University of Strathclyde

Advertising Research Unit

Director: Dr. D. S. Leathar

Department of Marketing

Stenhouse Building, 173 Cathedral Street, Glasgow G4 0RQ
Tel: 041-552 4400 Ext.
Secretary Ext.

THE SCOTTISH PUBLIC'S ATTITUDES TO BLOOD DONATION

Susan G MacAskill
Margaret Dickie
D S Leathar

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1.0 INTRODUCTION

The Scottish National Blood Transfusion Service (BTS) is currently examining the future role and use of mass media advertising. After internal review and on the advice of its advertising agents, the initial suggestion considered was to launch a new publicity campaign to 18-24 year olds, since intuitively it was felt that they would comprise the greatest source of potential donors. However, some concern was expressed about the nature of the proposed material, and also whether this emphasis might adversely affect support from older age groups.

In late 1982, the Advertising Research Unit (ARU) was asked to comment on the proposed strategy. Preliminary discussion highlighted the need for the BTS to set more stringent objectives for the campaign relative to its target group(s); and for it to ensure that the choice of both objective and target reflected objective evidence on their importance. Also discussed was the importance of having a detailed understanding of donors' and non-donors' motivations, in order to determine whether their needs and requirements could be fulfilled by a mass media approach, or whether some other strategy was required. Finally, it was also pointed out that mass media publicity should be incorporated into overall promotional and educational policies, which in turn required an integrated strategy towards all sectors of the public involved in blood donation.

In essence, the above requirements necessitated a deeper understanding of the public's attitudes towards blood donation than existed at that time, and the use of this understanding to determine the optimum communication strategy, if any, to persuade the public to increase their levels of blood donation.

In practical terms, this requirement corresponded to the first stage of an advertising research system developed by the ARU and applied to the mass media publicity of the Scottish Health Education Group (SHEG). The system, which has been applied to virtually all SHEG's major work in the last five years or so, comprises four research stages in the development and assessment of material.

'Problem definition' is the first of these, and essentially involves determining the number of 'important' groups within the public as a whole; their needs, attitudes, values and motivations; the extent to which they respond to particular communication strategies, and how easily; and the nature of complementary strategies necessary - for example, whether to change procedures at sessions to ease concerns or worries. Underlying all the data collected is the requirement to develop optimum communication strategies, although the research in addition usually provides a wide range of data of interest for other purposes.

The ARU was therefore commissioned to carry out this problem definition research project exploring the public's attitudes towards blood donation. The main objective was to provide information about the feelings and attitudes held by the public in Scotland about the donation of blood and the BTS. Full details of the areas explored are given in the next chapter, but basic issues covered included knowledge about blood and blood donation, feelings about the BTS and donor sessions, motivations underlying the donation and non-donation of blood, and awareness and reaction to current publicity material.

Details of the research procedures used are given in the next chapter. The principal findings are given in Chapters 3-8.

2.0 METHOD

This type of research can theoretically be carried out in two ways:-

(a) by quantitative research methods, usually involving questionnaires
(b) by qualitative research methods

In using questionnaires, one can ask about obvious dimensions, such as knowledge, actual behaviour, etc. In practice, however, with complex social advertising topics, answers to direct questions often fail to reflect the subtlety of emotion underlying them, and can lead to misinterpretation and misdirection. Often, apparently logical statements are given as explanations for an opinion, when in reality they might be rationalisations of views held for totally different reasons.

In view of these and other difficulties, it was considered that qualitative methods, which can go beyond conventional question and answer procedures, were more suitable for the type of research envisaged. They normally take the form of group discussions, and have many advantages. Areas are discussed rather than specific questions asked, and potential avenues for development examined. Furthermore, aspects considered relevant by the groups themselves are also covered, ensuring that the material discussed does not simply reflect the biases and preconceptions of the researcher and client. Topics can be explored by a variety of questioning techniques, if necessary repeated to assess consistency of opinion, and complex subjects such as imagery can be examined, since complicated questioning procedures are feasible. It is also possible to use such procedures to generate creativity, which can be useful in identifying new strategies for advertising.

It was thus decided that the research would take the form of 30 group discussions. Each group comprised between four and seven individuals of specified characteristics, as described below (2.1).

2.1 Sample

In selecting respondents to interview in qualitative research, it is important to remember that one does not necessarily select a sample that is proportional to population, but one that comprises all the important sectors within it, in order to identify the range of opinions that are held across the population as a whole. The objective therefore is to ascertain the range and depth of opinion held, rather than measuring its extent. This is achieved by structuring or 'quotaing' the sample by factors known or thought to be important in shaping relevant attitudes and behaviour.

Often, the selection of such factors or variables is a matter of some debate. They can be chosen on intuitive grounds; or on the basis of past research on the topic; or because of research or experience in related areas or in market research as a whole. In the present case, information on the socio-demographic characteristics of donors and non-donors in Scotland was not available, so on the basis of BTS advice, the assumption was made that they were fairly representative of the population as a whole. Other guidelines followed were that in market research in general, social class is an important factor to control, social groups ABC1 usually being interviewed separately from those of C2DE status; and that it is often useful to interview younger and older people separately. Other quotas often imposed (and followed in this research) are men v women, and regional variations, such as east v west or urban v rural.

On the basis of these and other considerations, the groups were structured by the following variables:

(i) Age

An interest in the age group of 18-24 year olds as a potential target group had already been expressed. They therefore had the largest representation in the sample (16 groups). The remaining age group of interest was 25-65 year olds, but ARU experience suggested that such an age span was too wide for meaningful discussion. It was

therefore divided into two categories, 25-44 and 45-65, with the former being of more interest as potential donors, and therefore with relatively greater representation in the sample (8 and 2 groups respectively).

(ii) Donor Status

This variable was of particular relevance to this study. After discussion with BTS staff the following definitions of donor status were agreed, for the purposes of this study.

- donor: someone who has given blood in the last two years.

- non-donor: someone who has never given blood.

- Lapsed and ex-donors: people who had given blood in the past but not for at least two years. It was intended that this category should comprise those who had actually decided not to donate again (ex-donors) and those who had merely not managed to do so within two years, for a variety of reasons (lapsed donors). However, it was not possible to make this distinction from BTS records, so these individuals were interviewed in the same groups. In the event, most people in the lapsed/ex-donor groups were lapsed donors rather than people who had consciously decided never to donate again.

Donors and non-donors were equally represented in the sample, ie 9 groups each. Of the donor groups, 8 had the normal restriction that discussants should not know each other, but the ninth group was composed specifically of donors who were friends, in order to facilitate examination of social motivation in blood donors ("Friendship" group).

A small number of groups (4) were made up of donors and non-donors, with the aim being to explore any potential conflict of attitudes that might exist. Such conflict groups are often revealing, in that they can highlight deeper emotions and complex attitudes and beliefs that conventional groups sometimes fail to identify.

Lapsed/ex-donor groups were also of interest in the research, as one hypothesis being considered was that it might be more profitable in strategy terms to concentrate on retaining existing donors rather than encourage new ones. Lapsed/ex-donor groups were therefore substantially represented (8 groups).

(iii) Sex

Men and women were interviewed in separate groups. In the absence of specific information about donor characteristics they were equally represented.

(iv) Social Class

As discussed, it is normal practice in market research to interview social groups ABC1 and C2DE separately. This facilitates more productive group interaction, and also helps highlight possible differences in social class values which have been identified as significant in previous research into health behaviour.

Again in the absence of information about donor characteristics, social groups ABC1 and C2DE were equally represented.

(v) Workplace/General Public

It was hypothesised that there might be differences in motivation between those who give blood at their workplace as opposed to at general public sessions. However, more factories are closing because of the recession, and workplace sessions are being reduced in number. To reflect this, a smaller proportion of such groups were interviewed compared with those donating at general public sessions (8 and 22 respectively).

(vi) West/East

Regional variations are of potential importance in a study of this kind. Most of the discussions were held in the Central Belt of Scotland with the general proportions of 2:1 West:East. However, the

BTS organisation is divided into five areas and so groups were also held in Inverness and Aberdeen.

(vii) Urban/Rural

It was suggested from BTS experience that differences existed in donation patterns between urban and rural locations, and interest was expressed in improving donation in urban areas especially. The proportions of 70% urban and 30% rural were therefore suggested and implemented.

Rural areas were defined as having a population of approximately 10,000 or less. "Rural" locations included Oban, Dalry and Inverkip in the West, and Forfar and Jedburgh in the East.

Overall, the total research sample was structured as follows:

	No of Groups	Variables
Age	15	18 - 24
	8	25 - 44
	2	45 - 65
	5	18 - 44
Donor Status	9	Non-donors
	8	Donors
	1	Donor (Friendship)
	4	Conflict (D + ND)
	8	Lapsed/Ex-Donor
Sex	15	Male
	15	Female
Social Class	15	ABC1
	15	C2DE
General Public/Workplace	22	General Public
	8	Workplace
West/East	19	West
	5	East (South)
	4	East (North)
	1	Aberdeen
	1	Inverness
Urban/Rural	21	Urban
	9	Rural

The location of the groups throughout Scotland was as follows:

West - Urban

General Public	Bishopbriggs	(2)
	Jordanhill	(2)
	Linwood	(1)
	Coatbridge	(3)
Workplace	Marland House (British Telecom) Glasgow	(1)
	Playtex - Port Glasgow	(1)
	WD & HO Wills - Glasgow	(2)
	Rolls Royce - East Kilbride	(1)
West - Rural	Dalry	(2)
	Inverkip	(2)
	Oban	(2)

East - Urban

General Public	Dundee	(2)
	Edinburgh	(1)
	Aberdeen	(1)
	Inverness	(1)
Workplace	Ferranti - Edinburgh	(2)
	Standard Life Assurance Company - Edinburgh	(1)
East - Rural	Jedburgh	(1)
	Forfar	(2)

The detailed composition of each of the 30 groups is given in Appendix 1.

2.2 Recruitment Procedure

Because of the range of interests within the research, recruitment of the groups took place in a variety of ways.

(i) General Public - Non-Donors

These groups were recruited by market research interviewers trained in qualitative research procedures, a procedure frequently used by the Advertising Research Unit for qualitative research projects. Selection was by means of a random route method, subject to normal rules and constraints (for example, respondents should not know each other, nor should they ever have attended more than three such discussions). A short questionnaire was used to help determine that individuals fitted the appropriate categories (Appendix 2).

(ii) General Public - Donors and Lapsed Donors

Because donors are such a small section of the population, the recruitment method for non-donors would not have been cost effective in their case. It was therefore necessary for the Organising Secretaries to provide lists of names and addresses of current and lapsed donors, chosen at random from existing records. These were then used as the data base for recruitment. The names were initially screened by BTS staff to ensure as far as possible that there were no unusual medical or social conditions which might make an approach difficult.

The information contained in the BTS records meant that names could be grouped within manageable geographical locations, and according to age, sex and donor status. However, information was not available about the social class of individuals. The lists therefore had to be large enough to allow for wastage when the recruiters tried to contact individuals of a particular social class.

Each person on the list was sent a standard letter about the research by the Organising Secretary for his or her area. The content was previously agreed by all interested parties and a copy is contained in Appendix 3. It advised donors briefly about the nature

of the research and asked for their co-operation. Those who did not wish to participate were asked to notify the BTS as soon as possible.

The lists, modified by the very few refusals which were received, were forwarded to market research recruiters working in appropriate areas. They made the final approach to the individuals, selecting them at random. A short questionnaire was used to establish that they fulfilled all required quota characteristics (Appendix 2). They then invited respondents to participate and gave details of the time and place for discussion.

In one rural area recruitment was carried out by a local BTS volunteer.

(iii) Workplace Groups

Suitable workplace locations were suggested by the Organising Secretaries, who made the initial approaches to management. Where co-operation was agreed, the researchers then liaised with appropriate staff to arrange recruitment. Most workplace donors were recruited during donating sessions, the remainder, together with lapsed and non-donors, being recruited at recreation locations within the workplace, usually the canteen. Again, a short questionnaire was used for screening purposes (Appendix 4).

2.3 Interview Content

As discussed in Chapter 1, the basic aim of the research was to explore attitudes and motivations towards blood donation, both among the public as a whole and particular sectors within it, and to ascertain future publicity strategies on the basis of this information. The group moderators were therefore given considerable flexibility on the aspects to explore, and allowed respondents to a considerable extent to determine their own priorities. However, to help the discussion leaders cover the subject in depth, a brief on possible content areas to cover was discussed and agreed with the BTS. This is given in Appendix 5 and highlighted such aspects as attitudes to health concepts; general attitudes to the BTS; perceptions about

giving blood, including factual knowledge; reasons for giving and not giving blood, and reasons for lapsing.

In the event, the interview content areas were amended and developed as the interviewing progressed. The specific content is thus best described in terms of the structure of this report, and this is given in detail below (2.5).

2.4 Interviewing Procedure

Each group discussion was led and directed by personnel experienced in this form of qualitative research. Four moderators were involved, two female and two male. Because it is desirable for group discussions to be held in an informal and relaxed environment, the majority were held in the homes of market research recruiters. However, some other locations were also used, depending on the group composition.

The following locations were used in total:

17 groups	-	recruiters' homes
5 groups	-	workplace situations - within working hours or at the end of work time
2 groups	-	BTS centres (Glasgow and Edinburgh)
2 groups	-	church hall
1 group	-	health centre
1 group	-	community centre
2 groups	-	Red Cross hall

The discussions usually lasted between one to one and a half hours. They were tape recorded with the knowledge of the participants, the transcripts providing the basis for the report. Interviews were conducted under the Market Research Society's Code of Conduct. This means the respondents were assured their comments would remain confidential and anonymous, analysed only by the researcher.

Expenses of £3 - £4 were given to General Public respondents and Workplace respondents interviewed outside their place of work.

2.5 Analysis of Material

The interviews were transcribed and the data analysed by the quota variables discussed above, eg age, sex, donor status etc. In the event, not all the variables were of equal relevance, some being much more important than others. The prime differences related to donor status, ie whether respondents were donors, non-donors or lapsed donors.

In contrast with most other areas of health education research, social class differences were not important: it was apparent that the degree of donor motivation was intrinsic to the individual and operated across all social classes.

Differences between workplace and general public sessions were apparent, but not as marked as those between donors and non-donors. More similarities could be seen between rural general public donors and urban workplace donors than urban general public donors and urban workplace donors, primarily in terms of group encouragement in donation. There was evidence of even apparently committed donors lapsing if their workplace donation situation changed, eg if they left a workplace visited by the BTS or if the BTS stopped coming to the workplace.

Differences between rural general public donors and urban general public donors were apparent in terms of feelings of group support and friendliness. However, non-donors in all areas gave similar reasons for not donating.

The report therefore discusses the principal findings from the discussions as a whole, in relation to the objectives of the research. An outline structure of the report is given below.

Chapter 3: Awareness And Knowledge of Blood Donation and the BTS

During the initial stages of the group discussions, respondents were encouraged to talk about their general awareness of the blood donation system in Scotland and elsewhere. The research then covered their knowledge of the Blood Transfusion Service in Scotland under three headings: function, structure and funding.

Prompted discussion of the function of the BTS was divided into four aspects: organisation of donation and collection, storage and distribution of blood. The BTS structure was explored in both geographic and organisational terms. The issue of BTS funding was also raised, as was its funding source. While funding was being discussed, some comments arose spontaneously on two other related issues. Firstly, the UK system of obtaining blood from unpaid volunteer donors; and secondly, the sale of blood to private hospitals. The final section of this chapter is concerned with an analysis of the BTS's image among the public. Projective techniques were employed to explore the underlying emotions and impressions held by the respondents.

Chapter 4: Attitudes Towards Donor Centres and Sessions

After the initial stages of the interviews had explored respondents' general awareness of the blood donation system in Scotland, the discussions spontaneously moved on to examining how blood was collected. Donor and lapsed donor groups were obviously able to discuss donating sessions in the light of their own experiences. However, non-donor groups were encouraged to discuss these issues as well, in order to explore their expectations. In this way it was possible to ascertain to what extent any misgivings they might have had were based on 'reality', or simply on misperceiving or misunderstanding what was involved. General feelings about donating sessions were discussed and this led onto the topic of the types of donating session organised by the BTS. These were:

- Donor Centres, both as a concept and a brief discussion of specific centres.

- 'Town Hall' sessions encompassing all the donating sessions that take place in local community halls, church halls and local town halls, both urban and rural.

- Mobile Donating Unit sessions that take place on the mobile BTS buses in some regions.

- Workplace Sessions; a small number of group discussions were held in workplaces with donors, lapsed donors and non-donors. These groups explored two particular issues. Firstly, their feelings about workplace sessions, and secondly the specific pressures to donate that might exist in this type of environment.

The discussions then covered the clinical procedure followed at the sessions, using the order followed there: initial screening and thumbprick test, donating procedure, the rest periods including refreshments, and the guidelines for behaviour after donation.

The final section of this chapter covers attitudes towards BTS staff at donating sessions. Both donors and non-donors discussed this area. Three aspects were explored - the occupations of the session staff, their treatment of donors, and their social class imagery.

Chapter 5: Knowledge of Blood

To serve as a background to later parts of the study, all respondents discussed their knowledge of blood. Several aspects were explored, namely:

- Storage of Blood. Issues such as basic awareness of blood storage and distribution were covered earlier in the discussions. This section explores respondents' knowledge of the storage process and some related aspects such as the length of time that stored blood remains usable and whether any is likely to be wasted.

- Testing of Blood. This is concerned with the testing of blood after donation but before use. The discussions covered respondents' awareness and knowledge of the testing process and their understanding of its purpose. As part of this the topic of blood groups was raised. Issues covered were the awareness and knowledge of blood groups, the advantages of knowing one's own group, and understanding of rare groups.

- Uses of Donated Blood. This section discusses respondents' knowledge of the uses of donated blood. A number of possible uses were mentioned and explored.

- Knowledge of Donor Requirements. The final area covered in this chapter is respondents' awareness and knowledge of the requirements potential donors have to fulfil before they are allowed to give blood. BTS specifications for weight, age, medical history and the required time between donations were discussed.

Chapter 6: Reasons for Blood Donation and Non-Donation

As an introduction to the examination of the factors which might influence an individual's decision whether or not to give blood, the respondents firstly discussed their general attitudes towards giving blood. The groups then explored views of 'typical' donors and non-donors to provide a further assessment of attitudes to blood donation and people who give blood. Factors which encourage the donating of blood were then discussed. This encompassed two major areas - initial stimuli to donate, and factors encouraging continued donation.

- Initial Stimuli to Donate. After exploring the general background factors underlying the desire to give blood, the discussions then examined the specific pressures triggering donation for the first time. These were group pressures, contact with illness requiring blood, a desire to serve the community, and a spur of the moment decision triggered by convenience.

- Factors Encouraging Continued Donation. Three main factors which encouraged continued donation were discussed. These were the continuing strength of the initial pressures, group pressures, and intrinsic rewards and satisfactions.

The chapter next discusses the factors inhibiting blood donation. All respondents were asked to discuss why they thought people did not give blood, and this section explores the major factors identified. Among the most important issues examined were the following: fear of needles, associations with hospitals/doctors, fear of the unknown, fear of 'something going wrong', other clinic fears, apathy, lack of convenience, and negative concepts about blood donation.

The final section in this chapter is concerned with lapsed donors, who were of considerable interest in the research. The fact that they had overcome the hurdle of the first donation, and indeed may even had donated several times, was considered to be of particular relevance in understanding donors' and non-donors' motivations. Three areas were explored in detail - reasons for lapsing, their attitudes to previous donating experiences, and lastly, their potential willingness to donate again.

Chapter 7: Awareness and Opinions of Current Publicity

A particular objective of the research was to assess donors', non-donors' and lapsed donors' awareness and opinions of current publicity on blood donation, and to relate this to their attitudes and motivations towards giving blood. In this way, it was hoped that the most relevant publicity themes, if any, would be identified, as would the role of publicity within particular strategies for expanding blood donation among the public as a whole.

The first section of this chapter covers respondents' awareness of current publicity on blood donation. This includes explaining and distinguishing between spontaneous and prompted awareness. At suitable points during the discussion, spontaneous awareness was measured by asking respondents whether they had seen any publicity material relating to blood donation and the BTS, and where it had been seen. After this, and always near the end of the session to avoid influencing responses about other aspects of donating blood, prompted awareness of BTS publicity as a whole and in detail was discussed. This included specific awareness of television advertising, poster material, session handouts, leaflets, newsletters and Christmas cards.

The final section of this chapter covers respondents' own spontaneous suggestions on useful approaches for encouraging blood donation. As the discussions progressed, both donors and non-donors showed a great deal of interest in the problem of how to encourage people to start and to continue giving blood. Suggestions included increased advertising campaigns, encouraging increased personal persuasion, and providing more information about blood donation.

Chapter 8: Blood Donation Segmentation

The concluding chapter of the report draws together the principal findings in relation to the objectives of the research. The first section of this chapter introduces the marketing principle of segmentation, and examines how this concept can be put into practice in the marketing of health and social concepts. The objective of social marketing segmentation is to identify those groups with the greatest potential, either in retaining their co-operation or in persuading them to act differently, and to optimise the resources spent. Equally, those groups most resistant to persuasion are also identified so that they can be avoided, or approached through some longer term strategy. The emphasis is on moving away from a generic strategy covering everybody, towards directing a particular strategy at those likely to be the most receptive.

This is achieved by dividing the public into groups on the basis of both their attitudes and behaviour towards giving blood, and highlighting their key characterisitics. Some of these groups or segments contain lapsed donors and their reasons for lapsing are related back to their initial motivations and attitudes, and procedures to overcome their reluctance to continue giving blood are discussed. There then follows some implications for the procedures followed at sessions - how people in each of the groups identified should be treated, important weaknesses in procedures, perceived fears and so on. Finally, comments are made on the importance of each group in policy terms, the general marketing strategy that should be adopted, and the role of communication within this.

2.6 Timing

The recruiting and interviewing took place during the period from 25 May to 14 September 1983. A verbal presentation of the findings was made on 7 October 1983. The issues were complex and writing the report was prolonged. Chapters were issued in draft form initially, prior to formal issues of the report.

3.0 AWARENESS AND KNOWLEDGE OF BLOOD DONATION AND THE BTS

During the initial stages of the group discussions, respondents were encouraged to talk about their general awareness and understanding of the blood donation system in Scotland and elsewhere. Many aspects were explored, such as knowledge of the process and its organisation, how blood is collected, opinions of donating sessions, and knowledge of blood. These and other aspects are discussed in this and the subsequent two chapters, before moving on to exploring basic motivations towards donation and non-donation (Chapter 6) and the role of publicity (Chapter 7).

The present chapter concentrates on examining awareness and knowledge of the blood donation system and how it operates. Three aspects are explored in detail:

- awareness of blood donation, and the organisation(s) responsible for collecting blood (3.1). This includes assessing both spontaneous knowledge of the organisation(s) involved, ie, ascertaining to what extent they are correctly recalled without prompting, and prompted awareness, ie the extent to which particular names or organisations are recognised when suggested.

- knowledge and understanding of the BTS itself (3.2),

- imagery of the BTS (3.3)

3.1 Awareness of Blood Donation, and Organisations Responsible for Blood Collection

Every person interviewed was aware that blood was collected in the community as a whole. To this extent, the concept of blood donation is widely and adequately established. Furthermore, virtually all donors and most non-donors were aware at a spontaneous level that there was a single organisation responsible for collecting it.

However, the characteristics of this organisation were often poorly understood (see 3.2 below), and there was also confusion about its name. No-one in any of the groups gave the completely correct title, The Scottish National Blood Transfusion Service. Instead, several names were put forward, some of which were very close to being correct:

- the Blood Transfusion Service
- the BTS
- The Blood Transfusion
- the BT
- the Transfusion Service
- the Service
- the Transfusion People
- them from St Vincent Street.

By definition, donors had attended a BTS session, so it is not surprising that they gave a more accurate range of names, most commonly quoting the Blood Transfusion Service and the BTS. Non-donors were in general less accurate, citing more alternatives. Many of these did not even approximate to the correct name, a finding reinforced by the fact that fewer non-donors than donors recognised the correct name when it was presented to them. A significant proportion of non-donors simply had no idea of the title of the organisation, merely giving general guesses such as 'the people who collect blood'.

This poor awareness of the correct title, even among donors, may or may not be an issue of concern, depending on BTS objectives. Certainly, there is usually little to be gained from having users of a service unaware of its precise title. On the other hand, the title was seen to be a complex one implying an element of formality, and it was the more formal elements, 'Scottish National' which were not recalled, rather than those suggesting blood donation.

Essentially, the decision as to whether poor recall of the correct title is an issue of concern or not will depend on two considerations:

- firstly, whether the incorrect name still adequately describes the organisation concerned. From the interviews it would appear that most donors recalled enough to identify the BTS and distinguish it from other health related organisations, but non-donors showed a confusion that a clearer title might, to some extent, help remove.

- secondly, whether one wishes to promote the organisation itself versus its functions, service and location. This will depend on the extent to which these are adequately known among the intended target, and this is discussed in detail below (Section 3.2 and Chapter 4).

In the meantime, it should be noted that if the BTS decide that more extensive promotion of the BTS title is required, then the 'natural' name as defined by the respondents' most common response would seem to be either 'The Blood Transfusion Service' or the term used in this report, 'the BTS'. The term 'Scottish' could prefix either, but the additional word 'National' was seen to be redundant, merely another expression of 'Scottish'.

3.2 Knowledge and Understanding of the BTS

This is discussed under three headings

- function (3.2.1)
- structure (3.2.2)
- funding (3.2.3).

3.2.1 Function of the BTS

Detailed understanding of the BTS's function was poor, with this usually described in general terms only, such as 'the organisation that collects blood'. Because of this, some possible functions were introduced by the group discussion leaders, and respondents invited to comment on those as appropriate. Four aspects were discussed:

- organisation
- collection
- storage
- distribution.

- Organisation of Donation: It was accepted without prompting that the BTS was likely to be responsible for organising blood donation among the community as a whole, but the exact nature of this function was vague and unclear. Upon prompting with alternatives, both donors and non-donors agreed that the BTS's responsibilities probably included the following.

  - organising and operating sessions, including responsibility for temporary and permanent centres, mobile units, and liaising with factories, offices etc.

  - providing administrative back-up for donating sessions, including the upkeep of donor records.

  - promotion and publicity, both in general terms and for specific sessions.

  - employment of staff, and specific on-job training for nursing staff.

It should be noted that although donors tended, on average, to be slightly more knowledgeable about the organisation of blood collection, primarily due to their experience of some aspects of the process, non-donors were still able to imagine the process reasonably clearly.

