

It's in Me to Give: Canadian Gay, Bisexual, and Queer Men's Willingness to Donate Blood If Eligible Despite Feelings of Policy Discrimination

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Abstract

Blood donation policies governing men who have sex with men have shifted significantly over time in Canada—from an initial lifetime ban in the wake of the AIDS crisis to successive phases of time-based deferment requiring periods of sexual abstinence (5 years to 1 year to 3 months). We interviewed 39 HIV-negative gay, bisexual, queer, and other sexual minority men (GBM) in Vancouver, Toronto, and Montreal to understand their willingness to donate blood if eligible. Transcripts were coded following inductive thematic analysis. We found interrelated and competing expressions of *biological* and *sexual citizenship*. Most participants said they were “safe”/“low risk” and “willing” donors and would gain satisfaction and civic pride from donation. Conversely, a smaller group neither prioritized the collectivizing biological citizenship goals associated with expanding blood donation access nor saw this as part of sexual citizenship priorities. Considerable repair work is required by Canada’s blood operators to build trust with diverse GBM communities.

Keywords

men who have sex with men; blood donation policy; willingness to donate; biological citizenship; sexual citizenship; thematic analysis; qualitative; Canada

Background

Blood donation deferral policies governing men who have sex with men (MSM)¹ remain objects of contestation by government, civil society, researchers, and activists in many countries (Caplan, 2010; Franklin, 2007; Wittock & Hustinx, 2019). This includes considerable contemporary debate in the Canadian context where the blood donation deferral policy has evolved over time while maintaining an MSM-specific exclusionary criterion (Grace et al., 2019). In 1988, a lifetime ban (or indefinite deferment) for MSM was enforced in the wake of the AIDS crisis and a tainted blood tragedy which resulted in an estimated 2,000 people in Canada contracting HIV, including many hemophiliacs (Gilmore & Somerville, 1999; Orsini et al., 2018; Picard, 1998). In 1998, Canadian Blood Services (CBS), along with its sister organization Héma-Québec, took over for the Canadian Red Cross Society and assumed the role of Canada’s blood operators (Charbonneau & Smith, 2015).

The initial blood ban for MSM was followed by three phases of reduction—what some have termed policy “relaxation” (Wittock & Hustinx, 2019)—of successively

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reduced periods for time-based deferral; that is, MSM could donate only if they did not have oral or anal sex in a given period of time and met all other eligibility criteria. The first policy relaxation occurred in 2013, with the implementation of a 5-year period of sexual abstinence for MSM to be eligible donors. The second policy relaxation occurred in 2016, when this abstinence period was reduced to 12 months. On June 3, 2019, a third incremental change was made: Health Canada reduced the period of sexual abstinence to 3 months for MSM to be eligible blood donors (CBS, 2019).

These recent policy relaxations are indicative of trends in many countries—including France, Denmark, Japan, Netherlands, the United Kingdom, and the United States—that have shifted to shorter finite deferral periods (between 3 and 6 months) while maintaining an MSM-specific deferral based on the “high risk” epidemiological category of MSM (Community-Based Research Centre [CBRC], 2020; Grace et al., 2019; Liszewski et al., 2017).² In early April 2020, the Food and Drug Administration (FDA, 2020) in the United States shifted to a 3-month deferral period for MSM in response to urgent needs in the blood supply amid the COVID-19 pandemic.

However, through these consecutive rounds of policy relaxation, a critical question arises as to whether gay, bisexual, queer, and other men who have sex with men (GBM) in Canada are in fact interested in and willing to donate blood. It is this question that our article qualitatively explores. Our results here build upon our previously published qualitative findings from interviews with GBM, including GBM living with HIV, about their perspectives on alternative blood donation policies such as a 6- or 3-month deferral policy, and a behavioral risk-based policy for all donors (Grace et al., 2019). Although some participants viewed the move to a 3-month deferral period as an incremental “step in the right direction,” the majority favored a policy based on individual-level behavioral risk—a policy that was “gender neutral”—and did not consider a 3-month policy deferral period to be a significant improvement given that it seemed discriminatory and out of step with scientific evidence (Grace et al., 2019).

The federal government has recently stated that reforming Canada’s blood donation policy to reflect current scientific evidence and remove unjustified MSM-specific deferrals is a priority (Canadian Broadcasting Corporation [CBC], 2018). Thus, this study was supported by a publicly funded national strategic initiative to help generate evidence that may inform alternative blood donation policy directions in Canada while maintaining the safety of the blood supply. In effect, this has been part of an evolving state project of *biological citizenship* (Rose & Novas, 2005)—an ongoing political exercise in

knowledge production and meaning-making whereby diverse GBM citizens and representatives from community and patients’ organizations have engaged with researchers and blood operators to mobilize and coproduce scientific knowledge.

Willingness, Altruism, and Citizenship

A body of empirical scholarship has examined GBM’s willingness to donate when and if they became eligible. This includes quantitative research in the United States that has indicated a high reported willingness among GBM to donate under a modified donation policy (Belanger et al., 2013; Liszewski et al., 2014). In a study conducted before the FDA ended the indefinite deferral (or ban) for MSM to donate blood in 2014, most GBM respondents (85.9%) said they would be willing to donate if they could (Liszewski et al., 2014). In a San Francisco-based study, 77% of GBM respondents indicated their willingness to donate if they were eligible (Belanger et al., 2013). In Canada, preliminary findings from the national *Sex Now* survey indicated that 92% of GBM surveyed were willing to donate blood if eligible (CBRC, 2019).

Some quantitative research on the blood donor pool has specifically focused on donor characteristics and how the “profiling” of potential blood donors may allow for optimal marketing to potential donors (Tscheulin & Lindenmeier, 2005, p. 173).³ This body of research asks: *what does a blood donor look like?* Among many profiles described, this marketing-focused literature has considered how, perhaps not surprisingly, “[a]ltruistic or humanitarian motives, such as the desire to help others, also appear to result in a higher willingness to donate” (Tscheulin & Lindenmeier, 2005, p. 167). Because blood donation is “strongly marketed as an act of public altruism”, many within civil society understand it as a form of *social citizenship*, including GBM who are deferred from donation (Valentine, 2016, p. 171).

Research has revealed historically and politically contingent aspects of blood donation, with altruistic motivations at times being shaped by a desire to help a more specific imagined other in the context of a shared threat (e.g., terrorism, homophobia) and contribute altruistically to a community response (Martucci, 2010; Tate, 2001). For example, GBM expressed a strong desire to donate blood in the wake of the 2016 Pulse night club shooting which occurred in a gay night club in Orlando, Florida (Liszewski et al., 2017; Trujillo & Hastings, 2018).

