

Ethical challenges in voluntary blood donation in Kerala, India

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J Med Ethics 2007;33:140–142. doi: 10.1136/jme.2005.015644

The National Blood Policy in India relies heavily on voluntary blood donors, as they are usually assumed to be associated with low levels of transfusion-transmitted infections (TTIs). In India, it is mandatory to test every unit of blood collected for hepatitis B, hepatitis C, HIV/AIDS, syphilis and malaria. Donors come to the blood bank with altruistic intentions. If donors test positive to any of the five infections, their blood is discarded. Although the blood policy advocates disclosure of TTI status, donors are not, in practice, informed about their results. The onus is on the donor to contact the blood bank. Out of approximately 16 000 donations in the past 2 years, 438 tested positive for TTI, including 107 for HIV. Only 20% of the donors contacted the blood bank; none of them were HIV positive. Disclosure by blood banks of TTI status by telephone or mail has resulted in serious consequences for some donors. Health providers face an ethical dilemma, in the absence of proper mechanisms in place for disclosure of test results, regarding notification to donors who may test positive but remain ignorant of their TTI status. Given the high cost of neglecting to notify infected donors, the authors strongly recommend the use of rapid tests before collecting blood, instead of the current practice, which takes 3 h to obtain results, and disclosure of results directly to the donor by a counsellor, to avoid dropouts and to ensure confidentiality.

METHODS

There are two sections to this study: the first part is a quantitative study on TTI among donors, to find out how many of them test positive for TTI. The second part of the study is a qualitative component in which blood bank personnel are interviewed concerning the mechanisms in place to inform TTI-positive donors.

The authors collected secondary data for the period January–May 2003 from a blood bank attached to a large, tertiary care government hospital in Kerala. After conforming individual consent, the authors conducted extensive interviews with three blood bank personnel.

Similarly, they examined the practice in five large government teaching hospitals and one private tertiary care hospital, and had telephone conversations with the respective blood bank personnel.

The authors were advised that ethical review clearance was not necessary, as this was research carried out by students and did not involve human beings.

RESULTS

The total number of units of blood collected during the study period was 15 344. The blood was screened for five infections—namely, syphilis, hepatitis B, hepatitis C, HIV and malaria.

Contrary to NBP policy, we found that there is no mechanism in any of the centres studied, to inform blood donors regarding their TTI status unless the donors themselves come back to inquire. The voluntary donors whose blood was destroyed are oblivious of their status, and have the potential to transmit the infection to their partners. The NBP claims that donors will be offered the option of knowing their TTI status. But, in practice, the onus is on the donor to find out the results. Only 20% of donors contacted the blood bank that we studied. None of them was HIV positive. The prevailing practice was similar in all five government hospitals. The private hospital differed by having precollection testing but had no counselling services.

We received the following replies when we asked why were blood bank personnel hesitant about contacting donors.

Respondent 1:

Any communication from the blood bank is thought to stigmatise the donor, hence, we don't inform donors of their TTI status.

Abbreviations: NBP, National Blood Policy; TTI, transfusion-transmitted infection

Voluntary unpaid blood donors are the foundation of a safe blood supply because they are usually assumed to be associated with low levels of transfusion-transmitted infection (TTI), including HIV and hepatitis viruses. Voluntary blood donors consider themselves to be healthy, have no infections to their knowledge and come to the blood bank with the intention of helping someone. Therefore, they become a part of the health process through an implicit relationship. They deserve the right to be informed about the status of their test results and certainly so if their blood is unacceptable for any reason. In 2002, the Government of India adopted the National Blood Policy (NBP), also known as the "Action Plan for Blood Safety", to ensure an adequate and safe blood supply to its blood banks. The policy claims to bring about a paradigm shift in the disclosure of the donor's sero-status,¹ which was not permissible previously. A blood bank is the point of contact between the policy and the donor. This is where policy is converted into practice. The authors tried to explore the gaps and consequent ethical challenges that are encountered during this conversion.

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Received 16 December 2005
Revised 9 May 2006
Accepted 15 May 2006

Table 1 Break down of the results of transfusion-transmitted infection among donors

TTI	Positive donors (n)	Positive donors (%)
Syphilis	41	9.4
Hepatitis B	159	36.5
Hepatitis C	129	29.6
HIV	107	24.5
Malaria	0	0
Total	436	100

TTI, transfusion-transmitted infection. Blood found reactive to any one of the infections was destroyed in accordance with the existing guidelines.