- Collection of Blood: This refers to the actual physical collection of blood from donors, and was assumed to be the BTS's primary function. Main responsibilities discussed were

  - the removal of blood from donors in a manner that was safe to their physical and mental health. This included 'scientific' testing to see if there was any medical reason for not

donating, such as anaemia, and also determining general suitability, eg age and weight.

- quality control of blood. The prime function of this was to ensure that the blood was safe for recipients, in particular that it was, in the respondents' own words, 'not contaminated or diseased'.

- proper treatment of donors, both physically and psychologically. This could encompass several dimensions, such as the need to make donation painless, offering reassurance, encouraging donors to return, and providing rewards - both physical (eg badges) and psychological (eg boosting feelings of responsibility).

- provision of appropriate equipment and facilities, including the proverbial cup of tea.

As might be expected, donors as a group described the process of collection in fairly precise and detailed terms. By contrast, non-donors gave a range of responses, running from ignorance on the one hand to quite detailed knowledge on the other. On average, though, they tended to be less knowledgeable, reflecting their lack of experience of the process.

- Storage of Blood: It was implicitly accepted that blood would have to be stored after collection, but this was not immediately seen as part of the BTS's function (especially by non-donors) until prompted. It was assumed that the blood was temporarily stored at the place of donation, but for how long was unclear. It was also thought that the blood was then removed to a centre, described as a 'Blood Bank'. This was felt to be probably located regionally, but no particular reason for this emerged, merely an implicit assumption that this would make distribution and use easier to organise. Finally, it was felt that the blood would be retained in the 'Blood Bank' for a certain period of time [the length of this was unclear, and is discussed more extensively below (Section 5.1)], before being distributed by the BTS, or destroyed (a view which tended to be

expressed more by non-donors than donors). There was no awareness at all of the exact location of regional storage facilities or laboratories, such as Law Hospital.

- Distribution of Blood: The physical distribution of blood was spontaneously mentioned as one of the BTS's functions by some respondents (mostly donors), but accepted by most only upon prompting. Distribution was defined merely as the transport of blood from the 'Blood Bank' to hospital, and was seen to be the responsibility of the BTS, not the hospital. Issues such as when, how and on whose initiative the blood was distributed to hospitals were unclear among both donors and non-donors.

3.2.2 Structure of the BTS

The BTS structure was discussed in terms of two criteria:

- geographic structure (3.2.2.1)
- organisational structure (3.2.2.2)

3.2.2.1 Geographic Structure of the BTS

Three aspects of the geographic structure of the BTS were explored - the geographic coverage, the regional structure and the location of headquarters.

- Geographic Coverage: Some differences were evident between donor and non-donor groups in their opinions of the BTS's geographic coverage, with non-donors in general showing greater uncertainty. The majority of discussants thought that the BTS was organised to cover the whole of Scotland. However, a minority (mostly non-donors) thought that the BTS was organised on a wider geographic basis than Scotland. Some of these respondents mentioned the UK, but others thought it was an international or a worldwide organisation. The geographic coverage of the BTS was never mentioned as being smaller than the whole of Scotland.

- Regional Structure: The collection and delivery of blood throughout Scotland is organised on a regional basis, Scotland being divided into five regions as follows:

- North of Scotland Blood Transfusion Service (Inverness);
- Aberdeen & North East Scotland Blood Transfusion Service;
- East of Scotland Blood Transfusion Service (Dundee);
- Edinburgh & South East Scotland Blood Transfusion Service;
- Glasgow & West of Scotland Blood Transfusion Service.

Perhaps not surprisingly, it emerged from the research that donors were much more aware than non-donors that the BTS was regionally organised. However, their knowledge of the exact regional structure was low. Few knew that five areas existed, and no donor interviewed could give the full title of his or her region (for example, East of Scotland BTS). Instead, regions were usually described in terms of the town or city responsible (for example, Dundee).

- Location of Headquarters: The topic of the BTS headquarters was introduced by the group moderators, as it did not spontaneously arise as an issue of interest or concern to any of those interviewed. The majority of respondents, both donors and non-donors, nominated either Glasgow or Edinburgh as the headquarters location. There was a marked tendency for those respondents in the West of Scotland to state that it was in Glasgow, with the St Vincent Street Donor Centre given as the location when specified. Conversely, those in the East of Scotland thought that the headquarters were in Edinburgh - Lauriston Place, the Edinburgh Royal Infirmary and Woodburn House were all cited as the specific location. Discussion groups in the Aberdeen, Inverness and Dundee regions tended to nominate either Glasgow or Edinburgh.

A few respondents, both donors and non-donors, gave London as the location. The remainder said they did not know. Throughout the discussions there appeared to be a tendency to guess at the location, which seemed to reflect the general feeling that this was an issue of little or no concern.

3.2.2.2 Organisational Structure of the BTS

In addition to discussing the BTS's regional structure, the groups also explored its relationship with other organisations or bodies. The consensus was that the BTS was part of the UK National Health Service. No respondent could be specific as to how the BTS was organised within the NHS system, however, the responses being both vague and uncertain. A few respondents in both donor and non-donor groups thought that the BTS was organised separately by the Government, outside the NHS, but again awareness was vague. There was no mention of the Scottish Home and Health Department, nor of the Common Services Agency - indeed, no-one interviewed had ever heard of the CSA, although the SHHD was known to a few.

No differences emerged between donor and non-donor groups, with both having equally low awareness and knowledge of this topic. As for the BTS's regional structure, its organisational structure did not seem to be an issue of concern to any of the discussion groups. The reason for this is probably that regional structure is likely to emerge as an issue of concern only if facilities and services are inconveniently located. This was not the case, as is discussed later (Chapter 4).

3.2.3 Funding of the BTS

3.2.3.1 Source of Funds

As part of the initial general discussion of the BTS, the issue of BTS funding was raised, usually on a prompted basis by the moderator. Following on from the previous section on organisational structure, where the consensus was that the BTS was part of the NHS, the NHS was also thought to be the source of BTS funds. No distinction was drawn between the Scottish Health Service and the National Health Service, nor was there any mention of financial support from local health organisations, the CSA or the SHHD.

> "It's all the one health service that's paying for it." (Donor)

Those respondents who had previously thought that the BTS was part of a worldwide organisation also concurred in nominating the NHS as the source of finance.

A small number commented on the level of funding received by the BTS. Where this was discussed, it was thought to be low.

> "It's the poor sister of the NHS, they appear to be left to their own devices." (Donor)

However, of the few respondents who were of this opinion, they tended to comment in general terms only. They offered no direct evidence to support their views, such as by citing comparable staffing levels, equipment or expenditure in other parts of the NHS.

During discussions of this point some comments arose spontaneously on two other related issues:

- the UK system of obtaining blood from unpaid volunteer donors (3.2.3.2);

- the sale of blood to private hospitals (3.2.3.3).

3.2.3.2 Volunteer Donors

Both the volunteer and paid donation systems received some support in the discussions, but the majority of non-donors and almost all donors expressed a preference for the voluntary system. This preference was based on a number of arguments. Firstly, it was argued that 'giving is its own reward'. Blood was donated for altruistic, humanitarian reasons; paid volunteers would be giving for the 'wrong reasons' (ie monetary gain). This aspect of donor motivation is also discussed in Section 6.4.

> "I think they might get more (donors), but that's getting away from giving your blood. You're giving it, you're not selling it." (Lapsed Donor)

> "You're giving for the money and not for the giving." (Donor)

Secondly, payment of donors would lead to recipients having to pay for blood to cover the costs involved, a situation thought to be undesirable.

> "I'd feel guilty about selling blood because obviously if you sell your blood, they'll have to get their money back some way, and they would be charging the people that take the blood." (Donor)

> "If they paid you for giving blood they would put more charges on someone else's prescription." (Donor)

> "Having lived in an African country where people don't have transfusion services of any type, it makes you realise how extra important it really is; when you have got to drag somebody off the street and pay them to give a pint of blood, it makes you realise how much we do take for granted in this country." (Donor)

Thirdly, it was argued that payment for blood donation could leave the system open to abuse from individuals who, for medical reasons, should not give blood, but nonetheless did so because they needed the money. This could result in 'poorer quality' blood being collected through over-donation, or ineligible donation. This could carry risks for both recipients and donors:

- recipients could get poor quality or 'unhealthy' blood:

> "Then you start getting things like AIDS*, people who're just not fit would be giving it just to get the money." (Donor)

> "You might have heard of the American problem, where for years now they've been paying for blood and as a result a lot of junkies, alcoholics and other people like that who are short of cash will give blood. The blood available for transfusion isn't as healthy." (Donor)

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* It should be noted that the AIDS controversy did not attract widespread media attention until after the research was completed. The issue is therefore not discussed in the detail that might otherwise be expected.

> "They're pretty strict now about your health when you're donating it. If it gets commercial they might start getting less and less careful about who they take it off." (Donor)

- the donors might damage their own health by giving too much blood too often:

> "When I was out in America they bought blood at five dollars, I think it was, and this guy donated three pints. When he was going out after giving the third pint he collapsed and had to be taken in and they had to give him a transfusion. God knows what he paid for it, but he probably paid more for the transfusion than he got for donating it. That's the kind of thing that happens when you start to make blood a commercial thing." (Donor)

> "In America there are some terrible cases: tramps giving 100% alcohol in their blood - giving pints and pints and killing themselves." (Non-Donor)

Two reasons were given by the minority of respondents who supported a paid volunteer system. Firstly, it was argued that payment might encourage more people to donate by acting as an incentive. In particular, unemployed people were thought most likely to be motivated by a monetary incentive, because of the financial pressure they might experience.

> "When I got the letter I started to talk to friends who do and don't go, and quite a few of them mentioned the money aspect. They said generally that people possibly would go if there was something given. They think it would be the young healthy people who would go - like the out of work and late teenagers etc." (Donor)

The consensus view, however, was that in general, payment would not attract enough new donors to compensate for the risks involved. This position is supported by the analysis of donor motivations to follow (Chapter 6), where it is argued that the decisions to donate and to continue to donate are complex ones based on the interaction of factors encouraging and inhibiting donation. The prime motivating factor is concerned with feelings of social responsibility and commitment, and donors without this tend to be more likely to lapse (see Section 6.6). It is doubtful if payment could compensate for

these feelings of commitment, and it is therefore likely to have an effect only when feelings are ambivalent, tipping the balance towards donation. In such a situation, negative feelings about donation would probably increase over time, thus leading to lapsing (see Section 6.6). The implication, therefore, is that payment is likely to attract only the marginal donor, and not retain his commitment.

Secondly, a small number of respondents made the suggestion that payment to cover travelling expenses to and from the donor centres might be beneficial. This again was thought to be of possible benefit, particularly to the unemployed.

> "If people are unemployed the cash is stretched pretty thin anyway, and if the cost of the transport locally is astronomical it would cost them a fortune. The last thing they'll spend it on is blood." (Donor)

However, the consensus position was similar as for payment in general - it would influence only the marginally committed donor and be unlikely to retain his or her motivation; advantages which would not compensate for the risks involved.

Finally, there was some evidence that, while payment was undesirable, some form of 'health credit' or voucher system might be acceptable.

> "There's more and more private health care now. If they need blood, where do they get it from? They get it from the National Health Service. I don't approve of actually selling blood - but when they're starting to put charges on things like prescriptions and dental care, if you have given a pint of blood, instead of actually getting money, they could give you credits. You could use it if you had to go to the dentist - instead of £10 you could give him two credits." (Donor)

> "A voucher system would be a good idea. If someone gives blood then you get vouchers for prescriptions or whatever, that you can cash in any time you go." (Lapsed Donor)

3.2.3.3 Use of Blood in Private Hospitals

The use of blood in private hospitals arose spontaneously in a few groups, but was not mentioned or introduced in most of the others. The reason for this was that there was some knowledge of the debate on the supply of blood free of charge to private hospitals, but this awareness was of a local nature as the subject did not receive national media news coverage until after the research was completed. Non-donors were generally less aware of the issue than were donors, possibly reflecting the latter's greater interest in the distribution of donated blood.

Of those who were aware of the issue, knowledge of the relative arguments was low. Few could describe the BTS's policy on the supply of blood to private hospitals, which was that non-profit making private hospitals had been supplied with blood for many years with no charge being made. In this regard, no distinction was drawn by the respondents between non-profit making and profit making private hospitals. They were simply referred to as 'private hospitals'.

Two alternative perspectives emerged on whether or not private hospitals should be charged for the blood they use. The first viewpoint was that blood should be given free of charge to those who need it, whether they are private or NHS patients. Of those groups who discussed the issue, the majority of respondents held this view.

The opposite position was that patients in private hospitals were paying for their health care, so they should also pay for the blood transfusions they received. Perhaps interestingly, this view was expressed by the minority.

In general in this research, though, the issue of providing NHS blood to private hospitals free of charge was not a matter of particular concern. However, this should not be interpreted as evidence supporting (or contradicting) current policy. The important issue is that opinions were expressed at the beginning of the controversy, and may well be different now. If this has indeed happened, and donors are against private hospitals being supplied with their blood free of charge, it should be noted that this is a change

of attitude triggered by media coverage and public debate, not through donors spontaneously changing their opinions of their own accord.

3.3 Imagery of BTS

Finally in this section is contained an analysis of the BTS's image among the public. An image as defined here is concerned with the emotional reaction or response to an organisation or the impression generated by it, in this case the BTS. It is made up of interacting components, one being the attributes of the organisation and the other being the characteristics of the respondent. The image that someone has of the organisation is therefore his "perception" of it, and this perception may or may not reflect reality.

As discussed in the original proposal, projective techniques are usually employed to explore underlying emotions and impressions (many of which the respondents will not be consciously aware of). In this research, the main technique used was 'personification'. This involved asking respondents to imagine the BTS as a person, and describing in as much detail as possible what that person would be like. The images that emerged from using this technique are discussed below.

In describing the BTS image, respondents universally saw it as female. She was thought to be in her mid-forties belonging to the upper middle class. She would be married and have two children. Her husband was thought to be a professional man in his 50's, typically a Bank Manager. They would own their house which was described as being an older type in a residential area. It was either detached or a bungalow with its own front and back garden.

> "They'd live in a posh area, in £30,000 houses or bungalows." (Donor)

Both husband and wife would own cars. His was described as one of the larger types of estate car, for example, a Volvo. The wife's car was smaller - a Metro or a Mini. She was not thought to read the popular press but rather newspapers like 'The Guardian' or 'The Scotsman'. Her television viewing would include most BBC2 and Channel 4 programmes, especially those concerned with health. Some

respondents felt that she would be unlikely to watch television at all. She would have many interests outside the house, especially being involved with the Church and local charity work. She was seen to be probably a member of the Woman's Institute or a Bridge Club, and to play backgammon. She had an interest in keeping fit and was sporty within limitations, probably attending a keep-fit class.

Thus a picture emerged of an upper middle class woman whose lifestyle was rather remote from that of the majority of the population. The woman was felt to be somewhat of a "do-gooder" and in some ways a bit "goody-goody".

In describing her personality a difference of opinion emerged. Some respondents thought that she was a 'nice' type of person who would be friendly and have a 'cheery face'. Others felt that she was more likely to be a rather 'frosty' type of person, slightly off-putting and not particularly friendly. The reason for this difference of opinion could be simply the respondents' differing perceptions of this type of upper middle class woman, as described above. Attitudes towards different social classes will vary with the individual's perceptions of their own social class, as this difference of opinion shows.

The overall image of the BTS was therefore seen to be very 'upmarket', which may well be viewed as an issue of concern. It does not mean, of course, that in donors' daily contact with BTS staff, they necessarily find them to project this image, and indeed as discussed in a later section (4.4.1) there was some evidence that they were not seen to be as 'upmarket' as first described. Equally, too, it has to be remembered that one is dealing with images and perceptions, not necessarily reality. Nevertheless, it is seldom advantageous in social marketing for an organisation to project an image that is substantially higher than the bulk of its clients or audience, especially if the latter's values are radically different from those perceived to be associated with it.

4.0 ATTITUDES TOWARDS DONOR CENTRES AND SESSIONS

After the initial stages of the interviews had explored respondents' general awareness of the blood donation system in Scotland, the discussions spontaneously moved onto examining how blood was collected. Four main aspects were explored:

- General feelings about donating sessions (4.1).
- Types of donating sessions (4.2)
    - Donor Centres (4.2.1)
    - 'Town Hall' Sessions (4.2.2)
    - Mobile Donating Unit (4.2.3)
    - Workplace Sessions (4.2.4).
- The clinical procedure followed at the sessions (4.3)
- BTS staff present at the sessions (4.4).

Donor and lapsed donor groups were obviously able to discuss donating sessions in the light of their own experiences. However, non-donor groups were encouraged to discuss these issues as well, in order to explore their expectations. In this way it was possible to ascertain to what extent any misgivings they might have were based on 'reality', or simply on misperceiving or misunderstanding what was involved.

4.1 General Feelings about Donating Sessions

This section deals with comments about donating sessions in general. Most of these are relevant to the reasons for giving or not giving blood, and are therefore discussed in detail in Chapter 6 on Donor/Non-donor Motivations. However, they are included here to give an overview of basic attitudes towards the sessions, and also to provide the context within which detailed comments can be judged.

One of the least surprising findings of the research was that donors and non-donors differed in their basic attitudes towards sessions. The former regarded them more positively, because of all their associations with the rewards and satisfactions derived from giving blood; the latter were more negative, primarily because they triggered all the reasons for not giving blood, especially those to do with deep rooted emotional fears. A possibly less obvious (and more relevant) finding, however, was that both donors and non-donors had positive and negative attitudes towards sessions, ie donors were critical of some procedural aspects, in addition to regarding others positively; and non-donors, despite all their reservations, still managed to see something potentially rewarding in them.

It seemed from the research that, in general, the more committed the donor, the more rewarding he or she found the process of donating, and consequently the more positively sessions were regarded. However, this was by no means always the case: some donors 'steeled themselves' to giving blood, and tolerated unpleasantness, anxiety and to some extent, specific fears for the sake of the benefits gained. As a result, while there is likely to be some general relationship between commitment and regarding sessions positively, one situation does not necessarily imply the other.

Instead, the importance of feeling positively (and negatively) disposed towards sessions, and its relevance to future donation, will vary from individual to individual, and depends on all the other reasons encouraging and inhibiting donation that exist at the same time. This is a complex issue, and is discussed fully in Chapter 6, but in the meantime it should be borne in mind that being positively oriented towards sessions does not necessarily imply continual commitment. Equally true, and possibly of more relevance, is the fact that being critical of sessions will not necessarily lead to the decision not to donate, at least in the short term. (The exact detailed relationship to lapsing is discussed in Section 6.6).

Bearing this in mind, it seemed that donors' positive feelings towards sessions derived from several sources. These are discussed fully in Section 6.4.2.3, but they included a sense of camaraderie at

the donating session; the psychological satisfaction of having given blood; the opportunity of participating in a 'nice' atmosphere; physical advantages, such as feeling better and having high blood pressure reduced; having a medical check-up; and having made a contribution to the stock of blood for their own potential use.

On the negative side, donors criticised several features of blood donation sessions. These included their:

- impersonality, especially through having to join 'factory production line' queues.

> "You go in, you get your card checked, then you wait in a queue to check your anaemia, then you get in a queue to check your weight and you're moving from one seat to another. I must have spent 25 minutes moving down these three queues." (Lapsed Donor)

- atmosphere, particularly in being reminiscent of hospital-like environments. White covered beds were especially mentioned.

> "It does look frightening when you see all these beds at one end and all the white mats." (Donor)
>
> "I don't like the size of the room. It looks like a hospital. It does look scary." (Donor)

- lack of privacy. This encompassed aspects such as embarrassment at climbing onto high beds, being near to strangers of the opposite sex, and revealing their fears to other donors.

> "You're afraid that you're going to show you're afraid to everyone else. Up at the University at the dental hospital they had a big room with lots and lots of beds in it and you see people you see every day and you think, 'God, I can't let them see me being afraid'. They'll be thinking someone else is afraid too. It's very impersonal as well. It needs a bit more privacy." (Lapsed Donor)

> "You could divide it into male and female. I'm not a sexist, but the last time I went in there was all men, and I had a dress on. I had to jump up on the couch and they were all workmen. They were making a joke and I felt so embarrassed. I just wanted to go away. I never had a screen around me. It was a big room. It was just all beds." (Lapsed Donor)

> "When I went in it was all young ones sitting round about me. I felt very old and I was more embarrassed because there was like men lying in beds beside you - that sort of thing. If there had been a woman I could have turned round and talked." (Lapsed Donor)

Again, it should be remembered that in judging the importance of these criticisms and comments, one has to bear in mind their relationship with other factors encouraging and inhibiting donation that exist at the same time. Their full implications and the extent to which they inhibit donation are therefore discussed later within their appropriate context, particularly how they relate to the rewards derived from donation (6.4) and reasons for lapsing (6.6).

However, the general point should be noted that while reservations about clinic procedures may not in themselves immediately inhibit donation, they will never enhance it. Because of this, the BTS should always attempt to minimise concerns wherever possible, even if these do not appear to be directly causing donors to lapse. If this is not done, the best that can be hoped for is that donors will tolerate them or regard them as inconsequential in the context of the rewards experienced. This is never likely to be satisfactory, because it puts the onus of dealing with them onto the donor rather than the system, and donors' attitudes and tolerance may change over time. (This is in fact what happens with some lapsed donors - see section 6.6). The implication, therefore, is that donor session procedures should be continually monitored and reviewed, and weaknesses removed wherever practicable.

Non-donors' views of sessions were largely negative, but also, as already discussed, not completely so. The prime expectation was that the session would be like a hospital, with all that this implied - white coats, white walls, doctors, machines, antiseptic, needles etc.

Often, these images triggered deep rooted fears of needles and intrusion into the body, and the implications of this are discussed in later sections (see sections 6.5.1 and 6.5.2).

> "It's just this preconceived notion of what it's going to be like. I've got a horrendous notion that I'm going to see all these white coats and white walls and big needles and things hanging up and the blood going into the bag. It's probably nothing like that." (Non-Donor)

On the positive side, however, the staff were thought likely to encourage donors to relax, and to talk to them as they gave blood.

> "You just lie there and they tell you to relax. Then you just sit looking at each other chatting about what they've been doing all day." (Non-Donor)

Even so, their white-coated image in the context of a hospital environment meant that irrespective of how friendly they might be, the overall impression was a negative one.

> "If I wasn't so frightened of hospitals it wouldn't bother me - the small room, the bed, white tiles, smell, antiseptic. They'd be friendly, it's not the people it's the atmosphere of the place." (Non-Donor)

In conclusion, therefore, discussion of general feelings about donating sessions revealed differences between donors and non-donors, as might be expected. Donors tended to be more positive, usually regarding sessions as relatively rewarding experiences, though not completely so. Non-donors were more negative, essentially equating blood donation sessions with hospitals, but they did concede that the staff were likely to be quite friendly and pleasant. However, the relative importance of these findings has to be judged within the context of all the factors encouraging and inhibiting donation, an issue discussed in depth in Chapter 6.

4.2 Types of Donating Session

The discussions on donating sessions in general led on to the topic of the types of donating sessions organised by the BTS. These were divided into four types:

- Donor Centres (4.2.1)
- 'Town Hall' type of session (4.2.2)
- Mobile Donating Units (4.2.3)
- Workplace Sessions (4.2.4)

4.2.1 Donor Centres

Two aspects of donor centres were discussed

- the concept, ie the idea of having a fixed as opposed to a temporary centre for blood donation;

- specific centres themselves.

- The Concept of Donor Centres. Most donors knew that such centres existed, although many had not actually given blood there themselves. Non-donors, however, were much less aware of them. Despite this, all respondents were able to discuss the idea, with those being unaware of the centres merely describing what they expected them to be like.

Two aspects were commented on favourably. Firstly, most donors and lapsed donors, irrespective of having attended, expected the physical environment to look less like the inside of a hospital ward, a position confirmed by most (although not all) of those actually using a centre. This was felt to be a potential advantage for first-time donors, by minimising the threatening connotations of clinical, hospital atmospheres, although it should be noted that for some actual donors, a medical environment was reassuring and even desirable (see Section 6.5.2.1).

The second potential benefit was a pragmatic one - donor centres offered the facility of not making an appointment, or having to donate on a specific day.

> "There's a Blood Transfusion Centre in Glasgow - did you know that? It's just by one of the main streets in Glasgow. You just go in and give blood, just pop in and give blood there and then." (Lapsed Donor)

To this extent, they were defined as 'convenient'. However, as is discussed later, it should be noted that inconvenience seldom emerged as a genuine reason for non-donation, often justifying or rationalising the decision made for other deeper reasons. The actual (as opposed to theoretical) advantage of convenience therefore has to be judged within the context of all the reasons for donating and not donating, an issue that is explored further in section 6.5.7.

No negative comments about the idea of donor centres were expressed by donors and lapsed donors. Non-donors' expectations were more negative, but they tended to reflect their feelings about not giving blood rather than the particular type of location used. They appeared unable to differentiate between donor and other types of centres, regarding them all as 'hospital type' environments.

- Specific Donor Centres. Virtually all donors and lapsed donors who were aware of donor centres were unable to name any centre other than their local one. The exception to this were a few who had moved from one region to another, but these were very much in the minority. Non-donors appeared to have little awareness of the names or locations of donor centres.

Few specific comments were made about donor centres, other than the following about St Vincent Street, Glasgow, Lauriston Place, Edinburgh and the Royal Infirmary, Aberdeen.

- St Vincent Street, Glasgow. This was mentioned specifically by a few donors as having a system that involved the donors going upstairs to the donating room and down again to leave. This was not thought to be particularly acceptable as people would have to negotiate the stairs while possibly feeling lightheaded after donating.

- Lauriston Place, Edinburgh. It was thought that the lounger beds used here were an improvement on those requiring donors to lie flat. However, one negative aspect mentioned by a few donors was that the signs outside the centre were not eye catching and could be easily missed.

- Royal Infirmary, Aberdeen. This was thought by a few donors to be difficult to locate in the hospital complex. There was also claimed to be a lack of signposting in the corridors leading to the donating rooms, and in the rooms themselves.

> "And when you actually get into the building to the rooms where they're giving blood there's no real signs saying 'sit there' or 'wait there'". (Donor)

In general, though, specific comments about particular centres (as opposed to opinions about procedures common to all, which are discussed below) were infrequent, the only issue of concern being signposting, which it may be useful to review.

4.2.2 'Town Hall' Sessions

The term 'Town Hall session' encompasses all the donating sessions that take place in local community halls, church halls and local town halls, both in urban and rural areas.