More expansive notions of *citizenship* have become key critical frames for conceptualizing the (dis)enfranchisement of GBM across a range of social and political issues (Adam & Rangel, 2015) beyond strictly legalistic definitions of rights codified by democratic states. For

example, the notion of *sexual citizenship* “refers to a range of structures and practices at the interface of state and sexuality such as (un)recognized claims by sexual minorities, heteronormative presumptions or the inculcation of sexual norms” that affect the capacity to participate in the full range of benefits and obligations as members of a nation (Adam & Rangel, 2015, p. 683; see also Epstein & Carrillo, 2014). LGBTQ2S+ populations have made claims for protection and rights in relation to their sexual and gender minority status and their sexual health interests to engage in civic society and everyday life with the same opportunities and security as their heterosexual and cisgender counterparts. Examples include struggles for same-sex marriage or anti-discrimination workplace policy, but also for freedom in gender expression and family formation. Johnson (2002, p. 319) explicates how “conceptions of citizenship have traditionally been both gendered and heteronormative,” arguing that

the privileging of heteronormative citizenship, and conceptions of citizen rights and entitlements, also often involve a politics of passing. The injunction to pass in certain circumstances can be a way of encouraging what Anna Marie Smith (1994, p. 207) has characterized as forms of “good homosexual” (as opposed to the blatant “dangerous queer”) behaviour. In such respects, governments can be involved in promoting a “good homosexual” subject. (Johnson, 2002, p. 320)

Within this citizenship literature, the question can arise whether integration, and thus conformity, to the structures of neoliberal citizenship are always indeed *desirable* for sexual and gender minorities or even *possible* for some intersectional subject positions, across axes of gender, race, and sexuality (Dryden & Lenon, 2015).

Meanwhile, *biological citizenship* has been used to conceptualize political processes of biomedicalization concerning how individuals and groups advance claims on the basis of the increasingly molecular-level knowledge of the human body (Rose & Novas, 2005). Young et al. (2019, p. 13) explain that “[a]ctive biological citizenship is about acts of risk calculation, choice, and the imperative to take ‘appropriate’ steps to maximise ‘health’” including the use of HIV treatment and prevention by GBM. For GBM, rights and the generation of state supports in the face of the AIDS crisis, and more recently increased knowledge on the microlevel dimensions of HIV biology and biotechnical advancement, have become key sites of biological—or *biopolitical*—citizenship activities (Epstein, 2007; Young et al., 2019).

Limited social science research has specifically mobilized the concept of biological citizenship to understand blood donation policy development and reform as a

negotiated and relational knowledge practice among state actors including patients, activists, researchers, and members of civil society (Martucci, 2010; Tran et al., 2013; Valentine, 2016). For example, Martucci (2010) has argued that in the United States, “the policy struggle to lift the MSM ban reflects a larger process through which the gay community has made claims of ‘biopolitical citizenship’” (p. 217). In the Canadian context, Tran et al. (2013) show how biological citizenship was enacted by Black community leaders who drew on local and international discourses of action to connect the work of community activism of the Canadian Sickle Cell Society and the Association d’anémie falciforme du Québec, to help those affected by sickle cell anemia.

Valentine (2016, p. 175) has likewise deployed biological citizenship to argue that appreciating the experience of GBM, HIV, and blood donation in Australia is not simply a matter of charting how communities were consulted in policy development but how they were active agents of knowledge construction:

Instead, the risk management practices developed by communities were incorporated into medical and policy knowledge, while community organizations developed and disseminated medical and policy knowledge. This activist, medically engaged, relational history, a form of biological citizenship (Rose & Novas, 2005), is at odds with the blanket deferral policy for sexually active gay men—a top-down, bureaucratic, un-negotiated rule.

Biological citizenship thus arises both *from below* (grassroots and community organizing) and *from above* (the state) as it simultaneously *individualizes* and *collectivizes* (Rose & Novas, 2005). It individualizes in the sense that individual sexually active GBM, for example, can envision themselves to be “at-risk” and can experience deferment if they seek to donate blood in Canada. It collectivizes in that GBM are then connected to each other—at least in the realm of policy formation and associated activism—because of their shared lived experiences with actual or anticipated deferment. As Girard et al. (2019) explain, biological citizenship focuses attention on the “political dimensions of biosocialities” which Rose and Novas (2005, p. 442) define as “collectivities formed around a biological conception of a shared identity.” Drawing from Foucault, scholars of biological citizenship detail how this leads to subject formation wherein individuals construct themselves as ethical subjects in relation to shared biological imperatives, such as the risks associated with donating blood (Girard et al. 2019; Rose and Novas 2005). The biological citizenship project of “more equitable” blood donor policy reform in Canada has involved multiple biosocial groupings (e.g., gay men’s health organizations, hemophilia patient advocacy groups), including those with different political concerns

and historical and contemporary relation to both HIV and blood products.

GBM, along with other sexual minority groups, have been involved in a range of political initiatives which overlap sexual citizenship projects (in relation to sexual identity and sexual practice) and biological citizenship projects forged through a shared biosocial identity, predominately, though not exclusively, constructed in relation to HIV risk as well as resistance to psychiatric pathologization and medical gaze (Foucault, 1978). Although distinct, the relationship between sexual practice and HIV, and thus between HIV risk and sexual identity, has created a *potentially* complex merger of sexual and biological citizenship claims such as those with GBM and blood donation, where a deferral rooted in questions of biology (epidemiology) can be experienced and understood as deferral based on sexual identity (Grace et al., 2019). Nonetheless, limited qualitative work in Canada has explored these complex dimensions of citizenship and biosociality in relation to blood donation, and, moreover, how these may inform potential motivations to donate blood in the future.

Hence, we interviewed a demographically diverse sample of GBM living in Vancouver, Toronto, and Montreal to understand their perspectives on alternative blood donation deferral policy futures, their interest in donating blood in the future, their sense of being suitable donors, and their opinions about screening procedures. Analytically, we explored *how*⁴ blood policy has meaning for them (Yanow, 1996) including the “political meanings of deferral policies, especially as they relate to marginalized groups” who have experienced disenfranchisement and exclusion (Valentine, 2016, p. 167). We understand our participants are not merely “passive recipients of a policy’s meaning” but rather active interpreters of real and imagined blood donation policy futures for themselves and their communities (Yanow, 1996, p. 26). Although quantitative survey research can document willingness to donate, our qualitative approach adds to the literature by focusing on the complex meanings and lived experiences that inform participants’ relationships to policy. We purposively recruited our participants to ensure that we gathered the perspectives of GBM who are considered to be at lower risk for HIV infection and thus the most likely to become eligible to donate under amended future donation policies. We focus on whether HIV-negative GBM participants considered themselves to be suitable blood donors and explore the factors shaping their willingness to donate blood if they were to become eligible under amended future policies. By willingness, we are referring to a participant’s general interest, motivations, and positive affinity to the idea of donating blood, which may or may not translate into them actually donating blood in practice.

Method

Recruitment

This analysis is drawn from in-depth, one-on-one interviews with 39 HIV-negative GBM living in Toronto, Montreal, and Vancouver. These men were recruited from a large respondent-driven sampling study called Engage. Engage is longitudinally examining the use of antiretroviral-based HIV prevention and psycho-socio-behavioral factors associated with the occurrence of HIV and other sexually transmitted and blood-borne infections (STBBIs) among GBM in Canada. We recruited from Engage because it provided us access to quantitative information that allowed us to purposively recruit qualitative study participants across a range of risk groups and sociodemographic profiles. Ethics approval was granted from the University of Toronto, Ryerson University, the University of Windsor, McGill University, the University of British Columbia, Simon Fraser University, and the University of Victoria.

We relied on community engagement committees (CEC) in all three cities to receive input on the interview guide, recruitment process, analysis, and knowledge translation activities. The CEC included key stakeholders—frontline service providers, community organizers, and advocates—working in the field of GBM in their respective cities. In addition to advice on the framing of research questions, CEC members offered input on the sociodemographic profile of our sample, ensuring not only a diverse sample but also acknowledging the limitations of our research design at addressing all groups affected by blood donation deferral policies. These committees met quarterly and included service providers working in GBM health as well as members from local GBM communities.

