MSM blood donation is significantly different between the three countries. The policy changed in similar ways, suggesting that, in the future, all three countries could converge in policy making regarding blood donation. Nevertheless, the AIDS epidemic effected these three countries at similar times at similar intensities.
The AIDS epidemic and its progression is relevant to observing changes in MSM blood donation policy because the onset of bans and restrictions was in direct reaction to the epidemic. If the epidemic influenced the United States, France, and Switzerland in similar ways, then the fact that all three countries have different polices can be attributed to something outside the impact of the AIDS epidemic. Though it is difficult to convey an entire nation’s attitude on social issues, the following analysis uses specific cases to encapsulate the general feelings toward MSM, and, consequently, their ability to donate blood, during certain time periods.

During the onset of the AIDS epidemic, when it became clear that the largest group effected by the disease were MSM, the narrative used by the public was intensely discriminatory and homophobic. In the United States, the epidemic started with the identification of 26 homosexual men with the disease. Various politicians shamelessly promoted that AIDS was a punishment for homosexuality echoing an opinion felt by 43% of Americans in 1987 (Heimlich, 2020). MSM blood donations, consequently, were considered harmful contaminants to the national blood supply.

In the United States, the epidemic started with the identification of 26 homosexual men with the diseases. Additionally, AIDS being a blood-borne disease was partially confirmed by transfusions recipients that were hemophiliac that were infected after receiving blood. Therefore, it was perceived that the MSM community was harming the very group they thought they were benefiting by donating blood.

Tests to identify HIV-positive blood was designed to screen blood products over diagnosing AIDS. Here starts an interesting relationship between MSM and blood donation. The safety of the blood supply was prioritized over high-risk populations during the height of the epidemic. The best way to eliminate the threat of AIDS/HIV in donated blood is to address the
epidemic and create policy to lower the rates for the entire population. However, this approach was not taken as the political pressure built to prohibit certain “high risk” donors from donating blood. Bans concerned gay organizations as they feared that it would add to existing stigmatization and homophobic attitudes.

The association between AIDS and MSM started to shift when 14-year-old hemophiliac Ryan White became the public face for HIV/AIDS. Due to the homophobic perception of the gay community, the public was more receptive to Ryan White as a symbol of innocence for the impact of HIV/AIDS. The use of Ryan White as a poster child represented the rejection of MSM as innocent victims of the disease. These perceptions made a blanket ban on MSM donors more acceptable and understandable. A combination of moral concerns and scientific knowledge backed the original ban.

Ending sexuality-based blood donation policy in France does not necessarily correlate with a significant shift in perceptions about the MSM population. In fact, France 24’s report on France changing the 12-month deferral to a 4-month ban states that the policy shift “owes more to medical progress than to changing attitudes towards homosexuality” (Dodman, 2019). This is further demonstrated by the ultimate plan to bring donor conditions for MSM in line with heterosexual donors pending relevant findings.

However, bills in the past to create criteria of exclusion based on high-risk behavior instead of sexual orientation have been struck down by lawmakers in the French assembly. In justification of this, France’s health ministry has states that donating blood is not a right and it is a civic gesture that is subject to safety rules. Though, as discussed under “New Technologies,” safety has not been a medical concern for MSM donors since the development of testing, France’s governmental organizations continue to cite scientific evidence for their policy.
“Our blood saves too” reads the Swiss Pink Cross’s webpage on blood donation. It is nestled under the politics tab of their website. “Well, it’s only a political issue, because there is no…evidence that MSM really have this much higher risk” (R. Heggli, personal communication, April 12, 2022). In all three countries, the shift away from a complete ban of MSM donors came after the political landscape shifted. Same-sex marriage was legalized, discrimination based on sexual orientation was criminalized, and more national organizations came out declaring that restrictions on the gay community were not medically founded.

Policy and politics go hand in hand. At the onset of the AIDS epidemic, when the bans were instated, the policy was a result of political pressure. Likewise, easing the restrictions in the 2010s reflects changing political landscapes. It is clear, though, how policy can become a pawn of political power. Roman describes how amending blood donation policy in Switzerland is a relatively “easy” step in working towards equality for the gay community. Furthermore, the shift to a 12-month deferral in all three countries was seen as an apprehensive step, one that was driven by fear of political backlash instead of science. Again, both the creation and removal of the MSM blood donation ban, was a result of mounting political pressure rather than a reaction to new scientific knowledge.

However, of the countries described in this paper, as well as many other European countries, Switzerland’s policy is considered one of the strictest with a 12-month deferral. Roman, of the Pink Cross, boils this difference down to a “homophobic mindset” in the country. There is the idea that gay sex is different, that gay men have a lot of sex and take on multiple sexual partners at a given time. If this were a true assessment, it would be reasonable to conclude that the MSM community is at a higher risk for HIV. However, the reality is that a lot of the LGBTQ+ community are in long-term monogamous relationships. Therefore, the risk could be
considered lower in the given population compared to a heterosexual woman with multiple sexual partners, for example.