Non-donors in rural areas showed a higher awareness of local donating sessions than non-donors in urban areas. This latter finding is probably due to the smaller size of the local community, with there being more likelihood of seeing the halls and posters about donor sessions taking place. Possibly, too, it may be due to greater community involvement in blood donation, and more frequent informal discussion about it.

Donors expressed both positive and negative views about 'Town Hall' sessions. The positive comments concerned the atmosphere, which was thought to be more informal, friendly and relaxed than in other types of session. In rural areas especially, both donors and

non-donors thought that meeting people they knew at the sessions was or could be an important feature.

> "When you come in you normally find people you know. You get caught up in a conversation during the waiting time and the time passes fairly quickly." (Donor)

> "I go to the local hall and nine times out of ten you'll meet someone that you know - a neighbour or someone from work." (Lapsed Donor)

Three negative aspects of town hall sessions were, however, mentioned:

- speed of service;
- physical conditions of hall;
- screening of waiting area from donating area.

- Speed of Service. It emerged from the discussions on town hall sessions that there could be a problem with the waiting time involved before donating. Rows of chairs were set up to seat potential donors, but in some cases the number waiting was more than the chairs provided, forcing the donors to stand, or even queue outside. It was also mentioned that the queues depended on when the donor went to the session, some periods being quieter than others.

> "It can put people off if they have to sit and wait. If you've got something planning for that night you have to think if you've got enough time." (Lapsed Donor)

> "It depends when you come. If you are lucky and come early you can get in and out but I've seen the queue right down the path. So you can be half an hour before you get in the door, then there's the three rows of chairs." (Lapsed Donor)

> "It's very difficult to hit the time when they are quiet - to try and judge it for 5 or 8. The last couple of times I came down it was mobbed and I had to sit for one and a quarter hours." (Lapsed Donor)

Clearly, the implications are self-evident - forcing donors to inconvenience themselves is unlikely to encourage future donation, especially among those who are ambivalent or lack commitment.

- Physical Conditions. Some of the halls were also felt to be uncomfortable in physical terms. The lighting was a source of concern to a few donors who felt that the BTS staff might not be able to see what they were doing.

> "It's so dark in that hall, too. I mean, I walked in and saw the beds. It reminded me of an army hospital and that put me off too. It's so dark I don't know how they see what they're doing." (Lapsed Donor)

Complaints were also made about halls being cold and draughty, especially in winter. This was thought to lead to some degree of discomfort, both for the waiting donors and for those actually donating.

> "In the Town Hall especially in the wintertime, it's a big place. The doors are opening and closing, and you're maybe getting a draught." (Lapsed Donor)

- Screening. This concerned the screening of the waiting room from the area used for donation. A few donors and lapsed donors commented that they did not like being able to look at others giving blood while they were waiting. This appeared to be connected with the fear of seeing blood, the specific implications of which are discussed in a later section (6.5.5). These respondents suggested that it would be preferable to have some kind of physical screening barrier to separate the waiting and donating areas. This was thought to be of particular benefit to those waiting for considerable periods, when fears could build up.

> "I think possibly the idea of having the area where they're actually withdrawing the blood from you in the bag is something which could be screened off. It prevents people from being squeamish in that way. If they're sitting waiting and watching, they're totally petrified by the time it's their turn." (Donor)

Non-donors did not express any specific expectations about Town Hall sessions, being unable to distinguish these from any other type.

Overall, therefore, Town Hall sessions were praised for being friendly, relaxed and informal, but they also elicited critical comment in three areas - length of waiting time, physical environment and screening. While physical conditions may be difficult for the BTS to control, particularly if it is dependent on the co-operation or goodwill of hall owners, changes to waiting procedures and screening could be usefully considered, and potentially advantageous to implement.

4.2.3 Mobile Donating Units

This section discusses the sessions that take place on the mobile BTS buses. These are used for some workplace sessions, and sometimes for the general public. Not all regions operate these buses, so awareness was lower in some parts of the country than in others. However, awareness was high where they were used, both amongst donors and non-donors. This seemed to be due to the buses' visibility when parked in a town centre or urban shopping centre.

There was a generally favourable response from those who had donated in mobile units. Particular comments were made about their organisation and atmosphere. Organisationally, they were felt to be well designed, allowing staff to work efficiently in the compact area.

In terms of atmosphere, the smaller size of the bus was thought by some donors to create a better environment than occurred in other, larger sessions. This was expressed in terms of more contact with the staff, and with other donors. Donors therefore tended to think they were more of an individual than one of a crowd, as could occur elsewhere. In this way the sessions were said to be more 'personal'.

> "I quite liked the bus. It was very compact they way they worked it. I felt it was more personal than going into a big place." (Lapsed Donor)

However, a small number of donors and lapsed donors criticised two aspects of the buses. Firstly, the waiting time before donation could be a problem, with donors having to wait in the street outside. This was felt to be due to the small number who could donate at any one time because of the limited space available. Secondly, the operating hours were regarded by some donors as too restricted. This could lead to problems of inconvenience, and also to queuing.

> "I used to donate to a mobile bus and there's maybe 250 people there, but it was only there for one day and the hours were that restrictive. By the time they'd set up and then dismantled the equipment they'd only done about 125 people and there'd be people queuing outside the bus, maybe during their dinner, and they'd no chance of getting in to give a pint." (Donor)

> "The van on the street closes from 12 to 2 pm which I think is ludicrous. That's when all the shops and works are out for lunch. They'd catch more people then." (Donor)

As for the other types of sessions, non-donors did not express any specific expectations about mobile units.

4.2.4 Workplace Sessions

A small number of group discussions were held in workplaces with donors, lapsed donors and non-donors. In addition to discussing all the other aspects covered in this report, these groups explored two particular issues: firstly, their detailed feelings about workplace sessions (4.2.4.1); and secondly, the specific pressures they experienced to donate in this type of environment (4.2.4.2).

4.2.4.1 General Feelings about Workplace Sessions

On the general issue of workplace donating sessions, donors were unanimous in their positive reaction to this type of session. There were three main reasons for this:

- friendly, relaxed atmosphere;
- convenience;
- time off work.

- Friendly, Relaxed Atmosphere. The workplace sessions were thought to have a relaxed and informal atmosphere. Two factors contributed to this. Firstly, the BTS staff were mentioned as being friendly, chatting to donors as they gave blood. Secondly, the atmosphere was thought to be relaxed. The donors were likely to know one another, and could chat to each other while waiting to donate, and during the session itself. This informal chatting, and in particular the repartee, was thought to contribute greatly to the overall atmosphere.

> "I think it's better in works where you can have a joke. One of the men will come in and say, 'move over Anne Marie I'm coming in beside you'. That makes the atmosphere a bit better."
> (Lapsed Donor)

- Convenience. Three aspects of convenience were mentioned - the proximity of the sessions, not having to plan when to go, and being reminded when they were taking place (especially through posters at work, and from other staff). These three factors gave workplace sessions the advantage of enabling people to donate with a minimum of effort or inconvenience.

> "I go from my work. A bus comes from Glasgow about twice a year. It's better at work, it saves time." (Donor)

> "I need to be sent for. It suits me because I'm working all day and have a family. It suits me to give during working hours." (Donor)

- Time Off Work. Being allowed time off was felt to be a benefit of workplace sessions. Going to give blood was said to break up the monotony of a working day.

> "It's a half hour off work with a cup of tea, and a biscuit afterwards." (Donor)

> "It breaks the monotony - tips the balance over whether you would go or not." (Donor)

Other specific benefits of workplace sessions, such as generating a good public image for the company, were not mentioned. On prompting

by the moderator, this specific view was said to be unimportant. There were, however, two negative aspects mentioned:

- queuing
- being turned away due to lack of time.

- Queuing. This was reported by some donors as an occasional difficulty. The waiting time before donation was thought to be too long, interfering with work scheduling. This could cause problems, particularly if donors were allocated a specific time by their supervisors and sessions 'ran late'. The reasons for this were usually attributed to be 'normal' ones associated with donation, such as difficulties in taking blood, dealing with sensitive donors, rather than poor organisation by the BTS. Even so, the problem should be borne in mind, and minimised wherever possible.

- Being Turned Away. Some donors reported problems of being turned away at the end of the day due to a lack of time before the session ended. Needless to say, this did little to encourage future donation, and is an issue that should be dealt with by staff as sensitively as possible.

Non-donors made both positive and negative comments about their expectations of workplace sessions. On the positive side, the convenience was mentioned, specifically that giving blood at work would be 'handier' in terms of both time and proximity of sessions. However, the fact that non-donors had still not given blood in such situations might suggest that inconvenience is unlikely to be the key reason for not donating. (This is indeed the case, as is discussed below in section 6.5.7).

It should also be noted, however, that this does not mean that convenience is irrelevant. For marginally committed donors, and non-donors possibly about to donate for the first time, it may well tip the balance. It is also an important issue for committed donors - there was little to indicate that most donors will actually inconvenience themselves to give blood.

On the negative side two aspects were discussed. Firstly, there was the fear of a hospital-like environment. Specifically mentioned were the smell of antiseptic, the instruments and the uniforms worn by the staff. However, there was little to suggest that these reservations were unique to workplace sessions, being instead more general expressions of fears associated with giving blood.

The second negative aspect was connected with a fear of the sight of blood. This was frequently mentioned by non-donors, who had the expectation that they would see the blood bags hanging by the beds. They claimed that this would make them squeamish and afraid.

> "The thought of seeing blood puts me off. It's just horrible." (Non-Donor)

Again, however, this should not necessarily be interpreted as a specific comment about workplace sessions - it is more generalised than this, reflecting broader attitudes towards donation. Nor should it be taken as indicating the main reason for not donating. Not giving blood is seldom due to a single factor, and the sight of blood on its own is not necessarily a key element. Instead, it is what it represents that matters, such as fears of needles and intrusion into the body (see Section 6.5).

4.2.4.2 Pressures to Donate in the Workplace

This is a particular aspect of the workplace environment where, because of the relatively high numbers of people donating, there might be more that the 'normal' pressure on non-donors to donate. This was explored in detail in the workplace groups. Many donors stated that they had initially been motivated to donate when in the workplace environment. They reported that hearing the subject discussed and being able to ask questions about the procedure encouraged them to donate. Another factor was that they could go along to the session with their workmates, which to some extent reduced their fear of the unknown. The regular appearance of the BTS at work also enabled them to acquire the donation habit easily. There thus existed a set of

practical circumstances that tended to make first time donation easier than it might have been elsewhere.

However, some donors also stated that they had felt specifically pressurised into donating to some extent. The Armed Services seemed to be a situation where considerable group pressures existed. Non-donors were labelled as cowards and laughed at.

> "I felt a coward - everybody was sort of laughing at me, saying, 'She's a big coward.'" (Lapsed Donor)

> "In the Royal Navy where I started if you didn't give they went, 'ha! ha!', you know. So everyone gave blood." (Lapsed Donor)

Some care should be taken in interpreting the role of pressure in workplace situations. While some donors did feel that pressure existed, non-donors and lapsed donors stated that they did not feel under any pressure from their workmates or superiors. It is possible that this was not recognised, but it is equally possible that it was tolerated or ignored, or even resented. Pressurising non-donors will therefore not necessarily lead to donate, and may even be counter-productive. The implications of this are discussed below in Chapter 6, but it should be noted at this stage that motivation to donate and to continue to donate is not simply a function of being asked or forced to do so, and that without other basic motivations, especially that of feeling socially or morally committed, the longer-term prospects are poor. (This has particular implications for lapsing, in that those who lapse have often been temporarily pressurised without having any basic commitment to donate - see Section 6.6).

4.3 Clinical Procedure Followed at Donating Sessions

The discussion of the clinical procedure follows the order of the procedure at sessions:

- initial screening procedure and thumbprick test (4.3.1);
- donating procedure (4.3.2);

- rest period, including tea/coffee/soft drinks (4.3.3);
- the guidelines for behaviour after donation (4.3.4).

Clearly, those with experience of blood donation were the prime group of interest in researching these issues. However, non-donors also discussed this topic in the light of their expectations. Where possible, therefore, the differences between donors' experiences and non-donors' expectations are also examined.

4.3.1 Initial Screening and Thumbprick Test

Two aspects are discussed.

- Comments about clinical procedures (4.3.1.1)

- Implications for donors rejected at this stage (4.3.1.2). Donor requirements and comments on these are discussed in a later section (5.5)

4.3.1.1 Procedures

- General Comments. The initial screening consists of prospective donors being asked to read a form which lists various diseases, illnesses and inoculations. The BTS staff then ask questions relating to this form, and also whether the prospective donor is on any form of medical treatment or is attending the Doctor for any reason. Recent ear piercing and tattooing are also enquired about. As part of this initial screening process donors' age and weight are checked where the BTS staff think it necessary. There was no evidence that donors resented being asked their age (see Section 5.5.2) or being weighed (see Section 5.5.1). Although most donors did not report any difficulty with this screening process, some negative comments arose concerning four aspects:

- Recall of Medical History. There were some comments that it could be difficult to recall past medical history, and that relying on the individual's recall rather than 'objective' testing left the system potentially open to collecting 'diseased' blood.

> "I mean, when you walk in and you get that questionnaire stuck in front of you, 'have you had such and such?' Half the time you can't remember what you've had and what you've not." (Donor)

- Speed at which the Questions were Asked. It was mentioned that the staff sometimes asked the screening questions too quickly, which led to the donors finding it difficult to keep track of what was being asked.

> "They go through it that quick - I'm just saying, 'No, no, no, no', and I don't know what she's saying to me." (Donor)

- The Possible Abuse of the Screening System. It was also felt by a very small number of donors that much was left to trust in this procedure and that the system could possibly be abused by 'fanatical' donors not admitting to certain diseases. However, this was only mentioned as a possibility by a very few people and none of them had any experience of donors not admitting to a medical condition.

- Queuing. Some lapsed donors reported problems with long queues before going through the screening procedure.

> "It's like musical chairs. You just sit and then you're moving along and moving along. It's not a very good set up that way." (Lapsed Donor)

Committed donors also commented on this aspect, but were prepared to tolerate it themselves for the benefits of giving blood. They did, however, regret it for the sake of others, especially sensitive first time donors.

- Thumbprick Test. As part of the initial screening process donors are given a thumbprick test which involves a needle being put into the thumb to extract some drops of blood. This blood is then used in an instant test for anaemia. The majority of donors and lapsed donors were aware of the purpose of this test.

The subject of the thumbprick test elicited a surprisingly strong negative reaction from both donors and lapsed donors. This test was generally disliked, and was thought to be more painful than the insertion of the needle when donating. This reaction did not appear to be connected with a fear of needles, simply with the pain involved.

> "It's the worst bit." (Donor)

> "I think it's antiquated. They have this bit of paper and they burst it and there you are, you get this needle. The number of times it's hit the bone in my thumb. When that's over, they can stick a hundred needles in my arm, I couldn't care less. It's the worst experience." (Lapsed Donor)

The introduction of the 'stapler' type of spring loaded needle was mentioned by some donors. This was regarded as an improvement as the person did not know quite when to expect the prick in the thumb. No other improvements were mentioned.

There was little awareness of the thumbprick test amongst non-donors, and of those aware of it, it was not an area of concern.

4.3.1.2 Potential Donors Turned Down at the Screening Stage

The purpose of the initial screening of donors and the thumbprick test is to check that donors are eligible to give blood. Those who are ineligible, for whatever reason, are then told that they cannot donate. In order to follow the sequence of donating sessions, this stage is discussed next.

In some of the groups, comments arose spontaneously about potential donors being turned down after the initial screening. When this happened, it often created feelings of rejection, anticlimax and disappointment.

> "I felt disappointed because I was sitting for so long and I'm the one who tells the family that they should all come down- at least I'm going. I was the one that was always in and out of hospital yet I was proving to them - I'll go and give blood and show the rest of them. But they never took me." (Lapsed Donor)

> "I was quite brokenhearted when I had to give up but I thought there's not much point in me taking iron tablets and giving blood." (Lapsed Donor)

It was also reported that there was a lack of information and advice about the reasons for rejection. In particular, complaints were voiced that not enough detailed explanation was given as to why they had been rejected, and that inadequate advice was offered about whether or not they should donate in the future. The advice given by the BTS was also said to lack consistency (see Section 5.5.3), as policies could vary from region to region. The majority of those turned down mentioned that they had been offered a cup of tea, and this was thought to lessen in some way the feelings of rejection.

In the light of these comments a useful practical strategy would be for the BTS to enforce the policy of offering refreshments to those rejected. Perhaps more fundamentally, it is clear that rejected donors have to be treated with sensitivity, and adequate information given as to why donation is inadvisable and whether blood can be given in the future. In particular, it is vital that donors and potential donors do not leave the sessions with feelings of rejection and failure, especially as the decision to attend may well have involved considerable emotional commitment and effort.

4.3.2 Donating Procedure

This section discusses donors' experiences of giving blood. Non-donors also explored this issue, giving their expectations about the process. From the discussions it emerged that both donors and non-donors were mainly concerned with two aspects - the insertion of the needle and the side effects of donating.

- The Insertion of the Needle. While most donors knew that a local anaesthetic was administered to numb the area where the blood was taken from, some donors were actually unaware of this, as were most non-donors. At first sight, this lack of awareness among non-donors of the use of local anaesthetics might be interpreted as

the key reason why so many non-donors expect the process to be painful (see 6.5). However, as discussed later (6.5.1.1), this interpretation is too simplistic - the fear of pain and needles is based more on emotional beliefs that the process 'must' be painful than on the absence of 'objective' knowledge. Promoting this information may therefore achieve less than might be intuitively expected, unless it is within the context of resolving emotional fears and providing reassurance as well, possibly through personal contact.

Although the majority of donors had no serious complaints about the actual process of giving blood, problems did occur for a minority. These ranged from occasional experiences of discomfort, to staff having to make several attempts at inserting the needle, sometimes causing considerable discomfort and concern to the donor. Some donors felt that this discomfort was directly due to the doctor.

> "I've had the occasional experience of discomfort with the actual insertion of the needle - nothing dramatic." (Donor)
>
> "Sometimes there's a little discomfort with the initial anaesthetizing of the area." (Donor)

However, it was also stated that session staff did attempt to help these donors and those who were scared of needles by asking them to turn away at the moment of insertion.

- Side Effects of Donating. These are discussed under four headings:

  - bruising;
  - bleeding;
  - fainting/dizziness;
  - tiredness.

- Bruising. This was given by many donors as a side-effect of donating. Some stated that bruising always happened; for others, though, it occurred only occasionally. Most did not attribute any specific cause to their bruising, although a few blamed 'clumsy' doctors.

"Once they put the needle in my arm quite rough and I had bruising from my wrist up past my elbow and that put me off as well, but I think it was just because the person was rough." (Lapsed Donor)

"I've given five pints of blood and the last time I went there was a right carry on. I woke up with a sore arm the next day because they had a carry on getting the needle into the proper vein in the right angle. I must have been there for about an hour and they got about half a pint out of it. It was an awful carry on to get it and it put me off. My arm was sore for two or three days after it." (Lapsed Donor)

Some non-donors were aware that bruising was a possible side-effect of donation. However, this did not appear to be a factor that on its own inhibited donation (see Section 6.5).

"It's the bruises it leaves, I've seen right marked arms." (Non-Donor in Conflict group)

- Bleeding. Bleeding from the arm after the needle had been removed was mentioned by some donors as a side-effect. However, it was said by those involved to be an unpleasant inconvenience rather than a major cause for worry, as it could be controlled by using bandages.

"I had given the blood and as usual I went to take tea. I must have put my elbow down at the wrong time and of course the next thing I looked and there's blood coming all over the sleeve. I was immediately rushed back and laid down again. I came out with a bandage like this (big) it was criss-crossed. But that was the only time. They said it was just one of those things." (Lapsed Donor)

"I needed packing up once. It didn't bother me though. I went to take my tea and the next thing thing there's blood all over the floor. It started to drip and they just bandaged it up. I didn't faint or anything. It didn't really bother me but it depends on the person. Some people pass out at the sight of blood." (Donor)

Although donors tended to tolerate the unpleasantness of bleeding and bruising, the possibility of the arm continuing to bleed was a point of some concern for a few non-donors. They appeared to think that the bleeding might be uncontrollable, possibly even resulting in too much loss of blood. Some reassurance that this is unlikely would therefore be beneficial, although it should be noted it may be more difficult to persuade non-donors of this than might be intuitively expected. The reason for this is that the fear is as much if not more emotional as rational, and what may be objectively true for the majority may not necessarily be seen as true for the individual regarding him or herself as the exception.

This raises the deeper problem of the extent to which emotional fears can be resolved through the presentation of objective, factual arguments, such as through the Noel Edmonds type of advertising approach. This issue is discussed more extensively in Chapter 7. In the meantime, however, it should be noted that the provision of information alone is only a part of the approach, and that emotional reassurance is likely to require a wider strategy integrating factual information with personal, face-to-face contact and discussion.

- Fainting/Dizziness. This possible side-effect was mentioned by more non-donors than donors. In the case of donors, they generally attributed these feelings to the fault of the individual, for example, getting up off the bed too quickly, or to a purely psychological reaction to their first experience of donation.

> "It's usually people who get up too quickly or something like that. If you've gone through the experience before and know what you're doing it doesn't seem to bother folk." (Donor)

> "I nearly fainted the first time I gave blood, I felt dizzy. It's just psychological as it's never happened since then, but I had to lie down." (Lapsed Donor)

"One of my pals gave blood and after he'd given it the nurse told him to lie down. He lay down for a couple of minutes, and stood up and his knees gave. He got up too quick and didn't give himself time." (Non-Donor)

Slight feelings of lightheadedness were commonly reported by donors, and some non-donors were also aware of this. However, this was seen as a very minor side-effect and not as a cause for concern in any way.

"You feel a wee bit sort of lightheaded."
(Donor in Conflict group)

Non-donors also regarded fainting/dizziness in these terms, but in addition saw it as a possible reaction at an earlier stage of the process, where it could be due to the sight of blood or the needle used. These views tended to be reinforced by this actually happening on other occasions, for example in hospital or at the doctor's surgery.

"Any time I've been in hospital or been anyplace where they need to take a sample of blood from me I always pass out. The last time I passed out twice. If that's what happens when they take a small sample I don't think I could possibly give a pint." (Non-Donor)

- Tiredness. A slight feeling of tiredness or feeling a little weak after donating was very common amongst donors, and was mentioned as a possible side-effect by some non-donors. However, neither donors nor non-donors regarded this side-effect as a cause for concern.

"Slightly drained feeling for an hour or so."
(Donor)

"My first time I felt a wee bit tired after it."
(Donor in Conflict group)

"He said after it you feel a bit weak but once you've had your cup of tea you are OK."
(Non-Donor)

In conclusion, physical discomforts tended to be tolerated by the majority of donors, because they were outweighed by the benefits of donation. They were, however, regretted to some extent, primarily for the sake of more sensitive donors, especially those giving blood for the first time. Later analysis of the reason for lapsing (Section 6.6) confirms that this is indeed a relevant issue, since many lapsed donors were more critical of clinical procedures than were donors. These complaints more often took the form of minor generalised concerns about these and other aspects of donating rather than being directed towards a single issue such as bleeding or bruising. However, it should also be noted that there was a small minority of donors, even fairly committed ones, who had decided to stop donating because of specific clinic experiences (see Section 6.6).

4.3.3 Rest Period

The next part of the donating procedure to be discussed is the rest period after donation, including the provision of tea, coffee or fruit juice. The rest period consists of two parts; firstly, the rest on the donating bed after donation. This was described as "normally five minutes". The second part when donors take a refreshment in an area set aside for that purpose. This was claimed to last for "about 15 minutes".

The rest period seemed to be accepted by the respondents - both donor and non-donor - as a necessary part of the donation process. It was thought to be necessary for two reasons. Firstly, it was felt to have physical benefits for the donor. Slight feelings of lightheadedness was a commonly reported side-effect of donation, and this was eased by a short rest.

> "They probably feel a bit lightheaded afterwards, but they get a wee break and a cup of tea." (Non-Donor)

> "I know they give you time to rest after you have given blood to make sure you don't feel dizzy." (Non-Donor)

Secondly, the rest period was also seen by some donors as a chance to relax if they were nervous during the donation process, and as a result was felt to be of psychological as well as physiological benefit. The rest period also serves the purpose of allowing BTS staff to keep a close watch over donors in case of any side-effects, for example, fainting or bleeding. However, this benefit was not mentioned by respondents directly, although in general they stated that they felt reassured by the presence of BTS staff in case of any difficulties.

Part of the rest period involving the provision of a cup of tea/coffee or fruit juice. Three aspects of this were discussed. Firstly, some donors and most non-donors appeared to think that the tea or coffee was in some way a reward for giving blood; a way for the BTS to say, thank you for donating. As already discussed, this service could be expanded to include rejected donors as a means of slightly lessening their disappointment, and thanking them for attending.

Secondly, some donors and a few non-donors saw the refreshments as a means of enforcing the rest period after donation, giving donors a chance to sit quietly for a short while before leaving the session. Thirdly, a few donors thought that the purpose of the drink was to help replace immediately some of the fluid lost in the blood donation. This latter function was not mentioned by non-donors.

In discussing this part of the donating process no donors stated that they did not want tea or coffee after donating, all seeming happy to have the refreshment for the various reasons described above. Similarly, non-donors did not express any reasons why they would not want refreshments. However, a small number of donors mentioned that they wondered why first-time donors were only offered cold drinks, and not offered hot drinks.

No comments arose about the cafeteria area itself in this discussion. However, the member of the BTS staff who served the refreshments was given special mention by a few donors. This 'tea lady' was said to be the nicest of the BTS staff, very friendly, and usually chatted to the donors. She was said to enquire whether the

donors were feeling well, and to take the time to talk to them. Where this was mentioned this 'human touch' was appreciated by the donors.

> "They ask, 'Are you feeling alright?' They're usually quite chatty." (Donor)

4.3.4 Post Donation Behaviour and Guidelines

The final section of donating session procedure covers donors' post donation behaviour and the guidelines offered to them. Most donors and some non-donors did appear to be aware that these existed, which were thought to be for the good of the health of the donor.

Both formal and informal sources of this information were quoted. The formal sources were usually associated with the BTS, either the staff themselves, or posters and leaflets issued by them. Informal channels comprised persons other than BTS staff, such as friends and family. Of those who were aware of the existence of guidelines, donors stated that they had received their information from either or both sources, whereas non-donors' knowledge was obtained more informally.