GBM who had completed the quantitative and biomedical components of Engage were recruited into this qualitative study via an email invitation that described the focus of this study on blood donation. We used the HIRI-MSM (HIV Incidence Risk Index for Men who have Sex with Men) score, which was drawn from our quantitative survey, as a way to purposively recruit into this qualitative study. HIRI-MSM scores quantify a GBM’s likelihood of contracting HIV based on age and self-reported sexual and other risk behaviors (Smith et al., 2012). We used the HIRI-MSM because we wanted to ensure that we were speaking to “lower risk” GBM who may be eligible to donate blood under modified policies. We also recruited a few “higher risk” GBM who would still likely be ineligible to donate under modified policies, unless their sexual behaviors were to change. The HIRI-MSM scores of potential participants were determined by using information collected from their answers to the Engage quantitative survey. We categorized “lower risk” as HIRI

scores of less than 10 (Low HIRI), “moderate risk” as HIRI scores between 10 and 15 (Mod HIRI), and “higher risk” as HIRI scores above 15 (High HIRI). Through quota sampling, we also made sure we spoke to GBM who identified across a variety of ethno-racial backgrounds, age groups, Canadian cities, and gender identities, including transgender men (Robinson, 2014).⁵

Interviews

The interviews occurred in-person and were conducted in English in Vancouver and Toronto and in English or French in Montreal. Research participants gave written informed consent prior to the interviews. We inductively constructed an interview guide with participation from our CEC. The interview guide had six overarching domains: (a) *introductions, sociodemographics, and relationship building*; (b) *understanding and opinions on past and current blood donation policies*; (c) *direct experiences donating blood or being deferred from donating*; (d) *views on possible future policies such as gender-blind screening, 6-month and 3-month deferral options*; (e) *risk evaluation for contracting HIV and STBBIs and desire and willingness to donate blood*; and (f) *views on modified screening questions and deferral procedures* (see Grace et al., 2019, Supplemental File 1, for a copy of the full interview guide).

The interviews lasted 30 to 90 minutes and were digitally recorded. Although there was flexibility in the interviewing process, the interviewers (Gaspar, Klassen, and Lessard) followed the interview guide closely to ensure a standardized process to data collection across all three cities. The participants received a \$30 CAD honorarium for this component of the study. Grace and the interviewers met regularly throughout the process of data collection to discuss emergent themes and the recruitment process. Post-interview reflections, documenting early observations and findings from each interview, were shared among Grace, Gaspar, Klassen, and Lessard.

Analysis

All of the interviews were transcribed verbatim, reviewed for accuracy, and de-identified. QSR NVivo 11 software was used to organize and analyze the interviews. We used thematic analysis to interpret the findings (Braun & Clarke, 2006). First, we became more familiar with the interviews by reading the transcripts and the post-interview notes. Second, we coded the interviews using broader categories (matching key components in the interview guide) to break down the material into manageable components. Third, preliminary analytic categories were constructed to make sense of the data on their suitability to donate (whether they thought their current risk

levels should make them eligible to donate) and their willingness/general interest to donate. These extended findings were then shared with the entire co-author team for initial input. Following this, Grace and Gaspar undertook two additional rounds of analysis to synthesize and further conceptualize the data. These results were reviewed by the entire authorship team for comment to help further refine the analysis and interpretation of study findings. Participants' quotations originally in French were translated into English below.

Results

Among the HIV-negative sample, 13 interviews took place in Toronto, 11 in Montreal, and 15 in Vancouver ($n = 39$). In our sample, 64% of men were identified as White ($n = 25$); 5% as African, Black, or Caribbean ($n = 2$); 21% as East Asian or South Asian ($n = 8$); 3% as Middle Eastern ($n = 1$); 5% as Latino ($n = 2$); and 3% as Indigenous ($n = 1$). 13% of the sample was under the age of 25 ($n = 5$) and 26% of the sample was over 50 ($n = 10$). 79% identified as gay ($n = 31$), 15% identified as queer or other ($n = 6$), and 5% identified as bisexual ($n = 2$). The majority (87%) identified as cis-gender men ($n = 34$), with 8% identifying as trans men ($n = 3$) and 5% identifying as gender non-binary ($n = 2$). In our sample, 21% were using pre-exposure prophylaxis (PrEP) ($n = 8$) at the time of the interview. PrEP is the daily use of HIV antiretroviral medication by people not living with the virus to prevent HIV infection and is a highly effective HIV prevention strategy (Grace et al., 2018; Spinner et al., 2016).

For the HIV-negative sample, 62% had lower HIRIs ($n = 24$), 8% had moderate HIRIs ($n = 3$), and 31% had higher HIRIs ($n = 12$). Twenty-two men (56%) indicated that they had donated blood in the past, with six of these men donating blood outside of Canada. Four HIV-negative participants had attempted to donate blood in the past but were deferred before they could. Although these numbers are not generalizable, they do indicate that our sample, when compared with the general population of Canadian blood donors (Cimaroli, 2012), were substantially more likely to have donated or to have actively attempted to donate blood in the past.

Self-Assessment of Suitability to Donate Blood: Individualizing Risk

Most participants believed that their sexual and HIV prevention practices and their general sense of being “healthy” rendered them “safe” donors who should be eligible to donate blood. Although men knew they were not currently eligible, many thought they would be *suitable* donors if the policy were to change. For example,

one participant who had previously donated blood in the 1970s mentioned that his good health contributed to his desire to donate under a modified policy: “Yeah, if they change their policy, I’ll start giving blood again. No problem. You know, I’m nice and healthy” (60s, Low HIRI, Vancouver). Another participant, who used to donate blood regularly before having sex with men, argued that he would make a good donor because he was just as “healthy” and “safe” as eligible heterosexual donors.

When asked if their current sexual risk levels should make them eligible to donate blood, all but four thought they were currently low risk enough to donate at the time of their interviews. One participant, for example, responded by emphasizing the importance he placed on sexual health and explicitly connecting his sense of being “healthy” and “safe” to being STBBI-free: “I’m very safe. I have never had an STI. If they tested me, I’m sure that they would find nothing so I think I should be eligible” (20s, Low HIRI, Toronto).

One participant argued that being in a long-term, monogamous relationship for over 30 years allowed him to be acutely aware of his own sexual health, which made him a suitable, low-risk donor (60s, Low HIRI, Montreal). Another participant also responded that he should be eligible because “Yeah, [I’m] low risk. No more [at] risk than any hetero guy out there as far as I’m concerned. Actually, I would consider myself lower [risk] because I’m very open about everything. I don’t lie” (60s, Low HIRI, Vancouver). Rather than relying on monogamy, this participant suggested that the frank conversations he has with his sexual partners, coupled with having sexual behaviors similar to those of heterosexual men, should make him eligible to donate.