Someone with a risky sex life should avoid donating blood. However equating MSM relationships with risky sex is a form of discrimination that is harmful to the LGBTQ+ community and results in policy creation that reflects perception rather than science and safety. Additionally, according to the CDC, any form of sex has carried a risk factor for sexually transmitted diseases (Karamitros, 2017). Requiring a period of abstinence for all donors for this reason, though, has never been considered a possibility. Part of the reason is the necessity of blood donations, and another part is the adequate testing available. Because policy and politics go hand in hand, it is difficult to deny the influence of public perception and culture. This can explain how MSM donors are regarded differently despite HIV being a disease that is blind to sexual orientation.

The perception of homosexual relationships in the three different countries show that the persistence of bans on MSM donors is indicative of perceptions of homosexual relationships. However, there is not enough evidence to conclude that the perceptions impact the varying policy between the three countries.

Another impact of culture on health policy is how a nation perceives “substantial” information for change. Specifically, in Switzerland, the policy-making entities have continued to cite a lack of evidence to lift strict restrictions on MSM donors despite an abundance of studies and evidence from the global community. Switzerland can fund national studies and do not feel the need to rely on other countries’ findings despite their validity. The requirement of relying on original research within the country demonstrates how there is a certain standard within Switzerland for medical research. However, other decisions for health policy have relied
on evidence from other countries, such as the benefits of paternity leave, for example. Therefore, there is potentially a mistrust of the MSM community within the country that can help explain this discrepancy.

**Conclusion**

Though early bans on MSM blood donors have been analyzed to be reactionary and created out of fear and political pressure, they were deemed necessary to protect national blood supplies at the time. Changes to these policies did come in the countries observed in this paper (The United States, France, and Switzerland), however there seemed to be factors outside of the progression of science motivating decisions regarding MSM blood donors. As discussed, these factors included historical context, new technologies, and public perception.

Both historical context and public perception seem to have delayed the change in policy whereas new technologies provided opportunities for more equal treatment of MSM donors and all other donors. Based on evidence in timelines, the delay between new technologies and policy change were unjustified as the policy-making entities preferred historical context and public perception over pure science in making decisions about MSM donors. Though there is no significant evidence to suggest that historical context and public perceptions should not be involved in health policy decisions, the clear disconnect from science in the decisions creates discriminatory policy.

How did the current policies come into play? Why is the policy where it is right now? In the United States, the current policy of a 3-month deferral was implemented recently, in 2020. However, based on the FDA’s timing and recommendation, it seems clear that the change was a result of the realization of the nationwide shortage of blood during the pandemic. Additionally, mounting claims of the FDA’s policy being discriminatory from other organizations of means
that the change was in part due to effective activism as well. The evidence provided by the new policy as well as the evidence described throughout the paper demonstrates how the previous restrictions were never really based on science.

Of the countries discussed in this paper, France is the only one to have moved away from the discriminatory policy and shift towards restrictions that are based on risk behavior rather than sexual orientation. By observing the timeline of change in France, however, this paper was able to critically analyze why there was a delay in when individuals within policy-making entities wanted to change policy and when the policy actually came into effect. Evidence points to the fact that the delay is associated with the gathering of significant evidence. Though the origins and persistence of the bans and restrictions on MSM are discriminatory in nature, the process by which France brought policy change supports the concept of health policy decisions primarily being based on the scientific process.

Roman Heggli sees part of the reason Switzerland falls behind in changing policy for MSM donors as that there is no need for more blood. Unlike the United States, there has not been a significant concern about the supply of donated blood. As Switzerland’s policy-making entities claim to be based on science, they continue to cite the lack of evidence supporting change. However, the evidence exists based on the changes taken in many other western countries, the data is just not from Switzerland. On the other hand, there have been no real efforts to conduct the proper research to demonstrate this evidence, showing a lack of interest in the government to make attempts to justify the restrictions beyond a blanket statement of insufficient evidence.

Overall, based on the theory presented by existing literature and the progression of policy in the United States, France, and Switzerland, there is more than scientific knowledge that is factored into health policy creation. Both the United States and Switzerland still rely on bans that
are no longer scientifically valid. However, countries that have shifted to blood donation restrictions based on risk behavior rather than individual identity demonstrate a shift. However, this shift is not necessarily regarding new scientific knowledge, it may represent a shift in perception and the understanding of historical context instead. In other words, health policy is not solely based on scientific knowledge, historical context and perception play a significant role. However, shifts in the biases held within historical understanding and public perception can cause shifts in policy, which is what can be observed in relation to blood donation policy.

Abbreviation List

AIDS: Acquired Immunodeficiency Syndrome
BTS SRC: Blood Transfusion Service of the Swiss Red Cross Ltd
CDC: Centers for Disease Control
ELISA: Enzyme-Linked Immunosorbent Assay
FDA: Food & Drug Administration
HIV: Human Immunodeficiency Virus
LGBTQ+: Lesbian, Gay, Bisexual, Transsexual, Queer
MSM: Men who have Sex with Men
NAT: Nucleic Acid Test
NIH: National Institute of Health
PEP: post-exposure prophylaxis
PrEP: pre-exposure prophylaxis
SpF: Santé publique France
SRC: Swiss Red Cross
US: the United States
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