In general, donors who had received their information through the more formal leaflets, posters, signs etc thought that it was likely to be more accurate and the implications would be for the BTS to continue their policy of making leaflets available on these issues. However, some donors and a larger number of non-donors appeared to be unaware of the existence of any guidelines to post donation behaviour, and indeed of the leaflets themselves (see Section 7.3.4) suggesting perhaps that more complex channels of information may be required. This issue is further discussed in Chapter 7.

While there was some awareness of the general idea of guidelines amongst donors and non-donors, knowledge of specific advice on particular topics was generally poor. Three areas of post donation behaviour were discussed:

- smoking
- rest
- alcohol

- Smoking. A number of donors were aware of advice to avoid smoking for at least one hour after donation. This was said to be because smoking within one hour of donation could lead to feelings of dizziness; no other possible consequences were mentioned. This advice was given by means of notices in the cafeteria area and read after donation. Some donors however said that they had been unaware of any such signs and had found out by personal experience that smoking immediately after donating was inadvisable.

> "When I had a cigarette afterwards I felt terrible. They should have told me, there weren't any signs or nothing." (Donor)

> "I gave some at St Vincent Street and had a cigarette afterwards and nearly collapsed. I felt quite drunk. I felt a bit dizzy and yukky after giving blood; after the cigarette I felt awful." (Donor)

The issue of smoking was not mentioned by non-donors.

- Rest. Some donors and non-donors mentioned that they thought a donor should "take it easy" immediately after donation, avoiding in particular any exertion or exercise. However, no specific information could be given as to which forms of exercise or exertion to avoid, or for what period, although it was implicit in the responses that this period did not extend beyond the day of donation. A small number stated that they thought this advice was given to avoid fainting or feelings of dizziness which would be brought on by exercise.

> "The last two times I've given it I was going home and I was rushing to go out and I was late that night and I'd just got into the house and down I went - it was my own fault because I rushed - because you know you've got to take things easy." (Donor)

- Alcohol. A small number of donors and non-donors stated that they thought alcohol should probably be avoided after giving blood.

However, no information was given by respondents from personal experience, or quoted as advice from the BTS. No-one knew how long it should be avoided or the reason why.

4.4 BTS Staff at Donating Sessions

This section is concerned with comments about the BTS staff present at the sessions. Both donors and non-donors discussed this area: donors from the point of view of their experiences, and non-donors in terms of their expectations. Three aspects were explored:

- the occupations of the session staff (4.4.1)
- treatment of donors (4.4.2)
- imagery projected (4.4.3).

4.4.1 The Occupations of the Staff at Donating Sessions. The majority of all respondents assumed that the session staff were doctors and nurses. The consensus was that the doctor's main function was to insert the needle into the arm, and to be responsible for removing it at the end. Some donors also thought that the doctor had a wider medical role, by being available in case anything went wrong. This was reassuring for some, although this reassurance did not extend to non-donors, who did not mention this aspect. There was only vague awareness that the doctor might have other responsibilities, such as in screening, although it was implicitly accepted that this was probably the case.

The rest of the BTS staff at the sessions were assumed to be nurses. The majority of donors and non-donors thought that these were medically qualified. However the remainder claimed that this was true for only some, the rest being trained in donor care by the BTS. A few donors were unaware of the presence of doctors at the sessions, and thought that it was only the BTS trained staff who attended them. In these cases this appeared to be a cause of concern, arousing feelings of insecurity.

> "I always feel quite insecure because that's all they were trained for - just to put the needle in the arm." (Donor)

While the absence of doctors did not seem to be a cause for concern amongst non-donors, probably because it did not occur to them that medical staff would not be available in what they regarded as a medical, hospital-like environment, reassuring those attending clinics that medical staff are available and take part might be helpful. However, this should probably be emphasised only for those with concerns in this area, in case it conjures up all the medical images that some first-time donors seem particularly sensitive about.

Some donors commented on the age of some of the BTS staff, claiming to feel more at ease with older rather than younger people looking after them. Perhaps interestingly, these comments tended to be expressed more by the younger 18-24 year olds than by older donors, possibly reflecting the former's relative insecurity or lack of maturity.

> "I think it puts a lot of people off when they're just young girls. You don't feel looked after. You need someone more like a mother." (Donor)

A few donors also mentioned that they expected the BTS staff to conform to high standards of neatness and tidiness. When members of staff did not match these expected standards this aroused comment, and a wish that they would tidy themselves up.

> "She had hair that was sort of hanging over her and I thought, 'I wish you would tidy yourself up a bit.'" (Lapsed Donor)

Finally, a small number of donors mentioned that they thought voluntary or Red Cross workers helped with the more 'menial' work such as serving tea, and taking the names of prospective donors at the door.

4.4.2 Treatment of Donors. Both positive and negative comments were made about the staff and the ways in which they treated donors. On the positive side, the great majority of donors thought that the staff were pleasant and friendly. Some typical comments were as follows:

"They're very friendly and always speak to you." (Donor)

"The staff are usually more than kind and very friendly and nice. They make you feel very much at ease." (Donor)

"Most of the staff were friendly. They didn't have much time to sit and talk to you but some attempted." (Donor)

Amongst non-donor groups as well, the consensus was that the staff would be friendly. They were thought to be likely to encourage people to relax, and calm them if they were frightened.

"If you do go and panic they'd probably calm you down and say, 'this won't take five minutes.'" (Non-Donor)

"They'd be understanding if you were frightened." (Non-Donor)

"They probably talk to you all the way through it - talk about everyday things. It would be over and done before you know it." (Non-Donor)

However, there was also a feeling amongst some donors and lapsed donors that the BTS staff could be impersonal, sometimes failing to give the donors adequate personal attention. In particular, staff were sometimes criticised for talking amongst themselves, often over the heads of donors.

"They talk amongst themselves about everything - if they would even bring you into that, it would help you to relax a bit." (Lapsed Donor)

"Sometimes when you're lying giving blood - the nurses are talking away at each other over your head. You're ignored completely." (Donor)

"If they just spoke to you now and again." (Lapsed Donor)

Response to staff was also influenced by the feeling of donors that they ought to be thanked for giving blood. Some felt they were actually donating their blood to the person standing beside their bed,

rather than to the BTS organisation. However, the expected thanks from that member of staff was not always forthcoming.

> "The nurses are always glad to see you. It would be nice if they just said, 'thank you', as you leave." (Donor)

> "It wouldn't take you a minute to attempt to say thank you - 'Well that's you finished. Thanks for coming.'" (Donor)

> "Do you not find when you go to give blood nobody even asks you to come back or encourages you? It's not a great effort. It just seems to be a routine job. They could say, 'hope to see you again in six months time.' Nobody ever bothers." (Donor)

Some donors did offer excuses for this type of behaviour by BTS staff - saying that if the staff were working all day then they were likely to be a little tired and perhaps not as cheerful when the evening session was in progress.

> "If they have been at it all day then they are bound to be a bit sick when evening comes round, saying the same thing every five minutes, it must be boring." (Lapsed Donor)

However, others thought that there was no excuse for this lack of thanks - it was a matter of common courtesy and its omission was noticed. Tiredness was not thought to be an adequate excuse as shop workers, for example, were always expected to say 'thank you' and be courteous to the general public.

It is important to note that none of these donors specifically stated that they would not donate again because of this lack of personal attention or thanks. However, analysis of the reasons for lapsing later in this report (6.6) suggests that while incidents such as these may have little immediate impact, their effects can accumulate over time, leading to a gradual drifting away from the intention to donate. This is especially the case for those with little awareness or experience of the rewards of giving blood, or with minimal feelings of social or moral commitment. It is therefore vital to note that while specific events may be objectively trivial, and may

elicit little complaint at the time, they can be nonetheless real and important in terms of their long-term significance. To this extent, it is the cumulative effect of little, apparently minor irritations that is important to monitor and be vigilant against, rather than the more obviously 'serious', but isolated, events.

To some extent, donors implicitly recognised this process themselves by stating that they felt a sense of personal responsibility for the BTS. In particular, while they claimed that they did not resent this treatment themselves, they felt that it was critical for those who perhaps lacked commitment, or were wary of what was involved. The prime example of this was the first-time donor, whom it was felt should be treated with extreme sensitivity.

> "If people have gone along for the first time and they're on their own, they often look quite frightened. It may be helpful if someone who worked there could look after them a little bit more. They could stick with them and stay with them right the way through to give them confidence the first time. It would be better than being passed from person to person." (Donor)

> "Do you not think it would have made an awful difference to you if somebody had said to you, 'Now this is your first time - you will be fine, you'll be alright', but nobody said anything to me. I wasn't reassured." (Lapsed Donor)

Finally, this lack of personal attention was not mentioned by non-donors, who appeared to feel that they would be given enough personal attention by staff, as discussed above. This makes the issue of impersonality even more critical, as there is little to be gained by non-donors not having their positive expectations confirmed.

4.4.3 Social Class Imagery of Staff. In some of the discussion groups comments arose spontaneously about the social class of the BTS staff present at the donating sessions. They were generally thought to be 'middle class' and were therefore seen to be one social class lower than the image of the BTS as a whole, as discussed in Section 3.3.

The general image of BTS staff seemed to be of a middle class woman in her forties, married, with children. She would live in a suburban, residential area, and own her modern, detached house. Her interests were felt to revolve more around her home and family than the BTS image as a whole implied, and included knitting, cake-making and jam-making. She was seen to read the 'Daily Mail' and watch a variety of television programmes, especially quiz shows. She was an ordinary 'suburban housewife type' and although middle class, she was described as "so nice, so ordinary". Overall, she appeared to be a friendly, approachable type of person. No negative comments about her being of middle class status were mentioned or seemed to be implied.

The image of the staff was therefore less extreme than that of the BTS as a whole. While they were seen to be middle class, there appeared to be none of the negative, pejorative connotations of officialdom, condescension or indifference often associated with middle class imagery, especially in social advertising. At the same time the possibility of these more typical attributes of middle class imagery developing in the future should be noted, as should the potential difficulties in persuading non-donors that these normally expected attributes will not occur.

5.0 KNOWLEDGE OF BLOOD

To serve as a background to later parts of the study, all respondents discussed their knowledge of blood. Several aspects were explored; as might be intuitively expected, donors tended to be more knowledgeable than non-donors. The issues covered were:

- storage of blood (5.1);
- testing of blood (5.2);
- blood groups (5.3);
- uses of donated blood (5.4).

Each of these issues is examined below. The chapter concludes by discussing respondents' knowledge of donor requirements (5.5).

5.1 Storage of Blood

Issues such as basic awareness of blood storage, 'Blood Banks' and distribution have already been discussed in Chapter 3. This section explores respondents' knowledge of the storage process and some associated aspects, especially the length of time that blood is thought to remain usable (its 'shelf-life'), and whether any is likely to be wasted.

In terms of the storage procedure, most respondents agreed that the blood would be kept in the bags that were used for donation. However, the process used to keep it usable was unknown to many, with a variety of methods suggested: refrigerated, frozen, kept at an optimum temperature, or stored in its constituent forms.

There was also widespread uncertainty about how long blood could be stored. Donors tended to be more knowledgeable about this, although still citing a fairly wide time-span, from a matter of days to six weeks. Some donors also claimed that there was a difference between storage of whole blood and storage of its constituent parts.

> "Some is used immediately as whole blood and the rest is sorted out and can be stored in different ways." (Donor)

> "Certain parts of it they can freeze or they use techniques and keep it for longer." (Donor)
>
> "There are ways of treating blood to keep cells on their own. I don't know much - I'm not a biologist. In that way they can keep some parts much longer than if you just left it as blood." (Donor)

By contrast, non-donors were much less precise, quoting the storage period as from several days to 'at least a few months'. They were also unaware of the distinction between storage of blood whole or in parts.

This is thus a major area of uncertainty in the minds of both donors and non-donors. Whether it should be clarified, however, depends on the extent to which it is an issue of concern, and in particular, whether the time period has any implications for how blood is used (or not). This immediately raised the topic in some of the discussions as to whether or not blood might be wasted. Upon prompting during the interviews, it was accepted by virtually all that it would be theoretically possible to waste blood. Whether this actually happened in practice, however, was an issue of some debate.

Donors and non-donors tended to differ in their views about this. Non-donors (and also lapsed donors) were more likely to think that not all blood was used. The prime reason for this was that they regarded blood as having a 'sell-by' date, after which it could not be used.

> "Blood only keeps for a certain length of time and has to be thrown out after its 'sell-by' date has passed." (Lapsed Donor)
>
> "I don't think the blood keeps any more than three or four weeks - then it'll be thrown out." (Lapsed Donor)
>
> "They throw a lot of blood away - what they don't use." (Lapsed Donor)
>
> "I'm sure it goes off after a time." (Lapsed Donor)

> "I think people are interested in knowing what happens to it; obviously it goes off after a while and some of it can't be used for this or that." (Donor)

The existence of this 'expiry' date was felt by some non-donors to preclude the BTS's guaranteeing that their individual contribution would be used. Indeed, some cited this as a reason for not donating, although as is discussed later (Section 6.6), this apparently simple factor for not giving often concealed other more fundamental reasons, such as deep-rooted emotional fears.

> "You often hear it only lasts for three weeks or whatever and it could be wasted. So you might think, 'well, I won't go this time or I won't bother going at all'." (Donor)

> "I've got the attitude - what's the point in me going there if they're going to pour my blood away." (Non-Donor)

Most donors tended not to accept that blood was wasted, for two reasons. Firstly, on factual grounds, they argued that passing the 'expiry' date did not necessarily prevent it from being processed for other purposes, especially in using it for plasma.

> "If they don't use it they can break it down and take the plasma and they can use that for anything." (Donor)

Secondly, for more emotional reasons, they tended to be unable to accept that their contribution was not after all required, despite all their physical and mental efforts.

> "I've never really thought about what happened to my blood when it goes away. I'd be disappointed if it was poured away at the end of the day and it wasn't actually used." (Donor)

> "You think your pint of blood could have been of use. You don't think they'll just throw it away." (Donor)

Donors therefore found it difficult to reconcile the idea of wastage with their own personal contribution, and great care indeed would be required in handling the concept if it ever became a public issue. Indeed, only two circumstances would appear to be acceptable to donors for not using their blood for the benefit of others.

- where it is used for testing;

> "Not all of it is used. I think they test a lot of it and the other half they use." (Donor)

This was still acceptable despite not being used as intended, because the testing process was nevertheless constructive in some way.

- where an accident occurred outwith the BTS's control. An incident of this nature took place in September at Law Hospital where microscopic holes in the bags were found and the blood could not be used. Such incidents are accepted by donors, although regretted, if they are seen to be isolated and random. However, because they are inevitably given media exposure, they are examined critically by donors and others, and considerable care should be taken as to how they are presented.

Whether the issue of viable storage life should be clarified will therefore depend on the extent to which the BTS can offer a guarantee that all donated blood will be used. If this can indeed be provided, it will clearly be beneficial to allay non-donors' fears, even though these may well be expressed more as rationalisations than real reasons. If no guarantee can be offered, however, and there is a risk of blood not being used (especially if the 'shelf-life' is for a short period) then there may be little point in drawing attention to the issue - it may raise anxieties among donors in a sensitive area that at the moment is not of concern.

5.2 Testing of Blood

This section is concerned with the testing of blood after donation but before it is used. The discussions covered respondents' awareness and knowledge of the testing process, and their understanding of its purpose. As for knowledge of storage procedures discussed above, donors had in general greater awareness and understanding than did non-donors.

The majority of donors were aware that blood was tested before being used in transfusions or separated into parts. Non-donors were in general much less aware of this. A number of non-donors and a few donors thought that blood was used untested.

> "Some people might have a disease in the blood. They don't check the blood when it's taken, I don't think. Somebody could come in with anything in them - and then just put it into somebody else." (Non-Donor)

> "You can catch that sexual disease, AIDS, from it. There was a programme last night about it - somebody could be a carrier. It should be tested." (Non-Donor)

While most donors were aware that some type of testing was carried out, their specific knowledge of how this was done and disorders tested for was low. Testing was merely described in general terms as a kind of check for diseases, the exact nature of which were unknown. Non-donors had virtually no knowledge of the testing process or the diseases checked.

Despite this, medical testing of this type (whatever it might be in detail) was thought to have advantages for both the recipient and the donor. The benefit to the recipient was simply that he or she would not be in danger of receiving diseased blood. The advantage to the donor was that any disorder in or of the blood would be identified potentially at an earlier (and hence possibly less serious) stage than might otherwise occur. In this regard, there were possibly exaggerated expectations as to tests that were carried out, and there did not appear to be any awareness that AIDS could not be detected by any blood test.

> "But all the blood that goes to the blood bank's bound to be tested a good few times before it's used." (Lapsed Donor)

Some non-donors also saw this early screening as a potential advantage, but it is relevant to note that others did not, claiming to avoid any situation where a disease might be found. (They thus tended to avoid other early diagnosis screening facilities as well, such as breast and cervical cancer screening.) The implication, therefore, is that offering such a service, even if it is feasible, may or may not be an advantage, depending on basic attitudes towards the benefits being offered (see Section 6.5.2.1).

5.3 Blood Groups

As part of this section, the topic of blood groups was raised. Issues covered were awareness and knowledge of blood groups, the advantages of knowing one's own blood group, and understanding of rare blood groups. From the discussions it emerged that all the interview groups - donors, lapsed donors and non-donors - were aware of the existence of blood groups. The majority of donors and lapsed donors also knew their own blood group, and could name some other types apart from their own. Non-donors, however, were much less aware of blood groups, either their own or in general.

The advantage of knowing one's own blood group was mentioned by a few female donors, who said that being aware of their own and their husband's group had been useful to them when they were starting a family. In these few cases, the wife's blood was different to her partner's and knowing this had been useful in alerting doctors to possible difficulties in pregnancy.

> "The two of us have got different types of blood and they've got to watch with the babies. It doesn't matter with the first one, it's your second baby you've got to watch. With the two - me and Alex - the blood mixes together and it's not good for the baby and they've got to take the baby's blood and change it." (Donor)

> "My husband started giving blood when it was actually outside the college and they all got their immunity cards after it. That was handy because his was different from mine and when we came to have children we knew there were going to be problems." (Non-Donor)

The other advantage of knowing one's blood group was suggested by a small number of donors and non-donors. This was that in an emergency situation where blood was required quickly, the correct type would be known, thus avoiding delay. No disadvantages of knowing one's own blood group were mentioned.

Finally, the topic of the BTS having a greater need for donors with a rare blood group was raised. This was a very common feeling amongst all the discussion groups. Two issues were mentioned. Firstly, it was stated that the BTS had a greater need for rarer blood groups than 'ordinary' blood types. Secondly, and following on from this point, a few donors and non-donors who knew their blood groups said that as their blood was of a common type, there was less need to donate, since enough would be available.

- Greater Need for Rare Blood Groups. It was widely assumed that the BTS had a greater need for the rarer types of blood. Donors in particular claimed this because of the extra attention that was apparently given to encouraging such people to donate regularly.

> "I think the negative's a bit rarer. I got a letter encouraging me to go regularly as my blood could be very useful." (Donor)

> "I keep getting letters from them 'cos I'm a 10% shot but it's six years and it's just a case of being there at the right time when they are doing it." (Lapsed Donor)

> "I never knew what my blood group was 'til I was expecting and actually in the labour ward. The nurse looked and said, 'Oh, you've got quite an unusual blood group.' After that I realised it's really important. If you have got an unusual blood group it's really important." (Donor)

Others, both donors and non-donors, gave similar evidence relating to friends or relatives who had rarer blood groups. Sometimes it was claimed that people who were in this category gave more than one unit at a time.

> "I know a guy who's got a rare blood type and the police came down one night and lifted him out of his bed to take him to hospital. They took a pint off him." (Non-Donor)
>
> "My brother's got a rare type so he goes - they take two pints off him sometimes." (Non-Donor)
>
> "My dad is 'A' negative, and they call him all the time." (Non-Donor)
>
> "If you've got a rare blood they give it more often under supervision. They're on call 24 hours a day. (Donor)

- Less Need for the 'Common' Types of Blood. This was a view shared by a few respondents, both donors and non-donors. There was felt to be less need for the more common types of blood - 'O' positive being mentioned in particular. These donors were not thought to be called upon as often as those with rarer blood groups.

> "I think perhaps if you've got a rare blood group you could perhaps be persuaded as you are one of the minorities. Whereas if you've got 'O' positive which is very common in Scotland then they wouldn't need you so much." (Non-Donor)
>
> "They don't call me up very often, possibly because I've a common blood type." (Donor)
>
> "I think if you've got a rare type of blood you're more inclined to go on a regular basis. Mine's not, and I always think that there's plenty of blood about because it's a common type of blood." (Donor)

The counter argument to this viewpoint was not mentioned, which is to the effect that because a large percentage of the population have the more common type of blood, then proportionately more of this would be required by the BTS. The fact that 'O' positive blood is known as the universal donor because in an emergency it can be given to people of all blood groups, was not mentioned.

5.4 Uses of Blood

This section discusses respondents' knowledge of the uses of donated blood. The following uses were suggested, and while most people were aware of at least one, knowledge was very fragmented and diffuse, especially among non-donors.

- Use in Accident Situations. In all the interview groups this was the first and also the most common answer. Blood was needed to save lives in emergency situations. However, there was little detailed knowledge of how exactly it might be used in this way - for example, whether it was used in whole or in part (the assumption being that it would be used whole).

> "It's nice to imagine you've helped save someone's life having come out of a car accident." (Donor)
>
> "To save lives really - emergencies. You know how people lose a lot of blood. You give them a blood transfusion." (Non-Donor)
>
> "They use it in accidents - I always think about car accidents." (Donor)

Furthermore, there appeared to be a feeling amongst a few donors and non-donors that they were relatively uninterested in uses of blood other than for accidents or major surgery.

> "You think you're saving life because you're giving it - you don't want to hear about parts of blood." (Donor)
>
> "I come to give blood thinking in terms of someone in hospital after a road accident, that's the picture I have in mind. I personally think that's the only reason I would dish it out. I wouldn't dish it out for any other reason." (Lapsed Donor)

Some other donors were also aware that the attitude existed that the use of blood transfusions in emergencies was of foremost interest and importance, claiming this to be the fundamental reason for donation. While this is somewhat of a simplification of the reasons for donation (see Section 6.4) the point should be noted that there is potentially

a risk in excessively emphasising other uses of blood at the expense of accidents/emergencies.

> "Most people like to think that you're saving a life because your varicose vein surgery is unromantic. Yet it's probably used more in that way than in emergencies." (Donor)

- Use in Operations. This was the second most popular answer. Both donors and non-donors recognised that hospitals required many units of blood for operations carried out all the time. Again, there was little awareness of detailed use, such as the types of illnesses, operations or patients requiring most blood.

- Research Purposes. Some respondents (mostly donors) claimed that blood was also required for research purposes, but this aspect was mentioned much less frequently than its use in accidents and operations.

> "The amount they need for transfusion, they need that amount again for research." (Donor)

> "There's a couple of things if a baby gets born or you are in an accident, but what about the wee daft things like research that we don't know about." (Non-Donor)

Comments on the exact research uses of blood tended to be vague, as in the examples given above.

- Babies Requiring Transfusions Immediately after Birth. Although this was mentioned by a few donors and non-donors, their comments were rather vague and non-specific. There was little indication of any detailed knowledge as to the medical conditions requiring blood or transfusions, other than general comments that it 'could be required for rhesus babies'.

> "They use it in blood changes for babies, in rhesus babies." (Donor)

> "If some babies are born and they had got the wrong type of blood - they need a transfusion." (Non-Donor)

"Giving wee babies a blood change and things."
(Non-Donor)

Awareness of this use of blood was said to come from BTS pamphlets and posters or from personal experience of this need.

- Making Medicines. This was mentioned by two donors only, one of whom claimed that the cancer drug Interferon could be made from blood. The other was aware of the general concept of making medicines using blood products, but could not give details. No-one else interviewed knew of this or any other similar use of donated blood.

- Extraction of Plasma. The extraction of plasma from whole blood was recognised by some donors and also, to a lesser extent, by non-donors. However, very few could give any specific uses for this plasma.

"They strip it and use the plasma after the fortnight is up. I don't know what they use the plasma for. They don't tell you." (Donor)

"Well, if they don't use it they can break it down and take the plasma." (Donor)

"They can take the plasma out and then the platelets and various other things which can be used all the time." (Non-Donor)

The use of plasma in the treatment of burns patients was not mentioned. Prompted comments on the use of plasma in burns patients are discussed in a later section (7.3.2.3).

- Treatment of Blood Diseases. The use of blood in the treatment of diseases of the blood was mentioned by few respondents: one of these claimed to have been informed about this through letters from the BTS.

"I've been told a couple of times in letters that it's for leukemia patients - I don't know whether it's my blood group." (Donor)

Another donor was aware of this need because of his personal contact with one of these patients.

> "Our manager has just been in hospital and he's been getting a lot of transfusions because he's picked up some type of blood disease where he's to get fresh blood all the time and he'll be in a bad state if he doesn't have it." (Donor)

The use of blood in the treatment of haemophilia was also occasionally mentioned, with specific reference to the use of plasma.

> "They also need blood to take out the plasma - for people who bleed if they're bumped and the bleeding doesn't stop." (Donor)

Overall, therefore, while most respondents could mention at least one use of blood, their detailed knowledge was low. Their comments seldom extended beyond general observations that it was used 'for accidents and operations', and there is clearly scope for educational improvements in this area.

5.5 Knowledge of Donor Requirements

The final area covered in this chapter is respondents' awareness and knowledge of the BTS requirements potential donors have to fulfil before they are allowed to give blood. In general, most of those interviewed were aware that conditions of some kind were imposed. Three aspects were mentioned spontaneously:

- weight
- age
- medical history.

5.5.1 Weight

A lower limit of eight stones was often quoted as a weight measurement, mostly by female respondents (both donor and non-donor). Feelings about this lower limit were divided. Some argued that it was desirable to impose for two reasons. Firstly, it was thought that people under eight stones needed all the blood they had. As a result, donation could be potentially harmful to their health. Secondly, it was suggested that it might be more difficult in physical terms for these people to donate, as the blood might come out slowly or hardly at all.

> "I've tried to give it a lot of times, but they won't take it. I've given it once. There's a lot of reasons - I was underweight. It took them a long time to get the couple of ounces that they got. I think they thought I was wasting their time." (Lapsed Donor)

The opposite view was that the BTS should take all donors regardless of weight. The reason for this was that no extra risk was seen to be involved.

> "I think if they're willing to give blood no matter what weight they are they should gie it. It'll no harm them, will it?" (Donor)

Some donors expressed disappointment at not being allowed to donate because they were under the weight limit (see Section 4.3.1.2) and disputed that their health would be at risk.