Most participants anticipated that their sexual practices would continue to make them “safe” donors in the future. When asked if they foresaw their sexual risk behaviors changing, most men said no, but a few recognized that their sexual practices (and risk levels) might change over time. For example, one participant anticipated no change in his commitment to safer sex practices. Despite a higher HIRI score, he perceived himself to be a more suitable donor than many other gay men because of his routine practice of testing for HIV:

Well, I’d be more willing to give blood because I’m more positively inclined to believe that I am HIV negative and want to stay that way so I would be I guess more inclined to want to give blood because I’m always going to stick to my safe sex routine unlike a lot of people I know. (50s, High HIRI, Montreal)

Other participants acknowledged that their sexual practices and perceived blood donation eligibility might change in the future due to a variety of factors including

initiating PrEP and relationship status changes. For example, one participant acknowledged that if his level of sexual risk increased, he would abstain from donating blood until he was certain of his HIV-negative status out of a sense of ethical duty:

I mean I’m not stupid in the sense that if I knew that I was doing something potentially risky that there’s a chance that I could’ve contracted HIV then I want to know for myself and I would certainly want to know before I donate any blood. So that goes without saying. It’s part of my ethics. (60s, Low HIRI, Vancouver)

A few HIV-negative participants agreed that they should remain ineligible to donate due to the perceived risk level of their sexual practices. Although most of these participants were in the “High HIRI” category, one younger participant with a low HIRI score expressed a significantly less common opinion that the 1-year MSM deferral was a good and reasonable policy and that he did not consider himself to be a suitable donor because he was sexually active (20s, Low HIRI, Toronto). Another participant (30s, High HIRI, Toronto) acknowledged the fluidity of his sexual practices and asserted that sometimes his risk levels change within a given month (e.g., occasionally having higher risk sex). A participant with a higher HIRI score argued that while his sexual practices did not put him at risk of contracting HIV (he was currently on PrEP), they might put him at risk of “other things . . . that the policies are trying to mitigate” (20s, High HIRI, Toronto). As a result, he currently thought that he should remain ineligible to donate blood.

Thus, while participants differed in their views on what qualified them as “safe” donors, the vast majority believed that sexual abstinence should not be the only criterion determining eligibility for blood donation for GBM. Most participants noted that abstaining from sex for the sole purpose of donating blood was not a likely option for them to pursue, given that it would be a substantial personal sacrifice. Some participants labeled such a planned sexual abstinence as unrealistic.

Accounts of Willingness to Donate Blood in the Future: Conceptualizing Citizenship

Positive affinity: Blood donation altruism and civic engagement. The majority of our participants described being willing to donate, with many viewing blood donation as “important.” Blood donation was often associated with altruism, citizenship, and self-fulfillment. Participants described blood donation in highly positive terms, defining it as “admirable” (60s, High HIRI, Vancouver) and “a simple act of kindness” (30s, Low HIRI, Vancouver).

This general sense of blood donation as altruistic contributed to the perceived importance of blood donation for many participants and motivated their desire to donate. For example, one participant mentioned that: “I feel like it’s really important. I feel like there’s a lot that my donation can do for people. It’s something that my body can replace regularly” (30s, HIV-negative, Low HIRI Toronto). Another participant described blood donation as potentially life-saving and an act of everyday heroism: “if somebody I loved, somebody in my family, or if there was a mass shooting of some sort, if there was a blood shortage, I would love to give blood if it’s within my power, absolutely” (20s, High HIRI, Vancouver). Many participants thus understood blood donation as something intrinsically important and altruistic. As Charbonneau and Tran (2013) observe in their reflections on the discursive strategies of Héma-Québec, “[t]he association between blood and life is the most frequently recurring element in the rhetorical discourse of blood product safety organizations” (p. 175).

Several participants explicitly described blood shortages as reasons why they wanted to donate. For example, one participant stated, “I know that there’s a great need very often. There’s often a shortage” (30s, Low HIRI, Vancouver). Many participants perceived the benefits of donation to outweigh any disadvantages with respect to time and energy.

Relatedly, some participants associated blood donation with contributing to society and being a good (biological) citizen, which further motivated their desire to donate. For example, one participant, who had donated blood prior to the initial ban on MSM donors, shared his perception that donating made him feel like a “responsible” and “civic minded” person (50s, Low HIRI, Toronto). Another participant stated, “I definitely want to [give blood]” because “I just want to be a better person or just like contribute in some way, in ways where I can because I think that’s a good thing to do” (20s, Low HIRI, Vancouver). For many participants, blood donation was thus viewed as a marker of virtuous biological citizenship and a means of contributing to the health of fellow members of society—within and beyond the gay community.

Some viewed donation as personally beneficial, demonstrating some of the individual-level benefits of expanded access to donation. One participant reflected on his experience with donation before he was sexually active with men and said, “it felt really good” to donate (20s, High HIRI, Vancouver). A few men noted that in addition to being beneficial to others, blood donation could also be “self-serving,” because, as one Toronto-based participant noted, “I never know when a time in my life comes when I’ll need it” (20s, High HIRI, Toronto).

A few participants described their interest to donate blood in relation to personal habits, family traditions, and values. Some men described that they came from families who donated blood regularly, while others were motivated by the donation practices or transfusion needs of loved ones. Collectively, the positive connotations of blood donation strongly influenced participants’ willingness to donate should they become eligible.

Lack of desire to donate: Accounts of indifference and resentment. A smaller subset of participants was more indifferent to donation and demonstrated *low involvement* (Bednall & Bove, 2011) by expressing moderate or minimal desire to donate for various reasons. For example, one participant stated that while he was not against donating, he was somewhat uninterested: “Maybe I would consider blood [donation] but it’s never been like a priority of mine” (20s, Low HIRI, Toronto). Similarly, another participant acknowledged his moderate interest in blood donation by stating, “My desire to give blood is normal. I don’t know. I won’t be the person always donating” (30s, Low HIRI, Montreal). Others were even less enthusiastic about donating, with one participant articulating that donation was “absolutely of no importance” to him (30s, Low HIRI, Montreal). Participants’ reasons for viewing blood donation as less important varied, with some citing general population deterrents common in the literature—*inconvenience, low self-efficacy, and lifestyle barriers* such as work conflicts and a lack of time (Bednall & Bove, 2011)—and others referencing past and ongoing MSM donation policies as the rationale for their lack of interest.

For example, one participant highlighted that while some GBM might be uninterested in donating blood because of the years of discriminatory deferral policies, the main barrier to donating—should he become eligible—was scheduling and energy: “I definitely think I would donate if it would change tomorrow. But would I do it tomorrow? Maybe not because [of my] schedule and how I’m feeling” (30s, Mod HIRI, Toronto). Some participants described the physical act of giving blood and their fear of needles as being the main barrier to donation (Bednall & Bove, 2011; Shaz et al., 2010).

A few men expressed a lack of interest in donating blood because they thought that it was not a high-priority political issue for GBM. While for some men an explicit sense of *biological citizenship* was foundational for their willingness to donate, these participants were not particularly bothered by the ban on MSM donors. For example, one younger participant, who was described above as saying the 1-year MSM policy was reasonable and that he was not a good candidate currently because he was sexually active, went on to argue that “this is not a service that people are being denied and also I feel like [CBS] has the

right to choose where their blood is coming from. And I think these screening procedures ultimately serve the public in terms of health” (20s, Low HIRI, Toronto). As the policy served as a means of protecting the public, he viewed it as entirely justifiable: “I just think people are misconstruing this to make it a political issue about denying service based off of identity when I think it really has nothing to do with that and I think it just has to do with screening out people who are at risk.” Another participant viewed MSM deferral policies more ambivalently and referred to the blood ban as “hypocritical,” but he was also cautious about labeling this as a rights-based issue (50s, High HIRI, Montreal). Rather, he described it as an issue of gay men’s “sense of entitlement.”