Respondent 2:

A letter was once sent from the blood bank to a donor, about his results ... he attempted suicide ... we are worried about such reactions.

Respondent 3:

Sometimes donors don't give their full contact information.

DISCUSSION

A voluntary blood donor goes to the blood bank with altruistic intentions. According to the NBP, every donor should be counselled before blood donation.¹ But, in practice, this does not happen, as was found in another study in Pune, India.² Only 1 of the 128 blood banks in Kerala has personnel trained in counselling.³

The NBP, initiated in 2002, depends heavily on voluntary donors (95%). Utmost importance is given to safe blood, but the rights of donors, who are at the centre of the issue, are often overlooked and neglected. The blood bank has a responsibility towards donors, especially as regards information that their blood could not be used as intended. The NBP may have recognised the importance of such disclosure. This could be the reason for the paradigm shift in policy, according to which it is now deemed correct to inform donors of the status of their blood, which was not permissible previously. The dilemma of whether to tell or not-to-tell has finally been settled in the NBP by its decision to inform donors. But the problem of what-to-tell and how-to-tell still remains. Although the method of disclosure is the crux of the issue, it has to be adequately discussed in the policy. There is a mention that "In case the blood of the donor is reactive to any of the 5 tests, he shall be requested to visit the blood bank personally by simply informing him/her that some of the immediate results are not conclusive, and need to be confirmed".¹ The donors are not, as a rule, informed about the results. It is acknowledged that "as far as possible, the results never be communicated via telephones".⁴ Some blood banks "do write to donors whose blood is found to test positive, cautioning them not to donate blood. However, opinion is divided on the subject of intimating HIV-positive donors of their HIV status".⁵

Disclosure becomes even more tricky when the test result is inconclusive. With an HIV prevalence of 0.3% in the general population, Kerala is a "low prevalence" state. A single rapid HIV test would detect at least 50% of samples as false positive. Therefore, caution must be exercised during disclosure. Although blood can be labelled safe, it is risky to label any donor HIV positive with such a test result.⁶

Ethical challenges faced by healthcare providers

A doctor in India, under oath of service to the patient, declares, "The health of my patient will be my first consideration".⁷ Among all the interventions that have a pivotal role both in treatment and in prevention, HIV testing and counselling stand out as paramount.⁸ By not informing the donor, health providers are missing a chance to prevent transmission of the disease and start treatment if necessary.

In India, stigma, widespread ignorance about HIV and a total disregard for confidentiality and personal privacy make it difficult to inform the donor in confidence. Although it is the responsibility of the blood bank to contact the donor, there is anecdotal evidence about relatives receiving phone calls and blood reports, leading to ostracism and incidents of attempted suicide by donors. The current practice at blood banks is such that it takes 3 h to obtain results, and donors usually leave without collecting them.

CONCLUSIONS

This article underscores the importance of voluntary blood donors knowing their TTI status to protect their own health and reduce the risk of transmitting infections to their partners. By not having proper mechanisms in place for disclosure of test results, health providers face an ethical dilemma regarding notification of donors who may test positive but remain ignorant of their TTI status. Practices that violated national policy guidelines were found to be common in many states of India and this could have a detrimental effect on the ongoing fight against HIV. Methods of disclosure must therefore be carefully considered, without jeopardising the confidentiality of the donor and overburdening existing resources.

Recommendations

- To increase the acceptability and effectiveness of voluntary blood donation, the authors recommend that blood banks employ trained counsellors.
- Single rapid test kits should be immediately made available in all blood banks. This will enable blood banks to obtain results in 30 min, which is the average time spent by a donor at the donation site. Disclosure of results directly to the donor by a professional counsellor will facilitate retesting, avoid dropouts and ensure confidentiality.
- In case a donor wants to leave before obtaining results, blood bank personnel should request complete information regarding how he or she could be contacted in case confirmatory tests are required. Donors should also be informed that there is no need for alarm if the blood bank requests a retest.

ACKNOWLEDGEMENTS

We thank Dr J Mathai, Dr Sulochana and R Cash for their useful suggestions and Dr V Choppella for critically reviewing the paper.

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Competing interests: None.

A part of the paper was presented in the First National Bioethics Conference, Mumbai, India (25–27 November 2005).

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