> "I was disappointed and I've often wondered why they say you've got to be eight stone - and I was exactly eight stone. They could have had me for a fraction of an ounce." (Lapsed Donor)

A few female non-donors reported trying to falsify their weight by wearing extra clothes. However, they did not pass through the initial screening stage undetected, being asked to stand on the scales to have their weight checked.

Donors who had been weighed by the BTS did not express any resentment over this. There was no mention of any upper weight limit. On prompting by the moderators, no-one seemed aware of this.

5.5.2 Age

Donors and lapsed donors were more knowledgeable about this requirement than were non-donors. Donors were generally aware that a minimum age was necessary, usually stating this to be 18. There was no evidence of any donor being reluctant to state their age if asked by the BTS. However, there was some evidence of giving a false date of birth in order to be allowed to donate, as follows:

> "You have to be 18 to give blood and they give you a card. It comes in useful because it proves in pubs that you are 18. But I suppose you could give a false date of birth, which I did." (Donor)

Non-donors were much more vague about whether there was any age restriction. The few who claimed to be aware of this quoted a range from around 16 to 21.

> "You have to be 18 before you can give blood - or is it 16?" (Non-Donor)

> "Maybe you could get donors when they're 21." (Non-Donor)

> "They should try to get the teenagers and young folk, the scouts and the Boys Brigade. It would be their good deed." (Non-Donor)

Knowledge of the purpose of this minimum age requirement was virtually non-existent among all respondents. Many asked why it existed and could offer no explanations themselves. No mention was made of any upper age limit, and upon prompting by the moderator, no awareness of this seemed to exist.

5.5.3 Medical History

There was almost universal agreement that medical preconditions to giving blood existed. However, there appeared to be little

certainty as to what these requirements actually were. Respondents' opinions of medical requirements are discussed under three headings:

- diseases/illness
- treatment
- medical 'conditions' (eg childbirth)

- Diseases/Illness. The condition of anaemia was the most commonly quoted illness preventing donation. It was generally recognised that not having enough iron in the blood was a condition needing treatment, and that donating under such circumstances would be harmful to the donor. Some non-donors who thought themselves anaemic give this as a reason for not giving blood. However, these respondents (all females) did not appear to have had their blood recently tested, if at all.

> "Most of us are anaemics. I am as well. They said that years ago and I used to take the faintings. I used to faint and that and that's what the Doctor said." (Non-Donor)

> "I wouldn't mind but it's because I'm anaemic and you cannot give blood. You've not got enough yourself - well, you've just got enough." (Non-Donor)

It was also thought that the blood without iron would be of little practical value to the BTS.

Glandular fever was also frequently mentioned as a disease that precluded donation, it being recognised that a donor suffering from it could endanger the health of the recipient. However, there was little awareness of when donation could resume after cure, if at all.

> "Then I had glandular fever so I haven't been since. I'm not sure how long that stays in your blood for. I had a feeling that it was quite a few years - so I just didn't go back. I meant to drop in and ask when I could give it again but I never got around to it. I knew I shouldn't give it because I had glandular fever and I didn't want to transmit it in my blood because I know that it stays in your blood a good few years anyway." (Lapsed Donor)

> "I was afraid of giving it after I'd had glandular fever because the antigen can still be in the blood and affect someone who receives the blood." (Lapsed Donor)

Jaundice came into the same category as glandular fever, with uncertainty as to whether past sufferers could donate, and if so, when.

> "I think they'd have to be really careful with jaundice." (Non-Donor)
>
> "How long does it take yellow jaundice to get out of your system?" (Donor)
>
> "They can use your blood if you've had jaundice or something else, or treat it." (Non-Donor)
>
> "I also had jaundice at one point but I believe now if you tell them they can still take it." (Non-Donor)
>
> "My mother was one who fell into that category - she'd had yellow jaundice when she was younger. She always believed that she couldn't give blood. She just happened to come along and one of the nurses said she'd check her blood to see if it was clear, and she went and now she gives blood. That was after many years of not going - not because she didn't want to but thinking that she couldn't because they didn't want it." (Donor)

A few other diseases which precluded donation were mentioned by a minority of discussants, but detailed knowledge was low.

- tuberculosis
- hepatitis
- diabetes
- malaria or possible contact with malaria.

- Acceptable Treatment of Current Medical Conditions. Some donors quoted examples of medical conditions during which donation was thought to be acceptable. Non-donors appeared to be unaware of this aspect. Two medical conditions were specifically mentioned in this category. Firstly, it was falsely claimed that blood could be given

while taking a course of antibiotics, and that there might even be an advantage in this.

> "You can give it if you're on antibiotics, it strengthens your blood." (Donor)

Others disagreed, saying that they had been turned away from giving blood after a course of antibiotics.

> "I was turned away because I was taking antibiotics about 4 weeks before that and they like it to be 5 weeks." (Conflict Group)

There did not appear to be any awareness of the reason for rejection, that is, that there are many people who are allergic to antibiotics and so could be endangered by a transfusion of blood containing them.

Chicken-pox was also mentioned as a medical condition during which blood could be donated. This was said to be due to the presence of antibodies in the blood which would be of use to some recipients.

> "One time I had chicken-pox and they asked me if I would come if they sent a taxi for me. It was something to do with antibodies in the blood." (Donor)

No other similar examples were cited for treatments or illnesses during which donation was specifically encouraged. A few donors were aware that donation was encouraged after certain injections or inoculations but no specific details could be given of this. It was not commented on by any non-donors.

- Medical 'Conditions'. Childbirth was the most commonly mentioned medical condition precluding donating, with female donors who had given birth most aware of this. One to two years was usually cited as the period after which donation could resume. There did not appear to be any knowledge as to why these mothers should not give blood for this period, and why it was then acceptable afterwards. There was little real resentment about this, although a feeling of embarrassment at being turned away was expressed by a few respondents.

> "I was embarrassed that time they never let me in. I'd had the baby about 10 months before and I didn't know. I was getting on the bus and she's turning me down. She said I could get my biscuit and I said, 'It's alright I'll just go back to the factory'". (Donor)

Hayfever, the Pill, during menstruation, taking headache tablets, during a cold and having cold sores, recent ear piercing or tattooing were also all given as conditions which would exclude people from donating. However, there was little awareness of why these restrictions might be imposed, with no mention being made of risks to health of donor or recipient.

> "My wife was on the Pill for a while and they refused to take blood from her because she was on the Pill. No-one said anything to her since, 'You're OK now that you're off the Pill.' She's never bothered going back as she doesn't know whether it's worthwhile to come down and sit for two hours to get sent home again." (Lapsed Donor)

> "If you've taken a headache pill for a hangover. My boyfriend went along and he'd taken Paracetamol and they refused him." (Donor)

In general, there appeared to be considerable confusion about the medical history requirements of donors, and in particular, about the conditions that precluded donation, and for how long. This confusion was thought to exist for three reasons:

- vague rejections
- lack of clear policy
- low level of knowledge.

- Vague Rejections. In some of the cases discussed in the groups potential donors recalled being turned down without being given what they felt was an adequate explanation. We only encountered a few cases of this, but to these people it was an important issue. It was unclear to them whether they had been turned down because of the medical condition itself, or because of the treatment they were receiving for it. Hayfever was one particular example. The

advantages of clarifying this for the individual concerned are self-evident.

- Lack of Clear Policy. It was mentioned by a few donors that there did not seem to be a clear national or regional policy on some medical requirements. Hayfever was again given as an example where some centres allowed donation from people with hayfever, so long as they were not on antihistamine treatment at the time. Other centres were said to preclude all people with hayfever, whether or not they were on such treatment. Other conditions such as glandular fever, jaundice and diabetes were also mentioned in this light.

> "That's not very clear - when you can give blood and when you can't. I can't get that cleared up - the donor centre says, 'no, you can't', yet my consultant says, 'yes, you can.'"
> (Donor after glandular fever)

- Low Level of Knowledge. In some donor groups it was mentioned that their own low level of knowledge of donor requirements led to confusion and uncertainty, and this was suggested as a possible reason for non-donation. However, while there may be some truth in this, care must be taken in interpreting such lack of knowledge as the reason for non-donation.

It is certainly possible that many potential donors are incorrect in regarding themselves as ineligible for donation, and are perhaps being lost to the system as a result. Equally, however, the importance of this lack of knowledge will depend on other reasons for non-donation that may exist at the same time, and on their relative salience. These issues are discussed more extensively in the next chapter, but in the meantime it should be noted that the prime reasons for not donating are not lack of knowledge (even though this is poor) but are to do with deeper rooted, psychologically based fears.

5.5.4 Required Time between Donations

This aspect of donor requirements was not spontaneously mentioned by respondents, and as a result was introduced as a topic by the group moderators. All the interview groups were asked how often they thought a person could give blood. The responses ranged from every week to every six months.

> "Couldn't you give it every week as long as you're healthy?" (Donor)
>
> "I was under the impression that you could give blood every three months." (Donor)
>
> "When I was a student I gave three times a year and that was acceptable." (Lapsed Donor)
>
> "You give blood every six months." (Donor)

Donor and lapsed donor groups appeared to have greater knowledge of the required time between donations, tending to quote either the number of times the BTS held donating sessions in their area, or the interval specified by the BTS. Non-donor groups were much more uncertain. It emerged from some of the discussions that there appeared to be variations between regions in the recommended period between donations. As a result, it was thought that the BTS should adopt a common policy between regions.

All the groups discussed the reasons for the required time lapse. It was generally thought that the period was necessary to make up the blood and hence protect the health of the donor. There did not appear to be any awareness of risks to the recipient.

6.0 REASONS FOR BLOOD DONATION AND NON-DONATION

6.1 Introduction

This section highlights the factors which might influence an individual's decision whether or not to give blood. As an introduction there is a summary of general attitudes towards giving blood (6.2). There then follows descriptions of discussants' views of 'typical' donors and non-donors (6.3), which provide a further assessment of the general public's attitude to blood donation and people who give blood.

The subsequent sections discuss, in turn, the factors which might encourage donation (6.4), inhibit donation (6.5) and cause a donor to lapse (6.6). Although these factors will be highlighted individually it is apparent that they all interrelate. Each person experiences both encouraging and inhibiting factors, each of which varies in importance. It is the combination of these weights that essentially decides whether the individual person will be encouraged or inhibited from donating. Furthermore, if the importance of one or more factors alters over time, then that person's feelings towards donation will be modified. This might cause a donor to lapse or to cease giving blood altogether, or alternatively, cause a non-donor to decide to donate.

This dynamic interaction between encouraging and inhibiting factors should always be borne in mind when analysing donors' and non-donors' motivations. As well as being significant in determining the end result of whether an individual will give blood at any given time, it also enables the individual to be seen as occupying a position on a continuum of commitment that may vary over time. The continuum ranges from committed donors who give as frequently as is physically acceptable to committed non-donors who will never donate.

These issues are explored in more detail in the following sections. Their implications are also discussed in Chapter 8, where different types of publicity strategies are recommended for different types of donors and non-donors.

6.2 The General Range of Feelings Expressed about Donating Blood

6.2.1 Donors' Feelings

In general, donors felt 'good' about giving blood. They tended to give themselves "a pat on the back", although in a modest way, feeling that they were doing good for other people.

> "I just gave because it was a good thing to do." (Donor)
>
> "A real good Samaritan." (Donor)
>
> "Every time I give I think the blood is helping to save someone." (Donor)

Donors usually felt a moral commitment to donate, that blood was needed and that they, as members of society, should help to give it.

> "That you're doing it because your conscience says there's something to be concerned about." (Donor)

Another range of feeling was related to people wanting to maintain the stock of blood in the community, rather than just "helping". This could be for their own future need or indirectly to replace blood that had been given to them, or, more frequently, given to a relative.

> "If you were in an accident you'd expect the doctor to be able to give you blood. I don't think you can expect that without doing something." (Donor)
>
> "What really made me think it was a right worthwhile cause was that last time I gave blood, and the next day my grandfather was rushed away to hospital and he had to get a transfusion. That made me think. You never know when it's going to happen. You think of your own family that needs it." (Donor)

Feelings of self-sacrifice were also expressed,

> "A human being is giving the ultimate. He's given physically part of himself for somebody else." (Donor)

although a few people tended to be more matter-of-fact about it.

> "I don't feel it does me any good but it doesn't do me any harm, so I just keep on with it." (Donor)

Many donors, especially those who developed regular donating habits, found giving blood was rewarding in itself. This enjoyment of the experience of attending a donor session helped develop self-commitment from the donor, as well as moral commitment.

> "You don't like to miss it once you've started." (Donor)

> "You just get satisfaction from giving it." (Donor)

The range of attitudes towards giving blood highlighted in this section will be discussed in more detail in the section on factors which encourage donation (6.4).

6.2.2 Non-Donors' Feelings

Non-donors were already aware of the possibilities of donating blood and, like donors, most felt it was a "good thing", that was worthwhile and needed to be done.

> "I think you'd feel good giving it - you've done something." (Non-Donor)

They would then qualify these statements with reasons why they themselves did not give blood, often expressing a degree of guilt. The detailed reasons are discussed later (Section 6.5), but encompassed a wide range, such as fears and apprehensions about donating, impressions that they were not eligible, and inconvenience.

Although most non-donors expressed strong feelings of goodwill towards the BTS, a small minority had more negative feelings about giving blood in general.

> "I don't feel morally obliged to give blood." (Non-Donor)
>
> "We never hear of anybody going into hospital that's needed blood and hasn't got it." (Non-Donor)
>
> "I've heard they throw it away after." (Non-Donor)
>
> "I've got other things to do." (Non-Donor)

Often, it seemed that such negative feelings were rationalisations for a decision not to donate rather than actual reasons for not doing so. Another small section of the non-donors interviewed, especially among the younger people in urban areas, said they had never thought about giving blood before being invited to the discussion group, or that if it had occurred to them, they had no idea about where to go and what to do.

The detailed reasons for not giving blood are discussed below (Section 6.5). In general though, BTS should feel heartened by the emotional commitment by the general public towards giving blood, although this is often latent among non-donors.

6.3 Descriptions of Typical Donors and Non-Donors

As part of the assessment of people's attitudes to donating and not donating blood, the groups were asked to describe what they thought was a typical donor (6.3.1) and a typical non-donor (6.3.2). This approach received unusually limited response, primarily because most people were adamant there was no such person.

6.3.1 Donors and Non-Donors Feelings about Typical Donors

(a) Donors Viewpoint about Typical Donors

Donors felt strongly that a blood donor could be any kind of person and that it was hard to say who would be typical. This was true of age, sex, and especially and most interestingly, of social class.

> "Most people who give blood are fairly ordinary people." (Donor)
>
> "If you go down to a blood donating session there are people from all walks of life." (Donor)
>
> "Just anybody - maist folk." (Donor)

Similarly, in terms of age;

> "When you go to give it there's different people from every age group." (Donor)
>
> "Last time I went there was a fellow next to me and he must have been over sixty and there was a lassie on the other side and it was her first time." (Donor)
>
> "In the hospital it tends to be the older, more experienced donors. There's just the odd one or two that are new. Whereas I think if you went to a college and it's all new folk it would be the hysterical females and the macho males." (Donor)

However, when pressed, people tended to think that blood donors were more likely to be younger than older. A variety of possible reasons were suggested for this:

- Young people might relish new experiences and regard being old enough to donate blood as a mark of coming of age.

> "I got really excited when I did it. I couldn't wait till I was eighteen when I could go and give blood." (Donor)
>
> "There's quite a few young ones who've never given blood before and they're quite excited by it (Workplace). It's the idea of it. The first time they'll be able to say 'I've given blood'. I think it's the kind of novelty, maybe." (Donor)

- Younger people tended to be less apprehensive about life in general and would be less fearful about blood donating. This was suggested mostly by older people.

> "I mean I didn't think anything about giving it when I was that age (eighteen)." (Donor)
>
> "By that time (sixteen to eighteen) they've had all their injections and things so therefore it's not going to bother them too much having the jag and pin pricks." (Donor)

- Young people have fewer other commitments and demands on their time, especially free time, and on their energies. This was suggested primarily by younger people.

> "You maybe just get away from it when you get older . . . I suppose you've got too much to do." (Donor)

- Young people may have more active social consciences and be more aware of the need for blood in the community, and as a result be prepared to act accordingly.

> "I think people are more aware of things at this this age (eighteen)." (Lapsed Donor)

- Younger people might also be more aware of technological developments in medicine and the important uses to which blood could be put.

> "I think nowadays, our generation doing it, we realise now what it can really do whereas older folk wouldn't really have as good an idea what it could do. I think you know more about it now . . . seeing operations on telly." (Donor)

Again, in terms of sex of donor, it was felt they could be of either sex, but when prompted, people (especially females) thought there tended to be more females than men. It was thought that women were less squeamish about blood and less likely to worry about "making a fool of themselves" if they reacted badly and fainted. It was also

thought that women could withstand pain better or cope better with the fear of pain.

Although not mentioned by respondents, underlying factors in these perceptions that women could cope better with giving blood, might relate to experiences of menstruation and childbirth. Women are normally regularly confronted with menstruation and have to cope in practical terms with a flow of blood as well as associated discomfort. Furthermore, many women donors will have experienced, or expect to experience, childbirth and the discomfort and outside intrusions involved. This will include frequent hospital contacts for antenatal care and taking of blood for testing. However, not all women react in the same way to these female experiences and many will feel antagonistic in varying degrees. It is therefore not automatic that all women, because of these experiences, will feel positive about giving blood.

Finally, donors felt that donors were people with a well developed sense of responsibility towards the community. This could be either in terms of helping people in general or, more specifically, recognising a responsibility to keep up the stock of blood for the health of the community. Indirectly, this also applied to the benefit of themselves and people they know.

> "They're life savers." (Donor)
>
> "People who are worried about what goes on, caring about what happens." (Donor)
>
> "At least 60% of donors come into that category, ie, had an experience or known somebody who's had an experience and they've needed blood." (Donor)

As further analysis will suggest, this factor of active obligation is probably a major distinction between most donors and most non-donors.

(b) Non-Donors Viewpoint about Typical Donors

Non-donors had similar feelings to donors about describing a typical donor.

They too thought donors could be from any social class, job or situation. This was interesting considering that the images of the BTS (3.3) and BTS staff (4.4.3) all tended to be middle class. While there is no evidence from the research that working class non-donors (and indeed donors) were deterred from donating by this general middle class image, it is important for BTS to remember that there is a potential risk in this situation: if working class people attend a session and perceive it to be a situation predominantly designed for middle class people and experience class distinctions and antagonisms, it might make the first donation a slightly disconcerting experience and be a factor in deterring future donations. It should be noted that this is likely to be a particularly critical issue for those who are extremely sensitive to their first clinic visit, as discussed in Chapter 8.

No age barrier was felt either, although if prompted they would tend to think there were more younger donors than older donors, for similar reasons that donors gave. Again it was felt that both sexes were equally represented, but that possibly there were more female donors. It was also mentioned that donors might have needed blood, or that someone they know had needed blood in the past. Non-donors regarded this as a particularly strong reason for giving, rather than the extra reasons suggested by donors of doing good in general or 'saving lives' in a non-specific way.

Non-donors also saw donors as people who had got into the habit of giving blood, and who had obviously taken the first step of giving blood and continued to do so.

> "It's a thing you do, it's a way of life (for donors)." (Non-Donor)
>
> "I know a couple who give blood, who want to get this wee medal." (Non-Donor)

Some non-donors saw donors as strong people, both physically healthy and mentally healthy. This aspect was not mentioned by donors.

> "A strong person - someone that's healthy - someone that's very healthy." (Non-Donor)
>
> "Brave - I think more, well, adult sort of people." (Non-Donor)

By implication, they were seen to be stronger than non-donors and to that extent, attracted some admiration.

In conclusion, it was apparent that donors and non-donors felt that a donor could be anyone, of any age group, sex, or socio-economic group who was physically able to donate. After prompting it was thought there might be marginally more women than men and more young people than older people. It also seemed that donors were seen by donors and non-donors to be people of some strength (sometimes unattainable for non-donors), both in social conscience and in physical courage. The latter in particular was emphasised by non-donors.

In terms of encouraging donation, it seems that people are not deterred from becoming donors by any aspect of the perceived image of a donor and that factors which inhibit donation are generated by each individual rather than as a reaction to the concept of becoming a donor. It was felt that anyone could become a donor, with the large proviso that they were morally or physically strong enough to do so.

This is therefore one aspect that BTS publicity does not need to counteract and indeed might do well to reinforce, ie that a donor could be anyone. This is further discussed in Chapter 7 where it is suggested that the use of well known personalities in publicity could be less successful than using "ordinary people".

It could also be useful to encourage non-donors to feel it might be possible to attain the physical or moral strengths that they feel donors have. This might be done by illustrating the fact that

existing donors often experienced apprehensions before giving blood, as will be described in Section 6.5. However, it should be noted that convincing non-donors that they could overcome their perceived shortcomings is probably too large a task for publicity alone, and is likely to be successful only as one aspect of a larger approach.

6.3.2 Donors and Non-Donors Feelings about Typical Non-Donors

(a) Donors Viewpoint about Typical Non-Donors

Donors found it relatively easier to express ideas about a typical non-donor than a donor, but again it was difficult for any clear cut composite picture to emerge.

> "I wouldn't say I could spot someone who wasn't giving it." (Donor)

As when discussing donors, the factor of social class was hardly ever mentioned, but after prompting, a similar proportion thought a non-donor would be middle class as thought a non-donor would be working class. This did not relate to the discussants' own socio-economic status.

Specific age groups were also rarely mentioned, but after prompting it was felt that non-donors were young rather than old, at least under the age of thirty-five years, if not in their early twenties. This is interesting as it was also thought that most donors were young.

As in the description of donors, the factor of sex was hardly mentioned, and there were no ideas on whether a non-donor would be more likely to be male or female.

In most cases, donors felt that non-donors were people who did not give because they were scared of some or all aspects of the procedure, but especially because of a fear of needles. Being usually kind people, they were mostly sympathetic to these fears, sometimes remembering their own anxieties.

More practical reasons were also put forward: that non-donors were not fit to give blood, being possibly anaemic or underweight. In some cases, however, they felt that non-donors who gave these reasons were perhaps at fault for not checking that they were ineligible.

> "I don't think enough people find out if they can give blood. You know, they just say 'Och, I had this years ago and they wouldn't take mine'." (Donor)
>
> "I think it's ignorance as well. They don't realise you can make up your blood." (Donor)
>
> "A lot of people have said to me that they can't go because they're working. They don't realise that it's open in the evenings." (Donor)

A few were much more critical about those who did not give blood, when they did not have a good reason.

> "They're pathetic as far as I'm concerned." (Donor)
>
> "Do you mean someone who doesn't care?" (Donor)
>
> "I think it's laziness and the bother to go and do it." (Donor)
>
> "Non-donors don't give because of apathy." (Donor)
>
> "Some are selfish and think somebody else can do it. There's always somebody else who does it to keep enough going." (Donor)

While some donors were scathing about non-donors, others would support them in their decision.

> "It's up to the person himself. I don't think you can persuade them if they don't feel they should. I think it's up to them." (Donor)
>
> "Especially when it's still a voluntary thing anyway." (Donor)
>
> "I'd certainly never condemn anyone for not giving blood." (Donor)

Another aspect mentioned by some donors was that some non-donors might think that donating blood was a "goody-goody" activity which might antagonise some people. However, no non-donor actually voiced this point of view.

> "I think people are less inclined to go and publicly do worthy things than they used to be. They think it's a terribly conformist thing to do, something that is socially responsible and useful such as giving blood, which is a highly praiseworthy thing." (Donor)
>
> "I think people switch themselves off. It's a goody-goody sort of thing to do." (Donor)

(b) Non-Donors Viewpoint about Typical Non-Donors

In general non-donors had similar views as donors about a 'typical non donor' and mentioned similar points.

They, too, were quick to say that many non-donors were frightened, and that this was understandable. While some saw no reason to feel guilty about not giving blood, many were critical of themselves and other non-donors, by saying they could be described as lazy or selfish. The latter group indicate some degree of acknowledgement that they should donate and so might respond to an emphasising of the reasons why their donation is necessary.

One extra point that was mentioned was that it was felt that a non-donor might be someone who got embarrassed easily and so would be deterred by the potential embarrassment of the donating situation.

In conclusion, just as a donor could be seen to be anyone, so could a non-donor, and no typical person was described, in terms of age, sex or socio-economic status.

Both donors and non-donors described non-donors from one of two different perspectives. Firstly, and most frequently, that they were frightened of some aspects of the procedure that inhibited them from donation. Both donors and non-donors felt this was understandable and acceptable, even though donors with stronger motivation had been able

to overcome similar fears, indicating that many apprehensions might be rationalisations rather than real reasons for not donating (see Section 6.5). Secondly, that non-donors were lazy and apathetic and did not care about others. Donors, who had a fairly well developed social conscience, tended to criticise this attitude although others, being generous people, were tolerant about this. Non-donors who admitted to feeling that they were apathetic or lazy, might be susceptible to arousal of guilt feelings, but only if this claim of apathy was not a rationalisation for deeper fears.

After prompting, it was thought that non-donors as well as donors might tend to be younger rather than older. This might indicate that it was felt that blood donating was something done by older people. However, it is more likely that people thought of defining non-donors as being young because it was felt that it was in the younger age groups that people were expected to give blood. Older people might not be expected to donate anyway, and therefore not be so strongly defined as non-donors. This, combined with the idea of donors being marginally more likely to be young, indicates that the general public already feels that it is the younger age groups that should donate, and therefore it would be acceptable for BTS to choose these as the target for campaigns.

6.4 Factors which Encourage the Donating of Blood

This section discusses two major issues which encourage the donating of blood:

- initial stimuli to donate (6.4.1)
- factors encouraging continued donation (6.4.2).

6.4.1 Initial Stimuli to Donation

Donors usually had some degree of awareness that it was possible and useful to give blood before they actually made the decision to donate, although there were a very few for whom it was a completely spur of the moment decision. Most people would then experience some extra stimulus or combination of stimuli which triggered them into

taking the step, often a large step, of giving blood for the first time. People remembered very vividly the circumstances which first stimulated them to give blood. Four main 'pressures' predominated:

- normative pressures - the importance of group feeling (6.4.1.1);
- contact with illness requiring blood (6.4.1.2);
- a desire to serve the community (6.4.1.3);
- spur of the moment decision - triggered by convenience (6.4.1.4).

6.4.1.1 Group Pressures - The Importance of Group Feeling

Most commonly, people were stimulated to donate by some sort of normative pressures: a group of people giving blood together and projecting a feeling that "everybody does it". It was quite unusual for people to have gone completely alone and unprompted to their first donor session.