Thus, these participants were critical of a conflation between sexual citizenship claims and biological citizenship claims. They argued that while some GBM are politicizing blood donation policy as a form of homophobia that needs to be changed, what makes sense for sexual citizenship cannot be exactly translated onto biological citizenship, especially because what is being denied is an opportunity to offer a service and not an opportunity to receive a service. These narrative accounts also show that although GBM can see themselves as part of a biosocial grouping—connected through shared biological interests—it does not mean that they all agree with each other about what is politically at stake with their biosociality.

For some, the biological citizenship claims of blood donation policy were a distraction from other necessary political work. One man described blood donation as “not that important,” because his community interests laid elsewhere:

I am committed in terms of my own political energy and opinions towards other issues affecting not just queer and trans people but lots of people. And so my ability to donate blood feels like it’s more tied up with my own sense of, or would be tied up with my own sense of, respectability or viability in a broader public health system and I’m like not particularly invested in [blood donation]. (20s, High HIRI, Toronto)

In contrast to blood donation—which he associated with the relatively *homonormative citizenship* projects (Duggan, 2002; Johnson, 2002) and goals of respectability and inclusion—this participant was more invested in other political causes, such as austerity and inadequate affordable housing.

Participants most frequently attributed their lack of interest in blood donation to their frustration over past and ongoing MSM-specific donation policies. For example, one participant described his declining interest in blood donation over the years as a result of decades of deferral practices:

It used to be a lot more important, but I just feel excluded so why bother? But I’ve kind of given up on the fight with that. Yeah. It feels like, I don’t know, I think I would still do it if it came up again but at this point, I don’t think it’s going to change. (40s, Low HIRI, Vancouver)

Another participant described a somewhat lukewarm interest in donating blood: “I don’t know that it’s crazy important to me. I guess I’d say maybe there’s a little bit of a resentment because of what the policies have been about blood donation from MSM in the past” (30s, Low HIRI, Vancouver). The resentment expressed by this man suggests that a change in eligibility policy may not be enough to prompt some GBM to donate blood given the legacy of donation bans for MSM. However, only one participant expressed that he would not donate blood even if he became eligible because he felt that he had been “wronged” by previous deferrals policies. Furthermore, even this participant said that he was somewhat ambivalent about boycotting donation altogether (50s, High HIRI, Montreal).

Discrimination, frustration, and restrictions on civic engagement. Many men expressed stark criticisms toward MSM-based deferral practices. For example, one participant explained that the MSM-specific nature of the policy made him “bitter” and “mad” (20s, Low HIRI, Toronto) and another labeled it as “personally insulting” and “discriminatory,” especially in light of the perceived need for blood products (30s, Mod HIRI, Toronto). Another participant was highly critical of the deferral policy and how it added to a host of factors marginalizing queer people:

I mean you have to just think of everything that goes on in the day to day up here. It’s like, we have a serial killer⁶ running around here, can’t donate blood [. . .] because you’re a queer, you can’t do this thing because you’re a queer. So there’s already a very stacked deck. So the deferral really doesn’t help matters in terms of self-esteem and self-worth and just feeling like you can actually give back in a really, really meaningful way. (30s, Low HIRI, Toronto)

These comments indicate how MSM-specific blood donation policies restrict the civic engagement of GBM and, in so doing, add to the systemic forces affecting their social value and self-worth—what the above participant called a structurally “stacked deck” for queer people. However, despite this participant’s sense of being discriminated against and rendered marginal by MSM-based deferral practices, he said he was still willing to donate due to the importance of blood donation as an altruistic civic activity.

A majority of participants viewed MSM-specific donation policies as heterosexist and discriminatory and

something that GBM should not be unjustly excluded from doing. Blood donation was conceptualized by some men as a form of biological citizenship and connection to the general Canadian population—that is, all Canadians are potential blood recipients. As many participants associated blood donation with altruism and citizenship, several noted that being unable to donate under current eligibility requirements meant that they were denied access to expressions of citizenship, which contributed to feelings of shame and marginalization. For example, one participant argued that the current policy

restricts people from participating in something that's so publicized as a way of taking care of your communities. And in that regard, I think for me and for many other people who are ineligible, it makes it seem like we're secondary and we're outside of that where their slogan is something like, "It's in you to give." (30s, Low HIRI, Vancouver)

While CBS has phased out their use of this slogan, the above reflections highlight how the construction of blood donation as a form of civic duty often leaves those left out feeling like lesser citizens.

Frustration over blood donation policy was particularly strong for trans men who discussed confusion over their ability to donate in light of problematic gender-based policies. For these participants, the policy was viewed as convoluted; trans MSM who have had bottom surgery are screened based on their affirmed gender and deferred according to policies associated with MSM. If they have not had bottom surgery, they will be screened based on their gender assigned at birth. One trans participant discussed how he would love to donate regularly and mobilize other people to donate, but it was hard for him to understand the policies as a trans man partnered with another trans man (30s, Low HIRI, Vancouver). Another participant, who had donated blood prior to transitioning, discussed how CBS staff were unsure how to apply this policy to him after he started transitioning, which led to an uncomfortable interaction when he attempted to donate (30s, Low HIRI, Vancouver). He went on to describe that when he refused to self-identify as female, he was deferred.

Discussion

Our data demonstrate that there are complex connections between sexual citizenship and biological citizenship in relation to blood donation. The majority of participants considered blood donation deferrals for MSM an affront to issues of equity and an expression of systemic homophobia. From the vantage point of assessing an injustice to sexual citizenship, they interpreted the biological risks associated with MSM blood donation in the current biotechnological context as

manageable and thus argued that GBM should have a right to donate. The men interviewed appeared to be strongly motivated to donate because they envisioned *the right to donate* to be part of their civic rights as GBM living in an equitable society. Conversely, a small group did not prioritize the biological citizenship goals associated with expanding access to blood donation or see this as part of broader sexual citizenship goals to increase safety and security of GBM. These men were seemingly less motivated to donate, and some were critical of the polemical nature of blood donation debates.

Biological citizenship was thus both an individualizing and collectivizing experience. At the individual level, individuals assessed their personal risks for HIV and their general orientation to health to make sense of their candidacy and motivations to donate. They were healthy as individuals (practising safe sex and using PrEP, for example) and thus believed they should be able to donate and would feel a sense of personal satisfaction and civic pride from doing so. At the same time, participants frequently understood themselves as GBM operating as a collective—not just as an epidemiological category of “MSM,” but as a biosocial category of GBM sharing common values of equality, justice, and fairness in the face of homophobia, other forms of systemic oppression, and HIV stigma.

At the individual level, there is no reason to assume that GBM are more or less likely to donate blood than their heterosexual counterparts. However, the biosocial formations of GBM in relation to blood donation policy have produced a strong collective desire to demonstrate that GBM would be good, motivated donors—at least in the context of an interview, and even as demonstrated by their willingness to contribute to an interview on MSM blood donation. Put differently, when asked if they would be willing to donate if they could, the participants responded overwhelmingly yes, not just because they were personally dedicated to the idea of donation (though, some with specific lived experiences and family ties were), but because it was viewed as part of sexual citizenship and a move toward greater equity.

Most participants conceptualized blood donation in positive terms—a voluntary practice that would allow them and/or other GBM to practice an altruistic activity with a positive impact on the lives of others. Although some participants had previous blood donation experience when they were eligible, many engaged in a process of imagining how they thought they would feel as blood donors. For most men we interviewed, the personal impact of donating, as well as frustrations with MSM-specific deferrals, was weighed against the public health good of being able to help others through donation. For some, being a blood donor was both symbolically important and a clear expression of acting as an engaged or

“good citizen” who cared for one’s community and contributed to society in general (Valentine, 2005).

At the time of the interviews, most participants were aware that they could not donate blood in Canada unless they were to abstain from sex for 12 or more months. Nonetheless, the vast majority of HIV-negative interviewees considered themselves to be suitable potential donors because of their self-assessed sexual risk levels. Some participants reflected on their self-described “low risk” sexual practices that rendered them *ineligible* and juxtaposed these behaviors (e.g., partner numbers and use of HIV prevention strategies, including condom use and testing) to other people, most commonly heterosexual men, who were *eligible* donors. As such, many participants constructed themselves as “safe” *good gay citizens* or “good homosexual” subjects (Johnson, 2002; A. M. Smith, 1994, p. 207).

In nearly all cases, participants’ sense of being at lower risk for HIV were aligned with their HIRI scores and/or were supported by the fact that they were on PrEP. In only a couple of instances did participants with higher HIRI scores think they were suitable blood donors, and in one case, a participant with a lower HIRI thought he was too high risk to donate blood. Although a discordance between subjective “perceived” risk for HIV and objective risk may exist for some GBM, many of our participants were knowledgeable about their sexual health and capable of accurately assessing their HIV risk levels (Grace et al., 2014).

Some GBM explained that they were “healthy” and “safe”—primarily referring to not having HIV or other STBBIs, and taking steps to avoid these infections in the future—and voiced their frustration with a policy that assumed them to be otherwise. This finding is consistent with our earlier work in which most participants expressed that their “actual risk” of having HIV or other STBBIs at an individual level and “not an aggregate understanding of risks for MSM populations, should be a key consideration in blood donor policy which requires screening for sexual behaviour for everyone and not specific deferrals for men who have sex with men” (Grace et al., 2019, p. 11; Kesby & Sothorn, 2014).

A few of the participants we interviewed, the majority of whom were in the “high HIRI” category, stated that they believed they should remain ineligible to donate blood based on their current sexual practices. Importantly, while many of our participants believed they should be able to donate blood given their individualized self-assessments of having low-risk sexual behavior, no GBM we interviewed conveyed any indication that they would be non-compliant with Health Canada’s current or future blood donation policy. This point is important to underscore given that some research with GBM has focused on questions of policy (non-) compliance by blood donors.

For example, research from observational studies in the United States and the United Kingdom suggests that some GBM have donated blood despite being in violation of policies that make MSM ineligible (Goldman et al., 2011; Grenfell et al., 2011).

Furthermore, while many GBM we interviewed discussed their openness to donation, other GBM may be uninterested in donating blood for various reasons including their exclusion based on other non-MSM-specific grounds including countries one has lived or traveled to (Grace et al., 2019). The intense emotions expressed by some participants when they thought about themselves being denied the ability to donate blood suggest that the legacies of these deferral policies will continue to negatively resonate within some GBM communities. Consequently, future policy changes will not be occurring within a neutral space, but rather one marked by a history of discrimination experienced by GBM.

Drawing upon a critical analysis of national and supranational European blood practices for MSM, with a specific focus on the evolution of the discursive framing of blood policy in Belgium over the last 14 years, Wittock and Hustinx (2019, p. 4) argue that

the negotiation of MSM donor deferral in heterogeneous networks of scientists, the knowledgeable public, policymakers, stakeholder associations, national and international political institutions, and the developers and users of technology is part of a more general process of co-producing what it means for blood to be safe, and for candidate donors to be safe donors.

Rather than conducting an analysis of key policy texts, correspondence, and media accounts as Wittock and Hustinx (2019) have done, our interviews have allowed us to consider participants’ reflections upon alternative blood donation futures and *how* the policy has symbolic meaning for them (Yanow, 1996).

Considerable repair work is required by Canada’s blood operators to build trust with diverse GBM communities. Our analysis helps to reveal not only *what* blood donation policy means for a sample of Canadian HIV-negative GBM but *how* it means (Yanow, 1996); for many, it has meaning because they see unjust discrimination practices codified in ongoing policies for GBM.

Limitations

Our analysis is subject to a number of limitations. It is likely that in speaking to GBM who were willing to be interviewed about blood donation, we spoke to some people more highly motivated or opinionated about blood donation. There may be more indifference or apathy among a larger segment of the GBM population. Our sample comes from GBM already engaged in a large HIV

and sexual health study called Engage, with recruitment occurring in three large Canadian cities. Social desirability may have informed some interview accounts with the participants wanting to present themselves as “doing the right thing” in the context of the interview (Hewitt, 2007). Our analysis also focused principally on blood donation exclusion from the point of view of same-sex sexual activity, rather than other intersecting dimensions of exclusions (such as those associated with race, trans identity, or substance use). For example, further research is required to understand the perceptions and willingness of GBM who are members of multiple Black communities within Canada, including within the Haitian community (Charbonneau et al., 2015; Tran et al., 2013). Although we refer to these various aspects in our analysis, a more comprehensive intersectional lens is necessary for future research in this shifting policy field (Dryden, 2016) especially given the multiple, heterogeneous biosocial groups involved in this contested project of biological citizenship. Finally, our data were collected when MSM were being deferred for 12 months before policy relaxation to 3 months, and as such, we collected data on participants’ perceived potentials and motivations for donating in a *hypothetical* policy context (i.e., *would you donate?*) rather than current policy context (i.e., *will you donate?*). It is possible that some participants would not answer these questions identically.

Conclusion

Although the population of GBM cannot likely be expected to add substantially to the current blood donor supply in Canada, our data suggest that many of the GBM we interviewed were willing to donate blood if they became eligible under existing or modified policies. The recent policy shift to a 3-month, time-based deferral for MSM represents a sign of progress for some of the men we interviewed and is in keeping with reforms in other jurisdictions, including the United Kingdom and most recently the United States. However, this “relaxation” in time will not resolve the fundamental issue of perceived population-based discrimination articulated by many of our participants. GBM community health organizations, such as the CBRC, continue to enact biological citizenship as they lead the political charge in this policy sphere—imagining alternative policy futures and advocating for further reform based on scientific evidence they have helped to coproduce (CBRC, 2020).

Like in other country contexts, we believe that key blood donation policymakers and professionals in Canada are also “seeking a balance between technoscientific reasoning and sensitivity to social and political considerations among the citizens they aim to serve and from whom they attract their blood donors” (Wittcock &

Hustinx, 2019, p. 3). We are hopeful that in the next iteration of policy reform efforts, the significant quantitative and qualitative research collected as part of these national studies will meaningfully contribute to alternative blood donation policy change efforts that have, at their core, a desire to use science to inform an evidence-based, safe, and just national blood donation policy. The use of this evidence may help in restoring trust among GBM communities, as well as help to meet the recent recommendation put forward by the House of Commons Standing Committee on Health “that the Government of Canada end all discriminatory practices related to blood, organ and tissue donation for men who have sex with men and trans people and adopt donor screening policies that are evidence-based, gender-neutral, and behaviour-based” (Standing Committee on Health, 2019, p. 46; *see* CBRC, 2020).