There were obvious areas where normative pressures could be strong:

- Where people gave at workplace donating sessions.

> "Everyone in the office went." (Donor)
>
> "My wife's always making excuses she's too scared - she didn't want to lose face in front of her friends so when they suggested it, she went. She was fine." (Donor)
>
> "They kept calling me coward and eventually I could not see any reason why not." (Lapsed Donor)

- This might be more extreme in the Armed Forces or in sessions at HM Prisons, although there were no research interviews in these situations.

"In the Royal Navy where I started if you didn't give they went 'nah, nah, nah, nah', you know, so everyone gave blood. You got plenty of blood out of the Services." (Lapsed Donor)

- Donation at College:

Many students seemed to have been carried along on a wave of youthful enthusiasm and had been able to overcome a lot of fears.

"I went twice when I was a student and there was a lot of pressure from other folk going along in a group." (Lapsed Donor)

"They had one big sort of session about the charities and everyone got a badge. I gave blood." (Donor)

"I went once. I was at the Tech and I plucked up courage because I was the only one (not going). It felt great. The courage of getting in through the door and signing and the standing on the scales." (Non-Donor - refused because under-weight)

However, students did not always continue to donate when their circumstances changed and they had moved elsewhere, making it less easy to attend a session. There may therefore be some potential in trying to maintain contact with this group.

- General public sessions in rural areas:

"We all talk about it for a fortnight before they come." (Donor)

"You always ken someone to talk to." (Donor)

- Families where everyone gave blood:

It was thought of as something one would start doing as soon as one was eighteen years old, and often they would have been taken along by one of the family.

"Both my parents gave blood and you just assume, because your parents do it, you do it without thinking." (Donor)

"I just followed on from my father when I was old enough, I was just carrying on." (Donor)

"My father took me in at first and actually held my thumb." (Donor)

While donors in the types of situations described above had responded to normative pressures by donating, it should be noted that many people in the same or similar situations did not always respond in this way, and indeed could be completely unaware of such pressures. [This is also discussed in section 6.2.4.2. For example, one youth described being one of two people left in a lecture room at college while a large class filed out to give blood. The reason he gave initially was that he "just didn't fancy it"; on further discussion it transpired that he disliked needles, was wary of the injection site and thought he would feel dizzy afterwards.

The reasons why some respond and some do not are complex. They relate to a balance between the variable strength of the pressure exerted by the group and the individual's susceptibility to respond to such pressure. This susceptibility depends in turn on, firstly, the inhibiting factors to donation that he or she might feel; and secondly, the way that individual reacts to group pressures in general, and in particular to the group's appeal to his social conscience. The extent of pressure to donate that a sub-group of donors can exert on a total group will also depend in part on the types of people they are and their attitude towards encouraging others to donate, and on the cohesiveness of the whole group. Among the critical issues are the following:

- The manner in which donors try to encourage group members will be important. Some may make active attempts to encourage others, trying to educate and to reassure about the procedure of donation, or alternatively to tease or jolly them into donating. Both result in relatively strong pressures. In contrast, others may act less positively, being consciously

reluctant to "preach", tending to give blood inconspicuously and providing pressure merely by their example.

Since group pressure does form an important function in encouraging donation, then it could be useful for BTS to provide material to help those who wish to encourage others. This could include information packs about blood uses and blood donation, or posters and leaflets to hand out, both of which could improve the "encouragers" own knowledge, and him or her better able to persuade others.

- The strength of group pressures will also depend on the degree of cohesion in the unit, including the extent to which they participate in other activities together. For instance, in a workplace if people eat together or meet together for evening activities, they might be more easily "carried along" in this further group activity of donating blood, than those who remain generally more isolated.

- Fears and apprehensions about the procedures are probably the most common factors that modify these normative pressures, although group feelings of encouragement and support often help people overcome these anxieties. (These fears and apprehensions are discussed in detail in Section 6.5). As well as fears about the procedures, apprehensions about "making a fool of yourself" by fainting or being sick could be relatively important in a group situation.

- Some people are not "joiners" and might be repelled by any group pressures, consciously deciding not to do what everyone else is doing. It is important therefore to identify those who are most receptive to normative pressures, and avoid the approach for those who are not.

- Some people have a very low altruistic drive and feel very little obligation to make any effort for others. This is especially so for people unknown to them, as is the case in blood donation. These people could readily ignore any

pressure (often without guilt), feeling it was nothing to do with them. They would not therefore be amenable to such an approach.

6.4.1.2 Contact with Illness Requiring Blood

A number of people mentioned that they decided to donate after the illness of someone known to the donor, usually a relative, friend, or workmate.

> "A friend was suddenly rushed into hospital, needed blood quickly and it suddenly registered afterwards if they hadn't had the blood that would have been it. I realised then that you or your family could be in the same situation and this triggered it off really." (Donor)

> "My wife needed quite a lot of blood during the operation. Later I sat down and thought about it, that the blood was available when she needed it . . . stirred me into going . . . I'd thought about it off and on but I'd never made the move to go but that spurred me. I was apprehensive but I was so determined to do it. I didn't feel it was a means of paying back. I felt it was an important thing to do. You go through the experience and you feel you want to give every ounce of blood that's in your body, just simply because you're feeling grateful." (Lapsed Donor - Temporary lapse due to illness)

A few people wished to donate through having received blood themselves.

> "I got my tonsils out and I had to have a blood transfusion. People laugh . . . but I say 'well it saved me' - and I think it was that that made me go on from that." (Donor)

However, some people who had had transfusions (especially for more serious illnesses) did not wish to donate. This seemed to be either connected with their hospital experiences, which made them wary of other hospital-like situations such as a BTS session, or just that they continued to feel unfit in some way.

> "I've never given a pint of blood to anybody for the simple reason that I think, going back to the age of twenty, I had an operation for a stomach ulcer and I always felt that's put me off giving blood. If you go through a big operation or any operation or any jags, then pain is unimportant. It was just the fact that I thought 'eugh' - and from then on I just felt I need what I've got." (Non-Donor)

> "My sister-in-law had a young one and lost four pints of blood and was really bad after it. I said to her 'Have you ever thought of giving blood yourself?' She says 'No'. I think that's selfish really. Someone really helped out. You'd think that would make people think about it." (Donor)

6.4.1.3 A Desire to Serve the Community

Some people chose to give blood because they were looking for something 'good' to do. For many, this was a relatively easy way of serving the community without involving great commitment in time and effort.

> "I started giving blood because the only worthwhile thing I could think of at the time was giving blood, because it was on my mind . . . I thought maybe I could contribute something." (Donor)

For others though, the involvement and effort in giving blood was a way of highlighting their commitment to the community.

> "It's easy to give money for a donation - like Cancer or Spastics; giving blood is really something." (Donor)

Although serving the community was not mentioned frequently, as a single initial stimulus it often underlay other stimuli to a greater or lesser extent. The acknowledgement of an individual's obligation to the community to help it, and put oneself out for it, can sensitise reaction to other motivating stimuli, as well as providing a stronger motive for continuing to donate.

6.4.1.4 Spur of the Moment Decision - Triggered by Convenience

A small section of people reported that they had just made the decision to donate on the spur of the moment. This might be when they saw a mobile unit, or an advertisement for a local session which was actually going on at the time near by, "and I just walked in". Usually these people would have thought about giving blood before, however, with the final decision stimulated by the convenience of the session.

> "I don't know anyone who gets up out of bed in the morning and says 'I'll give blood at 12 o'clock.' It just happens in passing, you've got an hour to kill and that's it." (Donor)

For BTS to take advantage of this, it would be necessary to make sessions as quick and easy to attend as practicable. It would probably also require a high level of local advertising, especially in areas which are only visited twice a year, thereby creating maximum awareness of where and when sessions are held. In this regard, it should be noted that central donation points such as St Vincent Street, Glasgow, where people can donate at more flexible times and thus more easily act on the spur of the moment, were not well known by non-donors.

6.4.2 Factors which Encourage the Continued Donation of Blood

The research identified three main factors which encouraged continued donation:

- continued strength of initial stimuli (6.4.2.1);
- group feeling and handholding (6.4.2.2);
- rewards (6.4.2.3).

6.4.2.1 Continuing Strength of Initial Stimuli

In many cases the motivating factors just described which trigger people to decide to donate once will be strong enough to ensure that they donate again, especially since they have overcome the major

hurdle of the first donation. These factors were identified as normative pressures, contact with illness requiring blood, desire to serve the community and spur of the moment decisions.

However, the strengths of these stimuli may fluctuate over time. If people had reacted solely to group feelings and felt no other motivation to give blood other than the fact that "everyone else is doing it", then they might lose commitment, especially if removed from that group situation. In the same way, people who gave on the spur of the moment might have no commitment to give again (see Section 6.6). Probably most committed are those who were aware of the need for blood due to personal contact with illness, and those who acknowledged a responsibility to serve the community by giving blood.

However, it is important that the initial intention to donate should be modified as little as possible by the actual experience of attending a donor session and giving blood. This should hopefully be no worse than people's expectations, and probably much better. While very committed donors appear not to be deterred by unsatisfactory experiences, those with less commitment could well be, and it is important for staff to be aware of the aspects of a session which people could find upsetting and avoid them where possible. (see Sections 4.0 and 6.6). This is particularly important for some of the specific sub-groups in the blood donation 'market', as discussed in Chapter 8.

6.4.2.2 The Importance of Group Feeling to Continued Donation - Handholding

As well as generating pressures to start donating, group feeling was also very important to help support people when actually attending a session. Where this functioned well, it could make the experience of donating enjoyable and minimise feelings of anxiety, and the prospect of donating again could be viewed with pleasure.

Group feeling and support were especially important when people were donating for the first time.

> "You wouldn't go yourself because you'd be frightened in case there's nobody there to help you." (Donor)
>
> "We went together because I was nervous. I wasn't sure what was going to happen." (Donor)
>
> "It all depends how people feel about walking into a large room on their own." (Donor)

Most donors remembered feeling anxious when they first donated blood, and some continued to feel nervous or squeamish at subsequent sessions, although to a lesser degree. Being in a group, or even just with one other person one was acquainted with, helped to overcome a lot of worries, partly through having the distraction in talking and having to keep up a brave face but also in making one feel more sure of care and support should something go wrong. This was one aspect of the popularity of workplace donation, or giving in rural areas: even if one did not attend at the same time as someone one knew well, there were always familiar faces and people to talk to.

Interestingly, this availability of friendly faces and "handholding" support seemed important not only at the beginning of the session to help give courage to attend, but also at the end of the session, when people needed someone to relax with and discuss their experiences.

> "You get the tea and you say, 'Oh my, that was terrible.' You relax. There's nothing worse than sitting beside strangers." (Lapsed Donor)

One lady noticed a great difference between her previous experiences of donating at workplace sessions, with lots of people to talk to, and then recently attending a General Public session in her lunch hour. On her return to the office she felt discouraged from talking about it.

> "I felt I was all chuffed because I'd given blood. I felt really great, but I felt as if they were all saying 'Who does she think she is?' So I just clammed up right away. I just felt they all went 'Huh - I'm goody-goody because I've been to give blood.'" (Donor)

Significantly, out of all the session staff, people often had warmest praise for the 'tea lady', who made a point of asking them how they felt and gave them an opportunity to chat. It is therefore important that staff should be available to fulfil the role of 'hand holder' when people attend sessions on their own or get separated from people they know. Again, the implications of this are further discussed in Chapter 8.

6.4.2.3 Rewards for Giving Blood - Encouragement to Continue

Many donors found it very rewarding to give blood and to be associated with the BTS. Where people felt a sense of reward from donating it stimulated their personal commitment to continue, enhancing the inital motivating factors. By contrast, those who did not perceive and identify with any sense of reward, while possibly donating a few times, might be less likely to continue on a regular basis if the initial stimuli to donate gradually faded, allowing inhibiting factors to gain precedence.

Some donors appreciated the formal reward of the BTS badge scheme (which will be discussed later), but many donors found aspects of attending sessions and giving blood to be rewarding in themselves. Indeed, this latter aspect affected a greater range of donors, since many people, especially those who have only given a few times, do not relate to the badge scheme in any useful way. These informal rewards were mostly perceived and described by donors, non-donors often being unaware of them. Since people have limited awareness of them before they have actual experience of giving blood, these rewards are rarely primary triggers to an initial donation; although hearing about them second-hand from another donor might be a secondary factor in encouraging someone to donate. However, they did have importance in encouraging continued donating, particularly for older donors.

Different donors found different aspects of the sessions to be rewarding to them. Among these were:

- Attending a session and giving blood often made people feel psychologically better for having done it.

"You feel right good after you've done it." (Donor)

"You just get satisfaction from giving it." (Donor)

- The sense or feeling that they had done something worthwhile was probably the most frequently mentioned factor.

"I think you feel important." (Donor)

"I feel smug about giving blood sometimes, because I know it's a worthwhile sort of thing to do, but not everyone's like that." (Donor)

- A number of regular donors also appreciated the opportunity of participating in the atmosphere of the sessions, which they enjoyed.

"It's peaceful and you get to lie down for a wee while." (Donor)

"It's very relaxing. It's nice to lie up for quarter of an hour. Usually someone sits beside you and you have a talk and the last thing you think about is your work and the fact that you're giving blood." (Donor)

"I quite enjoy it." (Donor)

- Some people felt physically as well as psychologically better for giving. Having blood taken from them was thought to have some cleansing effect and was also thought to help reduce high blood pressure.

"Physically I feel much better for giving blood. I do suffer from blood pressure. I can usually tell 'Now's the time I should go and give some blood.' I do feel much better afterwards." (Donor)

"I don't know whether it's that I feel good for giving it or whether it does your body good to give a pint of blood. You get rid of it and you're replacing it with fresh stuff." (Donor)

"It clears out your system." (Donor)

- Some donors felt that because the blood they had given was being tested, an indirect benefit of giving blood was having a medical check-up. It was felt that if "anything was wrong with me" it would be detected, although perhaps there was an unrealistic expectation of the range of illnesses which might be screened for.

> "It's nice to know your blood's right, because it's tip-top." (Donor)

> "If I go people say to me, 'Oh, they won't take my blood.' I say to them, 'It's no use to you either', therefore it's better going as a medical check-up. I tell the women in my family to go because women very often are anaemic and if you get your blood checked every six months I think that can be a very good plus point, particularly for females." (Donor)

> "If you have something wrong with your blood, you know. A friend of mine developed leukaemia and died. If he'd been a blood donor it would have been picked up. You get a constant check on your body." (Donor)

- More tenuously, people felt rewarded by the secure feeling of having made their contribution towards the stock of blood for the potential benefit of themselves and their family as well as the general population.

> "I wouldn't like to be in the position where I needed blood and I knew I'd never actually given blood myself . . . I'd prefer to think 'Well, I've given blood and I'm getting blood now, so I feel OK'." (Donor)

> "I'd hate to be in an accident - I'd feel right guilty about taking someone's blood when I wouldn't give them mine." (Donor)

Some sections of donors appreciated the more formal reward of the BTS badge scheme. This involves the bronze, silver and gold badges being awarded to people who achieve 10, 25 and 50 donations respectively. Only a limited number of badge holders were recruited to the donor groups, but other donors and non-donors were able to talk about people they knew with badges.

While most people had a vague idea that badges were given out, it seemed that those who were most aware of the badges and most interested in attaining them, were committed, regular donors, who could be from any age, sex or socio-economic group, but were characterised by their high degree of commitment. These donors would probably still give blood without the badge scheme but felt it provided goals worth aiming for and reinforced them in their intention to continue donating. While not expecting thanks, the badges were often seen and valued as a sign of appreciation by the BTS for their efforts.

Marginally less committed donors often seemed to relate more to the badge scheme when they neared a target number, especially the earliest number. For example, someone donating for their second or third time, might not consider attempting to obtain a badge, but by the time they had reached the seventh or eighth donation (admittedly already indicating a relatively high commitment) the desire to obtain a badge might then be an active encouraging factor.

> "I think you need an incentive, the reward syndrome of working towards the wee tin badge at the end." (Non-Donor)
>
> "It's good to encourage yourself. I need another four." (Donor)
>
> "Other people might wear the badge - like a medal for the Falklands. A lot of people are proud of the medals." (Conflict Group)

While not all respondents were willing to work for it, both donors and non-donors admired those who were seen to have achieved a high donation level, although some were a little amazed by the importance the badge assumed to those near the higher levels.

> "It's quite an achievement if you get to the top medal for giving blood. It's 50 pints." (Non-Donor)

Another benefit from wearing the badge was seen to be that it could give opportunities for donors to encourage other people to give blood.

> "By wearing a badge you're not just showing off. It jogs a person's mind who sees it. . . Maybe someone who's missed a couple of times and it'll remind them." (Donor)
>
> "People who have never given blood say 'What's your badge?' Then you start explaining it to them and they start getting interested." (Donor)

The badge system therefore appears to be a worthwhile exercise. It was not seen as a reason to donate initially, with non-donors and early donors not relating to it but it provides encouragement as donation increases. It thus fulfils a useful role by thanking regular donors, who are valuable to the BTS because of their high level of commitment.

It was also suggested in a number of groups, especially by early donors and younger people, that the BTS should also provide more concrete recognition of the first time donor to encourage them to donate again. This could take the form of a substantial badge or certificate, rather than the current practice of just sending them their card and a letter.

> "It shouldn't be a cheap badge. It should be something that looks good, like a club badge." (Donor)
>
> "They should give you a certificate the first time you give blood - to make you feel a sense of fulfilment." (Non-Donor)

Some people even said they would be willing to pay for a metal or enamel badge. This indicates an appreciation of the badge scheme for the reasons discussed, but also a realisation that it seemed too distant a goal to obtain at early donation.

Some people also wanted a badge to mark them out as having given blood, even if only once. It indicated that they had made a contribution to society and therefore been 'good'. As one smoker who felt ostracized because of his smoking said:

> "Smokers have been put in a class of their own now - why can't we (donors) be put in a class of our own now as well." (Donor)

If badges for first time donors were introduced (as opposed to the insubstantial stickers given at sessions), it would be important for them to be seen to be separate from the "merit" badges, to avoid devaluing them and perhaps offending valuable, committed donors.

A number of people found that even just receiving their blue donor card with their name and blood group made them feel good, and they enjoyed counting up the accumulating stickers. In many cases, this was a more satisfactory and immediate sense of reward in comparison with the traditional badge scheme.

> "You've got a little book and you get a sticker every time, and you can lift them up and count how many you've got, and once you've got ten you get a medal." (Donor)

> "Remember when you got your wee blue card, you think you're great." (Lapsed Donor)

> "I didn't get any personal satisfaction. The only satisfaction I got was when I got my wee card through the first time and I thought 'That's fine, I'm a blood donor.'" (Lapsed Donor)

It would be useful for the BTS to take advantage of this interest in receiving the donor card. Perhaps a personalised letter of thanks could be included, expressing the gratitude of the BTS and future blood recipients. It would also be a useful time to forward some explanatory leaflets about the need for blood and the uses to which it can be put. The new donor now knows he can cope with giving blood, and encouragement and information given at this point could affect the decision whether to continue to donate, not only next time but for a number of times afterwards.

A less conscious reward offered by the BTS was the refreshments after donating.

> "If I'm passing the place in town, I'll give it. You get a free cup of tea and a biscuit." (Donor)

> "I'd do anything for a cup of tea and a biscuit." (Donor)

While this may seem a frivolous aspect, it was often seen as a free gift from the BTS rather than being given for medical reasons. It was therefore gratefully received as a form of repayment and as thanks. In addition, the value of the cup of tea is shown by the observation that when intending donors were refused, they were always very impressed if they had been offered something to drink "anyway".

The topic of financial reward for blood donation was raised by respondents and has already been discussed (3.2.3.2). In general, most respondents did not approve of the concept, especially regular donors. Some non-donors, however, thought it might be a useful trigger to get people to start attending, even if the sum of money was small. For instance, £1 or £2 was thought sufficient or, failing this, travel expenses, or even vouchers for prescription costs.

> "If people are unemployed the cash is stretched pretty thin anyway, and even the cost of the transport locally is pretty astronomical, it would cost them a fortune. The last thing they'll spend it on is blood." (Donor)

As a footnote to this section about the many and varied reasons that trigger people to start donating and why they might feel encouraged to continue to donate, it is important to note that all these stimuli are available to a large proportion of the eligible population. For instance, most people are acquainted with someone who has given blood, or perhaps know someone who has received blood, although they might not be aware that they had. Most people could potentially respond to one of the rewards just described.

However, they do not all choose to respond by donating and some of the reasons for this will now be discussed. Perhaps, though, the BTS could usefully bring more of the positive rewards and advantages, as perceived by current donors, to the attention of non-donors.

> "The advantages are not put forward and these are things that could sell it." (Donor)

6.5 Factors Inhibiting Blood Donation

All respondents were asked to discuss why they thought people did not give blood. Again, as for the factors which encouraged donation, a wide range of factors emerged. These ranged from insurmountable fear about giving blood, to minor fears, to apathy and to negative feelings about the BTS.

As already highlighted in the introduction to this section (6.1) it is important to consider these issues in the context of an individual's total attitude towards blood donation. Different people will find different factors inhibiting and the relative importance given to each factor will vary from individual to individual.

These inhibiting factors thus interact with each other, but also with whatever combination of encouraging factors the individual experiences. Hence, someone who experiences quite strong inhibitions might still donate if the encouraging factors (mentioned previously in Section 6.4) are strong enough, especially if they are seen to be of personal relevance. Equally, someone who experiences no inhibitions will not necessarily donate if the encouraging factors are absent or limited.

The decision whether to donate or not is therefore a complex one, based on the interaction and relative salience of both inhibiting and encouraging factors at any particular time. Because of this complex interaction, some of the factors put forward as reasons for not donating will, on further analysis, turn out to be rationalisations rather than real reasons. For instance, a particular fear may be offered as a 'reason' for non-donation, but it may nevertheless be overcome for another purpose and in another situation (usually involving personal benefit) when the advantages outweigh the drawbacks. It is therefore important to analyse any inhibition or 'reason' for not donating within its complete context.

This section discusses the major factors identified as inhibiting blood donation. Some of these, such as fear of needles will be extensive and deep-rooted for many non-donors, but not necessarily for

all. Others, such as fear of the unknown, will be less important overall, although crucial for a few. The major issue to remember is that virtually any issue at all can be strong or mild depending on the individual who is experiencing it, and that its 'importance' in affecting blood donation depends not merely on the extent to which it is held, but on its interaction with alternative motivating factors.

Among the more important issues identified were the following:

- fear of needles (6.5.1);
- associations with hospitals/doctors (6.5.2);
- fear of the unknown (6.5.3);
- fear of 'something going wrong' (6.5.4);
- other clinic fears (6.5.5);
- apathy (6.5.6);
- convenience (6.5.7);
- negative concepts about blood donation (6.5.8).

Some common themes underlying these issues are discussed in Section 6.5.9.

6.5.1 Fear of Needles

For many non-donors, the implications of being subjected to a needle in order to give blood triggered deep seated fears and emotions. Two aspects predominated

- associations with pain (6.5.1.1)

- psychological implications of intrusion into the body (6.5.1.2)

6.5.1.1 Pain

On a general level, the most commonly expressed opinion about 'the needle' was simply that it would 'cause pain'.

> "You think that it'll hurt a lot. You do really think that it's painful no matter how often they tell you." (Donor)

This negative attitude is unfortunate, particularly as a substantial number of non-donors were unaware that a local anaesthetic is usually given before the main needle is inserted. (Indeed, some donors were unaware of this as well). One implication of this finding might therefore appear to be that such fears could be resolved by making non-donors more aware that local anaesthetics are used.

However, this implication is too simplistic. There was little evidence in the research to indicate that non-donors' perceptions of pain derived from any real knowledge of donors actually finding the process painful. Although examples of this were quoted during the interviews, they tended to be random and anecdotal, expressed more as justifications for already held emotional beliefs that 'the needle had to be painful' rather than 'objective' knowledge shaping opinions.

Instead, fear of needles seemed more emotionally based, for several reasons.

- There was some indication that needles were more threatening when associated with blood rather than with more 'neutral' uses, such as holiday injections, simply because blood is connected in many people's minds with injury and suffering.

- Many examples were quoted of situations where injections, while never pleasant, were relatively painfree. Prime examples of this were dental injections, and to a lesser extent, those for blood tests.

- Injections were often tolerated in situations involving personal benefit, such as for medical investigation, dental treatment, holidays, and even for cosmetic reasons, such as having one's ears pierced.

> "If you go to hospital for a reason, like you're sick and they're trying to do something to make you better, then there's a reason for coming in every day for blood or whatever. You accept that and the fears are not necessarily there." (Non-Donor)

> "I go to the dentist with trepidation but I go through with it and the needles. I'll go and do that, but when it comes to blood, mention needles and I won't go and do it." (Non-Donor)

> "With the blood you can just say 'I'm not going'. But if you're going to, say, Spain, you can't say, 'well, I'm not going because of the jag.' There's no incentive to give blood." (Non-Donor)

> "People go and have their ears pierced and that probably hurts as much. It's virtually the same thing." (Donor)

Both the emotional nature of these fears and the depth with which they can be held means that in practical terms, there are likely to be many difficulties in overcoming them. Because they are emotional and intrinsic to the individual, any statement that they will not be experienced may be irrelevant, no matter how well it is presented. Only the individual can judge how and when pain will be experienced, and to this extent, external 'authority' figures such as doctors, BTS personnel or even 'status' figures such as Noel Edmonds/Sue Barker, may be seen to have little competence or credibility in what they say. No objective standards exist: the perception of pain is internalised, confirmed or otherwise only after the experience of donating has taken place.

> "I mean the fact that it doesn't hurt you at all - you don't know that until you've been." (Donor)

An alternative strategy would be to encourage donors to persuade non-donors that the procedure is painless. Two problems exist here, however. Firstly, the basic issue that the perception of pain is an individual judgement is still likely to predominate, although the opportunity for discussion may allow opinions to be expressed more convincingly. Secondly, while donors often stated that they would like to reassure non-donors that the process was not painful, in reality this was sometimes not the case.

> "Sometimes you go down and you give blood and it's no bother, but other times there's obviously a bit of bother. Some of them are more skilful at taking it than others. If they're skilful you don't feel a thing." (Donor)

The eventual strategy to adopt in approaching this issue will depend both on the depth with which the fear is held, and the extent to which compensating, motivating factors exist. For some, fears will be extensive, with few compensating benefits of donation. In such circumstances, effective strategies are likely to be difficult to implement, and/or cost ineffective. For others, however, the relative balance between fears and benefits may be more encouraging, making them potentially more amenable to persuasion. This means that practical action will depend on the complete range of attitudes and motivations held, with different strategies suitable for different people. The full implications of this are discussed later, with Section 8 outlining alternative strategies for different groups.