Authors’ Note

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Notes

1. Consistent with our previous work, for analytic clarity “we refer to the target population of the current deferral policy as being for men who have sex with men (MSM), but

- reference the participants we interviewed as GBM [gay, bisexual, queer, and other men who have sex with men] to signify the diverse ways in which they identified themselves. MSM is an epidemiological category with policy relevance, but everyday people are more likely to refer to themselves and communities through common monikers or identities like gay, bisexual, and queer” (Grace et al., 2019, p. 12).
- In Canada, MSM experience disproportionately high rates of HIV and other sexually transmitted and blood-borne infections, representing nearly half of all incident (52.5%) and prevalent HIV cases (49.1%) (Public Health Agency of Canada, 2018).
 - This research reports on what is termed the “Psychographic features of donors and non-donors” (Tscheulin & Lindenmeier, 2005, p. 167).
 - We take inspiration from Yanow’s (1996) book *How Does a Policy Mean?* Focusing on the *how* question here—as opposed to only *what* policy means—allows us to examine the multiple ways blood donation policy has come to have meaning for GBM—and how it may have meaning in the future. Yanow explains the reasons for this seemingly odd but correct grammatical structure: “the adverb ‘how’ modifying the verb ‘mean’” with purposeful use of the “oddity of the locution” to help inspire and provoke critical thinking in relation to how policy meaning is conveyed and who the “readers” and “speakers” of policy meaning are (p. ix).
 - For this qualitative study, we also recruited eight HIV-positive men. As this current analysis examines an interest in donating blood should policies concerning eligibility change in the future, we focus exclusively on the perspectives shared by the 39 HIV-negative participants interviewed given that they may be eligible to donate blood in the future. The perspectives of GBM living with HIV on blood donation policy futures have been reported in our previous work (Grace et al., 2019). These men tended to view current deferrals as homophobic and exclusionary. We have not included their accounts here because we are specifically interested in understanding the relationship between notions of citizenship and the willingness to donate.
 - This participant was referencing the serial killer Bruce McArthur: <https://www.cbc.ca/news/canada/toronto/bruce-mcarthur-sentence-parole-eligibility-1.5009291>.
- ## References
- Adam, B. D., & Rangel, J. C. (2015). The post-migration sexual citizenship of Latino gay men in Canada. *Citizenship Studies*, 19(6–7), 682–695. <https://doi.org/10.1080/13621025.2015.1053797>
- Bednall, T. C., & Bove, L. L. (2011). Donating blood: A meta-analytic review of self-reported motivators and deterrents. *Transfusion Medicine Reviews*, 25(4), 317–334. <https://doi.org/10.1016/j.tmr.2011.04.005>
- Belanger, G. A., McFarland, W., Raymond, H. F., & Custer, B. (2013). If the permanent deferral were lifted would men who have sex with men want to donate blood, and if so, who would be eligible? *Transfusion*, 53(11), 2729–2733. <https://doi.org/10.1111/trf.12124>
- Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3(2), 77–101. <https://doi.org/10.1191/1478088706qp0630a>
- Canadian Blood Services. (2019, May 8). *Blood donation waiting period for men who have sex with men reduced to three months*. <https://blood.ca/en/about-us/media/newsroom/blood-donation-waiting-period-for-men-who-have-sex-with-men-reduced-to-three-months>
- Canadian Broadcasting Corporation. (2018, April 10). *Liberals face backlash over ban on blood donations by sexually active gay men*. <https://www.cbc.ca/news/politics/liberal-blood-ban-gay-men-1.4608769>
- Caplan, A. (2010). Blood stains—Why an absurd policy banning gay men as blood donors has not been changed. *The American Journal of Bioethics*, 10(2), 1–2. <https://doi.org/10.1080/15265161003622030>
- Charbonneau, J., Nathalie, Y., & Tran, L. (2015). The paradoxical situation of blood donation in the Haitian-Quebec community. *Canadian Ethnic Studies*, 47(2), 67–92. <https://doi.org/10.1353/ces.2015.0021>
- Charbonneau, J., & Smith, A. (Eds.). (2015). *Giving blood: The institutional making of altruism*. Routledge.
- Charbonneau, J., & Tran, N. Y. L. (2013). The symbolic roots of blood donation. *Transfusion*, 53, 172S–179S. <https://doi.org/10.1111/trf.12477>
- Cimaroli, K. (2012). *The frequency of blood donation in Canada: An exploration of individual and contextual determinants* [Doctoral dissertation]. <http://hdl.handle.net/11375/12512>
- Community-Based Research Centre. (2019, May 8). *EXPERTS: New blood donor ban misses the mark*. https://www.cbrc.net/experts_new_blood_donor_ban_misses_the_mark
- Community-Based Research Centre. (2020, April 16). *Ending the discriminatory blood ban: A safe, more inclusive blood supply*. https://www.cbrc.net/ending_the_discriminatory_blood_ban
- Dryden, O. H. (2016). *Unrepresentable blood: Canadian blood donation, “gay blood” and the queerness of blackness* [Doctoral dissertation]. <http://hdl.handle.net/1807/89242>
- Dryden, O. H., & Lenon, S. (2015). *Disrupting queer inclusion: Canadian homonationalisms and the politics of belonging*. University of British Columbia Press.
- Duggan, L. (2002). The new homonormativity: The sexual politics of neoliberalism. In R. Castronovo & D. Nelson (Eds.), *Materializing democracy: Toward a revitalized cultural politics* (pp. 175–194). Duke University Press.
- Epstein, S. (2007). *Inclusion: The politics of difference in medical research*. University of Chicago Press.
- Epstein, S., & Carrillo, H. (2014). Immigrant sexual citizenship: Intersectional templates among Mexican gay immigrants to the USA. *Citizenship Studies*, 18(3–4), 259–276. <https://doi.org/10.1080/13621025.2014.905266>
- Food and Drug Administration. (2020, April 2). *Coronavirus (COVID-19) update: FDA provides updated guidance to address the urgent need for blood during the pandemic*. <https://www.fda.gov/news-events/press-announcements/coronavirus-covid-19-update-fda-provides-updated-guidance-address-urgent-need-blood-during-pandemic>
- Foucault, M. (1978). *The history of sexuality* (Vol. I). Vintage.