In the meantime, it should be noted that even if non-donors with extensive fears of needles can be persuaded to attend a donating session, they will be extremely sensitive indeed to the procedures they experience at their first visit to a clinic session. The implications of this are self-evident.

> "I know two, maybe three, people where their first pint of blood was their last, and it was mainly because of the experiences they had." (Donor)

> "They didn't take blood that time. They attempted to take it but had a terrible time finding my vein, they had about five attempts so that put me right off. It was just horrible so I haven't bothered to go back." (Lapsed Donor)

6.5.1.2 Intrusion into the Body

As the group discussions developed, it seemed that many respondents had a generalised fear of needles that extended beyond mere fear of pain. This could apply not only to needles used in a blood donation context, but could also encompass other situations as well, such as their use in dentistry.

> "It's just the needle. I've asked for fillings without it. I don't want the needle. The drill doesn't scare me, but as soon as he gets the needle out I get petrified." (Non-Donor)

To prefer the pain of a tooth being drilled to being exposed to a needle indicates a much deeper fear of needles than just pain. This seems to be related at least in part to the feeling that inserting the needle and taking blood is a serious intrusion into the individual's body.

> "I've never found it hurt me when I had a needle in the arm. It's just the actual fear of thinking they're going into my arm." (Donor)

> "It's not the pain, it's just a phobia about things going under your skin." (Non-Donor)

It appeared from this research that many people experienced this fear, but usually to a fairly mild extent. This was illustrated in the tendency for some donors to look away from the site of the needles on insertion, a procedure in fact recommended by many doctors and nurses giving injections in general. It thus indicates that while some mild fear existed, the person coped with it with a minimum of effort, possibly because of the personal benefits gained.

> "I look away from it every time. I'll go up to that bed and I'll lie down and just look away. The next thing I know the tube's in and the blood's pouring away. I don't know whether I'd actually be able to watch them stick the needle in." (Donor)

An extension of this fear of intrusion was the idea that the consequences of so doing, ie giving blood, resulted in 'giving away' an important part of oneself, almost ones life force. This seemed a much deeper fear.

> "I think it might be akin to the old concept of some of the aboriginal peoples who were absolutely terrified if you took their picture because you were taking away the image of them and therefore they lost something - almost black magic. I think it's a very deep seated thing." (Donor)

> "I think this fear is the draining of your life-long blood. That's the thing with us if you cut yourself. A tiny nick on the finger will, because it's well supplied with blood, bleed like . . . . It really does bleed and everyone starts thinking 'It's my blood'. I think it's the same set up. You can see your blood drain away. It's all psychological - you think your life is going too." (Donor)

> "There's a personal thing involved in blood too - it's my blood, it's mine and I'm keeping it." (Non-Donor)

> "I just don't want to give blood out of my body to a bag hanging in some deep freeze." (Non-Donor)

As a further illustration of this fear, it is relevant to note that many expressing it used language such as 'your blood's draining away' and 'taking blood'. Equally, those more positively oriented, and perhaps those who see blood donation as a voluntarily offered part of ones own self, tended to use terms such as 'giving blood', rather than the more formal 'blood donation'. It is therefore important for the BTS to be continually aware of the voluntary nature of donating, and the immensity of the gift that many donors see themselves as providing.

Some non-donors also felt that the site of collecting blood, the crook of the elbow, was a particularly private and vulnerable part of the body. This was mentioned by both male and female non-donors in the younger age groups. The crook of the elbow, while not hidden, is not often exposed, certainly not to the extent of the artificially straight arm required for blood donation. These fears are difficult to interpret - possibly they may be related to the fact that the veins are highlighted, thereby making the sense of intrusion more vivid when punctured; possibly, too, there are sexual connotations. Those who were affected by this feeling claimed that they might feel better able to donate if the blood was taken from a different site.

> "If they took it from my legs I'd be all right. I think that's what's getting me too - can they not take blood from anywhere else?" (Non-Donor)

While blood donors can be offered the choice of blood being taken from the right or left arm, which was much appreciated, offering a wider choice of site could lead to clinical difficulties and be organisationally more cumbersome. Such changes would probably not be worthwhile to attract what would probably be a small number of donors, although the concern should be borne in mind by clinic staff.

In summary, this fear of intrusion into the body, and the implications of removing a part of it, were often quite deep-rooted. At its most extreme, it was entrenched to the point of being virtually irremoveable. For more moderate fears it may be helpful to promote information reassuring the individual that the body can easily make up the loss of blood, although the psychological nature of the fear may make this approach less productive than might at first sight appear. In its mildest form of all, people were able to cope with the fear merely by looking away from the site of the intrusion, an approach which could usefully be encouraged.

The extent to which this fear can vary illustrates again the concept of a continuum, where people will respond to fears in different ways according to the intensity with which they are held. Also of relevance is the extent to which encouraging factors exist at the same time, and their relative salience. Except possibly for those with deep-rooted fears about the loss of self, many non-donors claimed that they could overcome fears if the reasons were important and personally relevant enough. Often such situations were defined in very extreme terms, involving an immediate and livesaving need for their blood (and theirs alone) by someone they knew personally, or, to a lesser extent, in some very local, major disaster, involving a lot of people.

> If someone was to have an accident in my house and they really needed blood you would definitely do it. You wouldn't just sit and say 'Oh, I'm scared of that needle', you would do it to help them and then say I helped that person for the rest of their life." (Non-Donor)

Whether the intention to give blood would become a reality in the situation cited above is perhaps a moot point, but it does highlight a

potential alternative strategy in dealing with fears, particularly those that are so emotionally based and therefore possibly not amenable to rational, logical argument. This is to the effect that, rather than directly attack the fear itself, one should boost the importance of the encouraging factors that exist (or potentially exist) at the same time. This, in turn, means promoting the important benefits of blood donation and, as already discussed (Section 6.4), several of these exist. Among the more important to promote are likely to be the following:

- that giving blood can be rewarding to the individual. The major rewards that donors perceive have already been described in Section 6.4, but these are generally unappreciated by non-donors, except perhaps the good feeling of having personally saved a life;

- that the blood donated is important to real people. This could be achieved by giving information on why their blood is needed and what it will be used for, thus pre-empting the rationalisations that there are enough donors anyway and that other people can do it;

- that it is of benefit to each individual to maintain the stocks of blood, so that blood is available whenever he, or people important to him, need it. This is a necessary appeal to those who do not respond to the wider concept of serving the community in general. The value of this approach is also indicated by the strength of commitment of those who choose to donate because they know people who have needed blood.

In terms of publicity, the practical implication of this alternative strategy of attacking people's fears through highlighting the personal benefits of donation would be to promote a campaign that is positive, offers personal benefits and leaves behind attractive images of feeling 'good', rather than the Noel Edmonds type of approach which, as already discussed, may have limited impact. However, as discussed below in Chapter 8 it is important to note that such campaigns are likely to be effective only if integrated with

other forms of communication, particularly personal contact, especially if fears are in any way extensive. For non-donors whose fears are very deep-rooted, it is unlikely that such an approach will be effective, as discussed later, and there may be minimal potential in approaching them.

6.5.2 Associations with Hospitals/Doctors

Many people who expressed fears and apprehensions about attending the doctor or going to hospital were also frightened in the same way at the prospect of giving blood. They visualised many similarities between the two activities, being sensitive to both the clinical atmosphere and the association with pain and illness. These issues are discussed below (6.5.2.1). Respondents also compared fears of dentists with fears about donating blood but because these vary in cause and extent they are discussed separately (6.5.2.2).

6.5.2.1 Medical Implications

Fears about hospitals in general were experienced in varying degrees and from a variety of causes:

- Sometimes respondents were able to relate their fears to previous unhappy experiences.

> "I think I must have had a scare (in hospital for two weeks at four years old). At that time Mums were advised not to come in and see their children. You put your kid in and then came back to collect her. My Mother thinks I've got it there (fear of hospitals)." (Non-Donor)

> "The thing I always remember in school is when you got the long jags and I always tried to jump away but they always came back for you in school. I remember fainting when this guy put a jag in my arm. I don't know if it's related to that. I don't think too deeply. I've got a mental block." (Non-Donor)

- Other people had more generalised fears. These had no specific base, but were related to associating doctors and

hospitals with pain, illness and sometimes death, all of which they felt (at least emotionally) would come to them if they had contact with hospitals.

- Some susceptible people had the extra worry that something major might be wrong with them, which might suddenly be revealed after consulting a doctor, even for minor ailments.

> "My fear's right stupid. I just feel if I am going (to the GP) with something he's going to say, 'Right - hospital - emergency', and I mean if they said that I'd - I'd have to be unconscious the whole time I was in hospital." (Non-Donor)

- Sometimes the fears were focussed on specific aspects of medical situations, rather than the total experience of hospital contact. These included the fear of injections, squeamishness at the sight of blood, the smell of antiseptic and disinfectant, and the sight of uniforms, especially white coats. Unfortunately, many of these features also exist at a blood donating session.

Those who were frightened of hospitals found, or anticipated finding the environment of a donor session to be very like a hospital, for the above reasons, thus provoking similar levels of anxieties.

> "For a new donor there's nothing more frightening to walk up the stair into a converted lounge room and see something like sixteen to twenty bodies lying on stretchers with the bags hanging there." (Lapsed Donor)

> "The first time I went in I walked out - I saw all these bodies lying there." (Non-Donor)

> "If I wasn't so frightened of hospitals it wouldn't bother me - the small room, the bed, white tiles, smell, antiseptic. They'd be friendly. It's not the people, it's the atmosphere of the place." (Non-Donor)

> "It's just this preconceived notion of what it's going to be like. I've got a horrendous notion that I'm going to see all these white coats and white walls and big needles and things hanging up and the blood going into the bag. It's probably nothing like that." (Non-Donor)

In fact, these last two descriptions are probably not far from the truth in many sessions. It would seem that the interpretation of environment of a session will depend very much on the individual's own attitudes and preconceptions. Few regular donors complained about the medical atmosphere and in fact, with some people, the more like a hospital it could be the more reassured they felt.

The adverse reaction some people have to a hospital environment is something the BTS should be aware of, as well as respondents' general comments about the different types of session environments highlighted in Section 4.2. Medical and nursing staff should be conscious of ways in which detrimental aspects of a hospital-like environment could be minimised, bearing in mind the risk of appearing alarmingly casual. Developments could include the use of screens to break up the perspective of a large hall, coloured uniforms rather than white, and reducing exposure to the sight of tubes and blood. However, some clinical aspects would obviously need to be retained in the interest of safe procedures, although these could be reviewed from time to time.

It is also of relevance to note that comparable changes in hospital environments, for example small rooms as opposed to large wards, more interesting decor, and more informal uniforms, do not necessarily remove fundamental anxieties about hospitals and illnesses, especially those which are disproportionate to the apparent situation. It would therefore seem likely that most people who extend any deep-rooted fears about hospitals to a fear of donating blood would not find that fear modified to any extent by changes in environment. However, it is possible that those with milder fears might respond to such changes, although it should be borne in mind that some people find a clinical environment reassuring, even preferring to donate in hospital. The implication, therefore, is that while substantial changes would probably not be worthwhile, and might even antagonise regular donors, minor changes, such as smaller rooms and more interesting decor, would probably be beneficial.

One further relevant aspect of the fear of all things medical was that some non-donors were concerned about having their blood screened for illnesses. Such people also appeared to be reluctant to attend other screening situations, such as X-rays or smears, or even go to their doctor with a worrying symptom because they would rather not know if anything was wrong. In the same way, some non-donors did not want their blood to be tested for fear of what might be revealed, although they might have exaggerated ideas of what could be diagnosed from the basic tests.

> "If they took a sample of my blood and they looked at it and said, 'There's something wrong. I'm sorry, but you'll have to see a doctor back here.' I'd say forget it and be out of that door in seconds. I know it's a stupid attitude but I've just got that fear." (Non-Donor)

However, it should be noted that, in general, this reservation about giving blood because of fears of potential illnesses diagnosed, contrasted with the majority who thought that screening was a positive reason for giving blood (see Section 6.4.2.3).

Finally, it was clear that as for the fear of needles discussed earlier, people were usually able to overcome their fears eventually to attend for diagnosis and treatment if they felt strongly enough that it was necessary. However, while they could overcome these fears for the sake of their own benefit, it was evident that they would find it much harder for a much less personally relevant purpose, however worthy.

> "You give blood on your own bat - whereas if you get hospitalised, you're in hospital and you're under the control of that doctor and you do what you're told and take everything that happens to you. There's no choice - if you're just standing at a machine (at work) and this guy says 'Are you going to do this?' (give blood), you've got a choice in the matter." (Non-Donor)

6.5.2.2 Fears about Donating Related to Fears about Dentists

During the discussions respondents often spontaneously compared fears about donating blood with fears about attending the dentist.

> "Just like people are frightened of dentists. The dentist may never have hurt them but they still have a fear of dentists." (Non-Donor)

The two situations have many parallels: the use of needles, the clinical environment, the implications of possible pain, the existence of medical personnel and anxiety experienced.

> "Dentists are the same as the Blood Transfusion. They all have needles." (Non-Donor)

One aspect where dentists and the BTS were seen to be different, however, was their relative images. It was felt that dentists had developed and modernised their techniques more, not only in standards of their surgeries and sophistication of equipment used, but also in their manner towards patients, seeming, in many cases, to be more reassuring and understanding than they had been in the past.

> "Dentists have advanced over the years but giving blood's more or less the same as it was say 20-30 years ago." (Non-Donor)

This might be a factor in making it easier for people to go to the dentist than give blood, although it is probably a minor one as the following analysis will show.

As for many of the fears underlying non-donation, the fears associated with attending the dentist were usually emotionally based, rather than deriving from actual 'bad' experiences. Typically, people could not give a specific reason for being frightened, but nonetheless felt it vividly.

> "The one fear I have is the dentist. I really do panic. I sit on the dentist's chair and I just about freak out. I sit there and my hands are gripping the chair." (Non-Donor)

"My dentist - I burst the leather on his handle. I was terrified - I hate the needle as well." (Non-Donor)

"I have convulsions about three weeks before I go. I sit and go 'It's 15 days before I go . . . 14 days, 13 days' . . . It's a nightmare." (Non-Donor)

The key difference between the fear of the dentist and fear of giving blood is not that emotions are necessarily any less intense in one situation rather than the other, but more that for dentists, nearly everybody attends eventually, in comparison with blood donation where most people with fears, even less extreme ones, do not. Recent work* carried out by the Advertising Research Unit offers some insight as to why dental and blood donation patterns might vary, given this similarity in fear experienced.

For dental attendance, it is apparent that a continuum of attendance exists, affected primarily by the reasons why people choose to attend. At one end of the spectrum are "regular attenders" who attend as a matter of routine, whether or not they are aware of any dental problems. They believe regular attendance will have long-term benefits with the dentist protecting and looking after their teeth for the future. They also recognise some short-term benefits such as cosmetic improvement in the teeth, advice about oral hygiene, reassurance about dental health, and relief from any distress. They often experience anxieties about attending the dentist but nevertheless do so in order to benefit from these rewards.

At the other end of the spectrum are "pain attenders" who only attend the dentist for relief of any distress their teeth are causing, primarily toothache, which is too severe to control themselves. They are often aware of the long-term reasons why it is thought they should attend regularly, but reject them because either they disbelieve them or they feel them to be unimportant.

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* A S Blinkhorn, G B Hastings, and D S Leathar. Attitudes towards dental care among young people: implications for dental health education, British Dental Journal, November 1983, 311-314.

Pain attenders give many reasons for not attending, most of which are rationalisations. Fear is often a rationalisation; where it can be dismissed, other reasons are often put forwards such as economic considerations, inconvenience, poor dentistry and specific dislikes of dentists. Again, these are often revealed to be insufficiently important or irrelevant. It thus appears that the real reason is often a combination of laziness and "putting off today what can be done tomorrow." The only time when tomorrow will not do is when they need immediate relief from pain or some other discomfort.

In some aspects, the pattern of attendance and non-attendance at blood donating sessions runs in parallel. At one extreme there are committed donors, who give for long-term future benefits to both themselves and other people. They also often appreciated short-term benefits, such as participating in a group activity, the perceived psychological and physical benefits from attending the session and the rewards provided by the BTS (as discussed in 6.4.2). Like regular dental attenders, it was not unusual for them to experience some degree of anxiety and apprehension about the procedure, but nevertheless, they still felt committed enough to attend.

However, in the case of blood donation the continuum of attendance extends much further in a negative direction than it does for dental attendance because the majority of people do not attend at all. In many respects, non-donors have much in common with dental pain attenders, in that many of the reasons for not participating are similar. Thus they claim to be afraid of needles, medical atmospheres, hospitals, etc as already discussed. They are also often aware of reasons why it might be thought they should attend and give blood but either disbelieve them or feel they are not important enough to them personally. The major difference is that dental pain attenders will eventually go to the dentist for treatment, overcoming all their reservations. In contrast, a non-donor might not perceive any personal benefit to be gained from donating blood, and certainly not as immediate and obvious as the relief of severe pain. In the context of the dental analysis the non-donor could therefore be described as a pain attender who never experiences the stimulus of pain.

> "If you go to the dentist with toothache you're forced to go there. You don't have to give blood so it's an easy way out." (Non-Donor)

It therefore appears as if there is a need in blood donation to provide the non-donor with a stimulus that is conceptually equivalent to pain for the dental pain attender. This in no way implies, of course, that the stimulus should be pain itself, merely one that has the same psychological power. From the interviews it appears that this is potentially provided in the situation where non-donors are confronted by an obvious and very immediate need for their blood (and theirs alone) to save a life, and where there is strong personal relevance (see Section 6.5.1.2).

> "I'd like to see me help someone that was dying and give them blood. It would make you feel good." (Non-Donor)

Finally, it should be noted that although a parallel may be drawn between the patterns of dental attendance and blood donation, a direct relationship does not necessarily exist for each individual. Not all regular dental attenders will be committed donors and not all committed donors will be regular dental attenders. Clearly, the motivating factors will differ in each case, and the consequent balance of inhibiting and encouraging factors for any individual may differ for dental attendance compared with blood donation.

For example, a group of young working class girls interviewed all claimed to be frightened of the dentist and did not attend except in severe pain, but they were regular donors and felt a deep moral commitment to give blood "because they cared about what goes on". Nonetheless, the general relationship holds true: pain is the stimulus for dental pain attenders, and there is likely to be considerable potential in identifying the conceptually equivalent stimulus in the donation context.

6.5.3 Fear of the Unknown

This was a quite understandable area of concern for non-donors, who felt that no matter how often people were reassured or had all the procedures explained to them, they still would not know how they themselves would experience the situation. Some people likened it to going for an interview, when one would be apprehensive for a variety of reasons and did not know quite what to expect or how one would perform. There was also potentially the danger of feeling trapped in the situation - once the procedure had started one would be unable to change one's mind and escape.

> "You've walked in and they're going to take it. It's the fear of the unknown but you don't know how you're going to react. You don't know if you'll want to rush out half way through. You know you're trapped once you're in." (Non-Donor)

It is relevant to note that this range of fears and apprehensions were also described by many donors, who had experienced them either prior to donating, or during the sessions themselves. Nevertheless, they still gave blood, indicating that they had managed to overcome their fears, or at least control them to a tolerable level. In general, most people - donors and non-donors alike - agreed that the major hurdle was in attending for the first time, finding subsequent visits less stressful.

> "I've given pints of blood - but it's even worse if you haven't given a pint of blood. Your imagination runs riot then. You don't know what it's about and you always think the worst." (Donor)

> "I've always said I would do it one of these days - it's just getting round to it. Probably once I've done it I'd say, 'Oh heavens, that was OK' I'll go and do it again.' I think it's just doing it." (Non-Donor)

> "I think the hardest part is actually getting there the first time, for some people - or even just finding the time to get there. It's very easy to just not go." (Donor)

> "I suppose if you went along and did it a few times it would be like going for a coffee or a pint at the pub. It wouldn't bother you - the fear would be gone." (Non-Donor)

> "I think once you've done it the first time you don't really think about going back. It's just something you do. It's not like going to the dentist when you dread it the week before. It's just getting though it the first time." (Donor)

It is almost inevitable that people will experience some degree of anxiety about attending a donor session for the first time, even if it is just the anxiety one would feel in any new situation, such as where to go, what to do, and whom to approach. It is therefore crucial for BTS staff to bear these possible anxieties in mind. It is vital that the initial donating experience is as pleasant as possible, and that new donors leave with a feeling of reward or achievement, not stressful memories. Special treatment for first time donors should therefore be considered, such as efforts to reassure them by keeping them company, and explanations as to what is happening and why. It may also be helpful to minimise their waiting times, thereby avoiding a build-up of apprehension. In this way, not only will first time donors have more positive attitudes towards donating in future, but they will also leave with a good impression to impart to others.

> "Maybe if they just homed in on the first time donors, and said, 'We'll look after them and make sure their first pint of blood is a success', they would get a lot more support. (Donor)

At the same time, it should be recognised that not all donors find the experience of donating pleasant or enjoyable, no matter how well they are treated. Some were always apprehensive, but nevertheless continued to donate, most commonly from a deep sense of social obligation or commitment.

> "I'm always apprehensive, but then you always are apprehensive when you face a dentist or a doctor or an interview. It's the element of the unusual, but I don't lose any sleep over it." (Lapsed Donor)

> "I keep turning away from the needle, there's nothing to it. I don't think there's anybody who would say they enjoy giving it. The thing that a lot of men dislike is that wee jag in the thumb. Nobody enjoys it. It's the realisation of the importance and the necessity of it." (Donor)

One lady described attending a session recently, having not given for two years:

> "You steel yourself. I could feel my whole insides turning to jelly, and even when you lift up your thumb just to get that wee prick my hands actually going like this (shaking) - and yet as soon as I get on the table I'm all right. I just turn that way and don't look." (Donor)

It therefore seems apparent that there is a continuum of enjoyment experienced from sessions. At the negative end, where apprehensions exist, some donors will tolerate the discomfort experienced (whether real or psychological) for the intrinsic rewards offered. For others, though, apprehensions are critical, and care should be taken to minimise them at the first donating session. As will be seen in the next major section about reasons for lapsing (6.6) it is apparent that for some, apprehensions are not resolved adequately, leading to a tendency to withdraw from the donating situation (if not straight away, then after few subsequent donations).

6.5.4 Fear of 'Something Going Wrong'

Another fear that non-donors felt was that'something could go wrong' in the process, either with the equipment used, or that the donor could suffer ill effects. This was often an unspecified worry but might also include extremes such as a bag bursting, or a needle being knocked out or the donor having to be rushed off to hospital after becoming seriously ill.

> "She said she was ill after it, she felt as if she needed blood after they'd taken some off her. That's how I don't want to go to do it." (Non-Donor)

Again, some donors also continued to feel similar anxieties that something could go wrong but did not let it deter them from donating, suggesting that these apprehensions could be overcome if sufficient motivation existed.

> "I've always got the feeling when I'm lying on the bed that something will get knocked, that thing in my arm, it'll knock the bag off and pull it. That's all going through my mind. There's always nurses and assistants walking by. Maybe it's all fantasy on my part, but I still think about it. It wouldn't stop me from going. I wouldn't watch the blood - no way. I get over the panic the minute he takes the needle out."

> "I think I've always just got a fear something is going to go wrong." (Donor)

> "I know someone who wouldn't give blood in college because they felt if anything went wrong, they'd be in the wrong place. If they gave blood in hospital and then something happened they'd be in the right place." (Donor)

Other effects, and after effects, that non-donors were concerned about were being sick, fainting or having "a dizzy turn". This could cause particular difficulties if one had gone straight back to work and then became ill, or had to travel some distance home after the session.

> "I'd probably go if it was in Inverkip and you were just coming home and sitting down for the rest of the night, but I'm frightened of a dizzy turn as you're climbing down a big ladder." (Non-Donor - Shipyard Worker)

Moreover, some donors also experienced feelings of dizziness but tried not to allow this to deter them. Instead, they worked out what might have made them dizzy the first time and tried to change it at subsequent donations; for instance, they had perhaps got up too quickly or not had enough to eat during the day, before they attended, or perhaps put it down to first time nerves.

> "I nearly fainted the first time I gave blood, I felt dizzy, it's just psychological as it's never happened since, but I had to lie down. Someone who suffers like that (fainting, dizzy) all the time isn't going to do it." (Lapsed Donor)

Non-donors' concern about 'something going wrong' was often exacerbated by the thought of this happening in full view of others, irrespective of whether they were acquaintances or strangers. Women seemed to think this was especially true of men.

> "I think the main problem with guys is that they're scared. They're scared they're going to show themselves up." (Donor)

> "I think that's why a lot of males don't go - it's not manly. They don't like making fools of themselves. I mean, a lassie keeling over is one thing, but a guy falling in a heap in a room with a few people is something totally different." (Donor)

And indeed, one man did describe this as one of the reasons he did not donate.

> "I heard of one guy in the canteen. There was a couple of hundred just standing round after giving it and getting a cup of tea and he came out behind the curtains. He felt a wee bit light-headed and fainted and they all started laughing at him." (Non-Donor)

Again, it is important for session staff to always try to maintain levels of reassurance and be aware of the possibility that the donor, whether or not he has donated before, might be apprehensive about possible consequences. In this regard, the issue of staff talking among themselves at the bedside (as described in Section 4.4.2) not only runs the risk of making the donor feel isolated, but may add to fears that problems may not be noticed.

6.5.5 Other Clinic Fears

Many of the reservations about clinic procedures have been outlined already (Section 4.3). Many were minor irritations rather than extensive fears, but nonetheless could contribute to the decision not to donate, particularly in terms of repeat visits. It should be noted that on their own, such reservations were unlikely to determine

the major decision as to whether to donate or not, but could be useful rationalisations to justify the decision not to donate, especially in the absence of strong motivating factors.

Fear of potential embarrassment, even if nothing out of the ordinary occurred, was mentioned by a few people. Aspects of this have already been discussed (Section 4.1) and include, for example, having to climb up onto high beds, lying down in what feels a vulnerable position and being in close proximity to strangers of the opposite sex. These potential causes of embarrassment need to be remembered in clinic organisation: certainly, the thought that they might "make fools of themselves" in some way was an issue of concern to some people.

Some non-donors were apprehensive at the thought of seeing blood, not particularly their own, but just any blood. However, on its own this was a surprisingly low fear, unless it triggered the deeper emotions of intrusion and needles discussed earlier (Section 6.5.1).