- Franklin, I. M. (2007). Is there a right to donate blood? Patient rights; donor responsibilities. *Transfusion Medicine*, 17(3), 161–168. <https://doi.org/10.1111/j.1365-3148.2007.00754.x>
- Gilmore, N., & Somerville, M. A. (1999). From trust to tragedy: HIV/AIDS and the Canadian Blood System. In E. A. Feldman, E. Feldman, & R. Bayer (Eds.), *Blood feuds: AIDS, blood, and the politics of medical disaster* (pp. 127–159). Oxford University Press.
- Girard, G., Patten, S., LeBlanc, M. A., Adam, B. D., & Jackson, E. (2019). Is HIV prevention creating new bio-socialities among gay men? Treatment as prevention and pre-exposure prophylaxis in Canada. *Sociology of Health & Illness*, 41(3), 484–501. <https://doi.org/10.1111/1467-9566.12826>
- Goldman, M., Yi, Q. L., Ye, X., Tessier, L., & O'Brien, S. F. (2011). Donor understanding and attitudes about current and potential deferral criteria for high-risk sexual behavior. *Transfusion*, 51(8), 1829–1834. <https://doi.org/10.1111/j.1537-2995.2011.03078.x>
- Grace, D., Chown, S. A., Jollimore, J., Parry, R., Kwag, M., Steinberg, M., . . . Gilbert, M. (2014). HIV-negative gay men's accounts of using context-dependent sero-adaptive strategies. *Culture, Health & Sexuality*, 16(3), 316–330. <https://doi.org/10.1080/13691058.2014.883644>
- Grace, D., Gaspar, M., Lessard, D., Klassen, B., Brennan, D. J., Adam, B. D., . . . Hart, T. A. (2019). Gay and bisexual men's views on reforming blood donation policy in Canada: A qualitative study. *BMC Public Health*, 19, Article 772. <https://doi.org/10.1186/s12889-019-7123-4>
- Grace, D., Jollimore, J., MacPherson, P., Strang, M. J., & Tan, D. H. (2018). The pre-exposure prophylaxis-stigma paradox: Learning from Canada's first wave of PrEP users. *AIDS Patient Care and STDs*, 32(1), 24–30. <https://doi.org/10.1089/apc.2017.0153>
- Grenfell, P., Nutland, W., McManus, S., Datta, J., Soldan, K., & Wellings, K. (2011). Views and experiences of men who have sex with men on the ban on blood donation: A cross sectional survey with qualitative interviews. *British Medical Journal*, 343, Article d5604. <https://doi.org/10.1136/bmj.d5604>
- Hewitt, J. (2007). Ethical components of researcher—Researched relationships in qualitative interviewing. *Qualitative Health Research*, 17(8), 1149–1159. <https://doi.org/10.1177/1049732307308305>
- Johnson, C. (2002). Heteronormative citizenship and the politics of passing. *Sexualities*, 5(3), 317–336. <https://doi.org/10.1177/1363460702005003004>
- Kesby, M., & Sothorn, M. (2014). Blood, sex and trust: The limits of the population-based risk management paradigm. *Health & Place*, 26, 21–30. <https://doi.org/10.1016/j.healthplace.2013.11.004>
- Liszewski, W., Becerril, J., Terndrup, C., West, N., Lavin, B. C., Schieffler, D., & Van Sickels, N. (2014). The rates, perceptions, and willingness of men who have sex with men to donate blood. *Transfusion*, 54(7), 1733–1738. <https://doi.org/10.1111/trf.12535>
- Liszewski, W., Terndrup, C., Jackson, N. R., Helland, S., & Lanvin, B. C. (2017). The beliefs and willingness of men who have sex with men to comply with a one-year blood donation deferral policy: A cross-sectional study. *Transfusion*, 57(9), 2234–2239. <https://doi.org/10.1111/trf.14217>
- Martucci, J. (2010). Negotiating exclusion: MSM, identity, and blood policy in the age of AIDS. *Social Studies of Science*, 40(2), 215–241. <https://doi.org/10.1177/0306312709346579>
- Orsini, M., Hindmarch, S., & Gagnon, M. (2018). Introduction. In S. Hindmarch, M. Orsini, & M. Gagnon (Eds.), *Seeing Red: HIV/AIDS and public policy in Canada* (pp. 251–306). University of Toronto Press.
- Picard, A. (1998). *The gift of death: Confronting Canada's tainted-blood tragedy*. HarperCollins.
- Public Health Agency of Canada. (2018, July). *Summary: Estimates of HIV incidence, prevalence and Canada's progress on meeting the 90-90-90 HIV targets, 2016*. <https://www.canada.ca/en/public-health/services/publications/diseases-conditions/summary-estimates-hiv-incidence-prevalence-canadas-progress-90-90-90.html>
- Robinson, O. C. (2014). Sampling in interview-based qualitative research: A theoretical and practical guide. *Qualitative Research in Psychology*, 11(1), 25–41. <https://doi.org/10.1080/14780887.2013.801543>
- Rose, N., & Novas, C. (2005). Biological citizenship. In A. Ong & S. J. Collier (Eds.), *Global assemblages: Technology, politics, and ethics as anthropological problems* (pp. 439–463). John Wiley.
- Shaz, B. H., James, A. B., Demmons, D. G., Schreiber, G. B., & Hillyer, C. D. (2010). The African American church as a donation site: Motivations and barriers. *Transfusion*, 50(6), 1240–1248. <https://doi.org/10.1111/j.1537-2995.2009.02570.x>
- Smith, A. M. (1994). *New right discourse on race and sexuality: Britain, 1968–1990*. Cambridge University Press.
- Smith, D. K., Pals, S. L., Herbst, J. H., Shinde, S., & Carey, J. W. (2012). Development of a clinical screening index predictive of incident HIV infection among men who have sex with men in the United States. *Journal of Acquired Immune Deficiency Syndromes*, 60(4), 421–427. <https://doi.org/10.1097/QAI.0b013e318256b2f6>
- Spinner, C. D., Boesecke, C., Zink, A., Jessen, H., Stellbrink, H. J., Rockstroh, J. K., & Esser, S. (2016). HIV pre-exposure prophylaxis (PrEP): A review of current knowledge of oral systemic HIV PrEP in humans. *Infection*, 44(2), 151–158. <https://doi.org/10.1007/s15010-015-0850-2>
- Standing Committee on Health. (2019, June). *The health of LGBTQIA2 communities in Canada*. <https://www.ourcommons.ca/Content/Committee/421/HESA/Reports/RP10574595/hesarp28/hesarp28-e.pdf>
- Tate, R. (2001, October 23). Thanks, but no thanks: Citing 16-year-old ban, the American Red Cross still won't accept blood donations from sexually active gay men. *The Advocate*, 22.
- Tran, N. Y., Charbonneau, J., & Valderrama-Benitez, V. (2013). Blood donation practices, motivations and beliefs in Montreal's Black communities: The modern gift under a new light. *Ethnicity & Health*, 18(6), 508–529. <https://doi.org/10.1080/13557858.2012.734279>
- Trujillo, J., & Hastings, L. (2018, June 15). It's 2018, and gay men still can't give blood in America. *The Nib*. <https://>

- thenib.com/it-s-2018-and-gay-men-still-can-t-give-blood-in-america
- Tscheulin, D. K., & Lindenmeier, J. (2005). The willingness to donate blood: An empirical analysis of socio-demographic and motivation-related determinants. *Health Services Management Research, 18*(3), 165–174. <https://doi.org/10.1258/0951484054572547>
- Valentine, K. (2005). Citizenship, identity, blood donation. *Body & Society, 11*(2), 113–128. <https://doi.org/10.1177/1357034X05052464>
- Valentine, K. (2016). Blood donation in Australia: Altruism and exclusion. In J. Charbonneau & A. Smith (Eds.), *Giving blood: The institutional making of altruism* (pp. 183–189). Routledge.
- Wittock, N., & Hustinx, L. (2019). Negotiating risk-group categorization and the co-production of blood safety: The evolution of sociotechnical imaginaries mobilized in the public debate on the deferral of men who have sex with men as blood donors in Belgium. *BioSocieties, 1*–31. <https://doi.org/10.1057/s41292-019-00161-9>
- Yanow, D. (1996). *How does a policy mean? Interpreting policy and organizational actions*. Georgetown University Press.
- Young, I., Davis, M., Flowers, P., & McDaid, L. M. (2019). Navigating HIV citizenship: Identities, risks and biological citizenship in the treatment as prevention era. *Health, Risk & Society, 21*(1–2), 1–16. <https://doi.org/10.1080/13698575.2019.1572869>

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