> "Some people are scared just at the sight of blood. They'll say 'I know I'm being silly, but I just can't stand the sight of blood." (Donor)
>
> "That would frighten me, watching people with bags filling with blood." (Non-Donor)

Although some of these non-donors were aware that they might be able to avoid seeing their own blood because it was under the edge of the bed, this essentially was irrelevant: they would still have to look at other people's blood, which would make them squeamish. Again, this was a worry experienced by some donors as well.

> "I tell you what I don't like about it. I'm very squeamish and I don't like the plastic bags they have. I look at everyone else's. I'd rather have the glass bottle. It didn't seem as bad." (Donor)

A final worry with non-donors was that their arms might be bruised or swollen. Unless the effect was prolonged most donors were

unconcerned about this, but the sight of a bruise or bandage on a donor's arm was unappealing, to say the least, to many non-donors. Again, this was little to indicate that this on its own inhibited donation: it was more likely to act as a rationalisation for the already made decision not to donate. However, a more serious risk was that it could highlight the fact that needles were used, thereby triggering all the emotive fears already discussed.

It is again vital that staff should treat new donors with considerable sensitivity, and explain both why people might have bandages on rather than elastoplasts, and that any bruising will disappear in a few days. Such simple reassurance can be surprisingly effective, as described by this donor's experience when he first attended:-

> "The first time I went in I saw people coming out with big bandages. I says, 'wait a minute'. I was ready for going back out, but she says, 'Some people bleed a lot afterwards and some don't. Some people just need an elastoplast.'" (Donor)

6.5.6 Apathy

A substantial proportion of non-donors, after considering all the potential reasons for donating and not donating, basically concluded that there was no obvious reason for their failure to give blood. They had no particular objections to donating, but they could think of no particular personal advantages in so doing. In many respects, they appeared apathetic to the idea of giving blood.

> "I don't give blood for any particular reason. I've just never given it. There is no reason why I don't give." (Non-Donor)

In some cases, this apathy was quite genuine. Some non-donors, especially younger ones, were vaguely aware that blood could be donated for use in a variety of medical situations. However, this had no personal relevance to them, either as donors or patients. Furthermore, because they had never seriously thought of blood donation, they experienced no guilt.

For others, this apathy was slightly less extreme, in that vague intentions to donate did exist. However, these had never been acted upon, for no ostensible reason. There was no actual intention not to give, merely undeveloped convictions that such action was required.

> "I've never got around to it either - I've always imagined I would do it sometime." (Non-Donor)
>
> "I've walked past a unit. I worked in hospitals and the unit's been there. I could have given blood but I just never really got around to it. I haven't got any excuse at all. I'm not frightened of going or scared of needles or anything else." (Non-Donor)
>
> "I used to say when I turned 18 I would go, but I've never seemed to have got around to it. I think it's with working shifts." (Non-Donor)

In general terms, some care is required in interpreting apathy as a reason for non-donation. Often, it was the first 'reason' to be cited for not giving, but revealed itself during later discussion as a rationalisation concealing deeper fears, such as deep-seated worries of personal intrusion. For some non-donors, however, it did appear to be a genuine reason, basically reflecting the absence of positive pressures to donate. The most important of these seemed to be the absence of group pressures - apathetic non-donors seemed unlikely to be acquainted with donors.

> "None of my friends to my knowledge gives blood, or has given blood." (Non-Donor)

Non-donors might be less likely to know donors for two possible reasons. Firstly, donors may be reluctant to talk about blood donation, for fear of being regarded as somewhat evangelical, or even 'goody-goody' people. While some donors did express such reservations, merely making it known that they were donors, available to reassure and inform non-donors, would be useful. A badge for all donors could have importance here in making it obvious who donors are. If people are encouraged to "stand up and be counted" as donors then not only will they act as a contact point but there would be a gradual

increase in the feeling that "everybody gives blood", which is a useful feeling to generate for uncommitted non-donors.

Secondly, and more tenuously, the interviews did suggest that donors might have more in common with each other (in addition to giving blood) than with non-donors. This is because many donors seemed to have generally similar attitudes to life, such as a high degree of social commitment and feeling of moral obligation. It may therefore be that they naturally mix with each other, rather than with non-donors.

The fact that non-donors tended not to know donors reduced their motivation to donate in a number of ways:

- non-donors tended to be lesser aware of donor sessions and locations. This was especially true for younger people, and for general public sessions, but could occur even in large factories where regular sessions were held. This is a particularly critical issue, as it seemed from the research that first time donors were more likely to hear about sessions from other donors than from advance publicity.

  In general, not knowing where and when a session would be held appeared to be more of a rationalisation for not giving than a genuine reason. Basically, most non-donors did not know about sessions because they did not want to know, for other, deeper reasons. For some, though, it is a more important issue: some uncommitted non-donors appeared willing to be led by the hand to a session, and indeed almost expected this. Not knowing someone who could fulfil this function could be a serious drawback for someone in this situation. It would therefore be helpful to explain these concerns to donors, provided they are also cautioned about the dangers of becoming too evangelical or zealous.

- They missed the stimulus of feeling that giving blood is 'normal' and acceptable, supported by society and by other people, particularly groups of friends or 'mates'. Indeed,

group support could provide not only emotional reassurance, but practical help if it were needed.

> "It'd be a lot better if you went with someone you knew - that's if you're scared." (Non-Donor)
>
> "You need somebody the first time in case you do faint and need to be taken home." (Donor)
>
> "If you're going with someone, it would help and they would say, 'It's OK, it's just a needle', and they took you along with them." (Non-Donor)

- They were less likely to be asked to give blood. Personal appeal, especially from a friend or acquaintance, seemed a more powerful impetus than generalised advertising. This is an important issue, and is discussed more extensively in Chapters 7 and 8.

> "If somebody did say to me, do you want to come along, say a couple of mates, to give blood, I'd go along." (Non-Donor)

Some apathetic non-donors did indicate that they would give blood if they could see a reason for it. However, the reasons were extreme, such as crises among their friends or family requiring their blood, and theirs alone.

> "I'd only give if it was some personal disaster, something really heavy - it might make me do it." (Non-Donor)
>
> "If a disaster happened just now and the three of us were asked 'Look, there's a chap here who needs a pint of blood to keep him alive', you would give it." (Non-Donor)
>
> "It would need a crisis before I go - a life and death situation. Maybe not as drastic as that - like if you came up to me next week and say, 'We need 10,000 pints of blood in this area' - then maybe, yes I'd go." (Non-Donor)

It is probably significant to note that many non-donors who said that they were frightened of giving blood quoted exactly the same extreme situations as the 'exceptions' when they would, in fact,

donate. This again may indicate, as discussed already, the fact that apathy may often conceal deeper underlying fears. Where this is the case, it is obviously more relevant to direct efforts towards removing or lessening these alternative reasons for non-donation, rather than attempting to jolt non-donors out of their apathy (which may actually be non-existent).

The exception to this, of course, is where the apathy is genuine. Here, fears will be relatively minimal, but motivating factors also weak. In this situation, there may be some potential for expanding donation.

> "If somebody actually asked me to go - you know, say, 'Would you mind coming in and giving some blood,' or go with a couple of mates even to do it. I'm not going to get up my own steam to do it. If I was just pushed a little bit, I think I would go and do it." (Non-Donor)

This issue is discussed more fully in Chapter 8. However, it should be noted that for there to be any future potential in approaching this group, motivating factors must exist to at least a minimal extent. Where they do not, ie where there is apathy in its purest form, then it is unlikely that any campaign can succeed - developing motivation from non-existent levels is a wider issue, probably involving educational strategies at primary and secondary school level. In this regard, it is worth noting that the absence of school education on blood donation was both observed by respondents, and commented on as an omission that seemed inexplicable.

> "Take it to schools and educate them that way. Make it a way of life." (Non-Donor)

> "If I'd had this discussion at school I'd maybe had done it from that age and still be giving it now. They should have discussion groups in colleges when they were 18 and old enough to do it then." (Non-Donor)

> "You've got to educate them in school about these things, before you start anything else." (Donor)

6.5.7 Inconvenience

Inconvenience was often claimed to be a reason for not donating, and encompassed a variety of factors, such as session location, opening times, and waiting time.

> "You're not going to queue to give something are you? You'll queue to get something, you won't queue to give." (Non-Donor)

> "It's just laziness. I can't be bothered. It's not near enough." (Non-Donor)

However, it quickly transpired during the discussions that the conditions that the BTS would have to fulfil before sessions were judged to be convenient were often so unrealistically extreme that they would be difficult, if not impossible, to implement. These included, for example, a mobile unit being brought to the door or the end of the road, and the assurance that they would never have to wait at all, under any circumstances.

The fact that convenience was often defined in this extreme way might imply that for many non-donors, it tended to be used as an easy excuse or rationalisation hiding deeper concerns, rather than a genuinely inhibiting factor. Further analysis supported this interpretation. For example, when asked what activities would replace the time spent donating, for most people these were not essential tasks and commitments, but rest and relaxation.

> "A lot of people are willing to donate but they'll not put themselves out too much. If you're there and you want a pint of blood you can have it but there's no way they're going to come out on a Sunday. They'll maybe go for a pint on a Sunday, or go fishing, all kinds of things, it's their time off." (Donor)

> "I think it's the actual fact that you've got to go from either the house or from work and get to where it is, instead of maybe just coming straight home or going on and doing something else." (Non-Donor)

Furthermore, the suggestion that giving blood could take only one to two hours twice a year was unanswerable, especially when compared with spare time available. Indeed, many non-donors were eventually prepared to admit that time did, in fact, exist - the essential issue was simply that they did not want to spend it by giving blood. (It is worth noting that this situation is not unique to blood donation. Recent work by the Advertising Research Unit into attendance at other types of clinics, including Family Planning Clinics, Well Woman Clinics, and Breast Screening Clinics, has indicated that for all, inconvenient location is invariably cited as a prime reason for not attending. However, 'inconvenience' has in all cases concealed deeper anxieties, such as fear, which are the real reasons for poor attendance.)

In some cases, inconvenience was cited as a defence against weak feelings of guilt. In others, however, it tended to conceal underlying fears. This is illustrated by a donor now living in Oban, who used to rationalise about the inconvenience of getting to sessions when she lived in Glasgow, but who finally admitted that she was too scared to attend.

> "I always thought I'd have to give blood when I grew up, but I was always too scared to go. I used to find excuses. 'It's too far to travel. There might be a big queue. How do I find the place if I don't know Glasgow too well?' Here in Oban it's a lot handier." (Donor)

At first glance it might seem that she was now able to give blood because it was more convenient living in Oban - travelling distance to the session was less, and the hall used was better known. In fact, while convenience was a minor consideration, of far greater importance was the fact the she now lived in a small rural town, where group pressures and support were stronger.

In conclusion, inconvenience often concealed other reasons for not giving. Sometimes, these were substantial, and it is clearly more relevant to direct attention towards these underlying causes than the more cosmetic one of convenience. Sometimes, however, inhibiting factors were minor or virtually non-existent, and inconvenience really

indicated the absence of positive reasons for donating. To this extent, convenience is really on the same side of the coin as apathy, and all the issues previously discussed on heightening motivations for apathetic non-donors will also apply in this case.

Finally, it should be noted that just because inconvenience is often a rationalisation concealing other reasons for non-donation, this does not imply that it is an unimportant issue for the BTS. For marginally committed donors, and non-donors on the verge of donating (and indeed for many committed donors as well), there is little to indicate that people will inconvenience themselves for the sake of giving blood. It is therefore vital that efforts are continually made to minimise difficulties in finding a blood donation centre, such as through providing mobile vans, visits to factories etc. (This has implications for lapsing and is discussed more fully in Section 6.6).

6.5.8 Negative Concepts about Blood Donation

Most non-donors interviewed were positive towards the general idea of blood donation, but chose not to do so for the reasons already outlined. A minority, however, were quite definite that they would not donate, and equally negative about any expectation that they should do so.

> "I don't see there's any motivation to give blood." (Non-Donor)

For some, these attitudes derived from beliefs that they were physically unable to donate, in that the process would detract from their own health.

> "I need it more than they do." (Non-Donor)

> "If you don't think you're fit enough to give blood it's up to yourself. I'm never going to give blood." (Non-Donor)

Others felt that their contribution was unnecessary, that there was plenty of blood and no shortages.

> "I don't think they need blood desperately." (Non-Donor)
>
> "You don't hear of people dying for lack of blood." (Non-Donor)

Still others were unconvinced that their blood would be 'properly' used and not wasted, a view quite widely held by non-donors. (It is interesting to note that some donors also held this view, but chose to give nonetheless, 'just in case it was needed.')

> "I've got the attitude 'What's the point in me going there?' I'm not going if they're going to pour my blood away." (Non-Donor)

Some care is required in interpreting entrenched attitudes such as those expressed above. Certainly, there did seem to be those whose attitudes reflected fairly deep convictions that it would be medically undesirable for them to give blood. In such cases, the promotion of more detailed information, such as how much blood it was 'safe' to give, the conditions and exceptions for giving blood, etc, might prove useful.

Equally, there also seemed to exist those who held particularly insular, self-centred views towards blood donation, and, because no personal benefit was involved, regarded donation as a task for others. In such cases, there would seem to be little scope for altering their views through conventional approaches. The solution lies deeper than this, and will be similar to that required for convincing genuinely apathetic non-donors, as discussed earlier (Section 6.5.6).

However, these genuine reasons for holding antagonistic attitudes towards blood donation seemed to be more the exception than the rule. Most who were antagonistic seemed to express this because of deeper underlying concerns. Often these were limited to emotional fears but occasionally they were symptomatic of guilt as well. Sometimes, this guilt reflected not simply reluctance to donate because of the inhibiting factors discussed in this section, but also guilt at feeling apathetic in the context of knowing that they were 'expected'

to give blood, feeling pressurised from both overt (eg donors) and insidious (eg cultural values) sources.

Again, the relevant issue is to approach the causes of the attitude, such as fear or whatever, rather than its consequence, antagonism. However, as antagonism is a deep emotional reaction, it is likely that its causes are also deeply held, possibly linked with fears of intrusion. To that extent, antagonistic non-donors are likely to be a difficult group to convince. As this would require considerable and probably disproportionate resources, the practical implication is that they should not be a primary target.

6.5.9 Factors Inhibiting Blood Donation - Conclusions

This section has analysed eight major factors that contribute to inhibiting blood donation. Some, such as personal intrusion, were of deep psychological significance; others, for example convenience, appeared more obvious. In identifying and discussing these issues, several themes recurred.

- For each factor identified, its importance varies from individual to individual. No single factor was crucial for all non-donors, although some, such as fear of needles and personal intrusion, had threatening implications for many.

- The importance of each factor or group of factors for the individual in determining behaviour depends not only on the extent to which they are held, but on their interaction with motivating factors, if these exist.

- Many inhibiting factors can be observed among donors as well as non-donors. Their importance in affecting donation (or as discussed in the next section, lapsing) is a function of the motivations that compensate in addition to the factors themselves.

- Some factors, especially those such as apathy and inconvenience, often rationalise or excuse non-donation due to deeper causes, especially personal intrusion.

- The practical implications in resolving concerns depend not just on the issue itself, but whether others exist at the same time; their extent and depth, and whether they are positive or negative. Chapter 8 is devoted entirely to this issue.

Some of these issues and their implications are also discussed in the following section, covering reasons for lapsing.

6.6 Lapsed Donors

People who had not donated for some time - in this case at least two years - were of considerable interest in the research. The fact that they had overcome the difficult hurdle of the first donation, and indeed may even have donated several times, was considered to be of particular relevance in understanding donors' and non-donors' motivations, especially over the long term. There were also practical policy consequences in understanding this group, in that it is possible that it might be more productive for the BTS to concentrate their efforts in encouraging lapsed donors to donate again, rather than attempting to recruit new donors.

In the event, it transpired that most of the lapsed donors interviewed were unaware of having made a conscious decision not to donate, but instead had drifted away from the system, for a variety of often minor reasons. No single cause emerged for donors to lapse, except for a small number who had experienced severe physical discomfort at sessions. Instead, lapsing would seem to be a function of fluctuations in the interaction of inhibiting and motivations at any particular time. This results in the individual donating when the interaction tends towards the positive end of the donation/ non-donation continuum, and vice-versa. The fluctuations can be due to either the inhibiting or motivating factors changing separately, or to their both changing in combination. These issues are futher discussed below, where three aspects are explored in detail:

- reasons for lapsing (6.6.1);

- lapsed donors' attitudes to previous donating experiences (6.6.2);

- lapsed donors potential willingness to donate again (6.6.3).

6.6.1 Reasons for Lapsing

The majority of lapsed donors explained their behaviour by stating that they had just not got round to attending again. Usually, they were unaware of any specific reason for not continuing to donate.

Some said they were lazy or could not be bothered.

> "I've only to go up the road from work to the donor centre so I can't excuse myself because I've got to travel - it's just basically lazy I suppose." (Lapsed Donor)

Others found that they tended to forget when the next session was due.

> "I see it in the paper and I think I'll have to go and the next thing the date's past. You used to get a letter but they've stopped that." (Lapsed Donor)

> "It does slip your mind quite easily." (Lapsed Donor)

Some felt that they fully intended to give blood again, but found themselves making excuses when the actual session time arrived.

> "If you're working all day, you get home and you have your meal at night and you get sat down there. You feel it's a full day. It takes a lot of spirit to get up and walk down and start giving a pint of blood. You could find 101 excuses." (Lapsed Donors)

> "The last few times that the service has been here I've missed them - for about two years now. The last time was the day I came back from my holiday and I had a lot of unpacking to do. It was an excuse. I could still have gone. That's the point I was coming to. There's been once or twice I had a cold or something. If there's an excuse for me I'll probably take the excuse. Whereas if there's no excuse, such as my wife's going so I can't refuse, I'll be back again." (Lapsed Donor)

This range of comments indicates that there was usually a lack of commitment among lapsed donors towards giving blood. They found it relatively easy not to donate, making excuses that were recognised as such. Where non-donors expressed similar 'reasons', it was often revealed that they concealed fears about aspects of donating. Lapsed donors, however, tended not to have the same depth of fear, although they did sometimes find the procedures anxiety provoking and unpleasant; not the enjoyable activity that regular donors often perceived it to be. [This is discussed in more detail below (6.6.2)].

Analysis of lapsed donors' responses indicated that it is the gradual alteration in the interaction between encouraging and inhibiting factors that leads to lapsing. For most lapsed donors, the initial stimuli to donate were weak and limited, and because they did not become enhanced by other factors, such as a sense of reward for donating, they weakened over time.

By contrast, inhibiting factors tended to maintain their strength, and therefore increased in relative significance (see Section 6.6.2). The notable exception to this gradual drifting process occurred for some committed donors, whose initial stimuli to donate were high and maintained for some time. When lapsing did occur among this group, it tended to be for circumstantial reasons such as moving house, or in response to some important clinic incident, such as a particularly bad experience in giving blood, or having their blood temporarily rejected on medical grounds (often with inadequate explanation).

A number of initial stimuli to donation were outlined in Section 6.4.1. These were normative group pressures, contact with illness requiring blood, a desire to serve the community and spur of the

moment decisions. It is relevant to note that a higher proportion of lapsed donors seemed to have started donating because of group pressure, often at work or through friends' persuasion. Furthermore, they often appeared to have little personal motivation for giving apart from this outside stimulus, although they had a slight idea that it was a 'good thing'.

> "I started by accident, a friend said 'I'm going along tomorrow, why don't you come' - I'd never thought of it before." (Lapsed Donor)

> "Probably someone said and I went along with them. It's quite a good thing. Well, I don't know how much they need but if you have it to give and don't mind giving it . . ." (Lapsed Donor)

They thus did not seem to have internalised any other motivating factors, and were especially lacking in a feeling of moral or social obligation to give, apart from having vague feelings of guilt. Furthermore, they often did not appreciate the rewards that regular donors perceived from the actual process of giving blood itself (6.4.2.3), and in fact might react negatively to the sessions (6.6.2). Among donors, these two aspects of social obligation and personal reward were important in maintaining donation.

Some lapsed donors also doubted that their contribution of blood was needed.

> "You don't ever hear of somebody dying because there wasn't blood available so therefore people don't think that there's not enough and it doesn't matter if you don't give it." (Lapsed Donor)

> "Nobody actually tells you they're short of blood." (Lapsed Donor)

In many cases this would appear to be a rationalisation to excuse their guilt (which many lapsed donors felt in a mild form), since it is unlikely that they did not feel blood was needed when they first donated.

A more important aspect to emerge was that some lapsed donors wanted to feel more 'needed' and more involved with the BTS. They felt that the BTS could tell them more about blood and the need for it, and that if the facts were presented to them, they would be willing to co-operate. Phrases like "you're kept in the dark" and "if they were straight with you", were sometimes used, with vague implications that the absence of such information might even indicate a deliberate policy of concealment, for no apparent reason.

> "I don't think it's deliberate, but you are kept very much in the dark. You just go in and hand over your blood and come away again. You never know whether it's used for an individual or for research. I've never seen statistics published." (Lapsed Donor)

> "I presume the Transfusion Service are doing this (research) because they reckon they are short of blood and I think maybe if they had been as straight . . . (I would give blood)" (Lapsed Donor)

> "It's difficult when people don't really know what's happening to their blood - they can't see any results from it." (Lapsed Donor)

Again, this may be a rationalisation - many committed donors donate on the basis that it might help someone without needing to know that it has actually been of benefit. However, it does indicate that the BTS could, with advantage, disseminate more information about the actual need for and uses of blood, which might influence these lapsed donors enough to give again. Although the BTS can rarely tell people what their blood is used for, they could describe actual people who have benefited from blood donation in their publicity. Alternatively, a newsletter could be used, which would also make people feel more involved in the system. Staff could also talk to people who showed interest in the uses of blood and stress how valuable their contribution would be.

Since a high proportion of lapsed donors were motivated by group pressures to donate, their motivations tended to decrease if these pressures were dissipated due to changes in circumstances. Such situations were most marked in changes of workplace and leaving

college. Thus people who had given at work, and who had benefited from the convenience, support and comradeship that this could bring, found it harder to continue to give if they left a work situation visited by a mobile unit, or if the BTS stopped attending. For example, one lapsed workplace donor described expending a lot of effort to arrange for a mobile unit to come to her new workplace, and to stimulate enthusiasm there for the BTS. However, she had felt unable to attend a general public session in her own time, despite obviously thinking that giving blood was important.

> "I'm trying to brainwash them all. Since I got that letter (about the survey) and with one thing and another . . . I'm on the works council and I just said to Mr ..., I thought it was a good idea, could he possibly get the van to come. That's why I'm lapsed - it's just there's no van coming." (Lapsed Donor)

Leaving college was also a frequent cause of lapsing, particularly those whose first donation had been made there. Such lapsing could be due both to circumstantial reasons, such as leaving the area, and also the breaking up of the group pressure that initiated and maintained the desire to donate.

> "I was at college when I gave and it was just because it was there really. I've only given it once since. You get letters but I'm not in the town very often. It doesn't stick in my mind somehow. I watch them putting the needle in - it doesn't bother me at all really." (Lapsed Donor)

On a smaller scale, people who initially attended General Public sessions because of friends' encouragement might tend to lapse if they did not make firm commitments to attend the subsequent sessions with the same people.

> "I think it's better if you organise it with somebody and they come down. If it's left to yourself and you look out the door and see - 'Oh, it's raining, I'll not bother', or there's something good on TV - it doesn't take much to distract." (Lapsed Donor)

Since many of these donors started to donate as a reponse to outside pressures, rather than an inner conviction that giving blood was important, they seemed willing to respond once again to outside pressures. These could be from friends and acquaintances again or from the BTS.

> "If I was sitting in the house on my own and someone said, 'Come and go down and give blood', I'd go like a shot." (Lapsed Donor)

The BTS would therefore probably find these lapsed donors receptive to a personal approach, such as a personalised letter, and especially favoured, a phone call just prior to a session. An appointment system might also make them feel more committed to attend, giving a feeling that "someone was personally waiting for them". Session staff could also foster some degree of group feeling by appearing pleased to see the individual, thanking them afterwards, and giving the impression of being keen to welcome them at the next session.

A number of other factors were mentioned by lapsed donors, but they appeared to be cited more as rationalisations concealing the basic problem of lack of motivation, than genuine reasons for lapsing. One frequent suggestion of this type was that it was relatively inconvenient to continue to attend.

> "It's not a case of wilfully not doing it and saying I'm killing all these people. It's just time and place." (Lapsed Donor)

As has been discussed in Section 6.5.7 the idea that there is not enough time available to give blood almost invariably emerged as a rationalisation. However, some people did find that their flexible free time became more limited as their circumstances changed. These could include an increased work load and responsibility as one got older. Similarly, some people had gradually acquired increased evening commitments, perhaps in voluntary work or study, or had donated blood when single but were less likely to do so when family time commitments built up.

In such circumstances it is possible that convenience plays a minor role, but this is likely only for those who are very marginally committed - all it essentially does is tip the balance in a highly unstable situation. The more seriously committed person tended not to cite convenience as a reason for lapsing, being unable to accept that a few hours every few months was genuinely inconvenient.

A number of lapsed donors talked about how important it was not to get out of the habit of donating blood. This could be true of long-term donors as much as people who had given only once or twice.

> "I gave blood from 18 right up to three years ago, twice, sometimes three times a year and just because of two or three things that cropped up I just stopped." (Lapsed Donor)

Some felt it might be easier to maintain the habit if donation could be more frequent.

> "I think it's a sort of habit thing. It's a long time to have to wait till the next time you give blood and that's a problem in terms of getting into the way of giving it." (Lapsed Donor)

This could be especially so in areas where sessions were only held twice a year. If even one were missed, perhaps because of a cold, then the next possible session would be at least a year after the first one.

Once people got out of the habit, it seemed progressively harder for it to be re-established. This might be due in part to it becoming easier to make excuses to oneself, and in part to first time fears and apprehensions recurring (an aspect discussed further in the following section).

> "Now I think I'm getting frightened to go back if I had to - it's been that long." (Lapsed Donor)

Lapsed donors also claimed to get out of the habit of donating as a result of illness. This could be minor illness on a session day, longer term illness over a reasonable period, or even an operation.

> "Twice in a row I was on antibiotics and therefore couldn't, and that just broke the habit. I feel quite guilty about it." (Lapsed Donor)

> "My daughter gave blood but gave up. She got married and had a baby and just felt she couldn't give blood." (Non-Donor)

Sometimes reluctance to give in such circumstances derived from not knowing when it was permissible to resume donation, especially after a serious illness such as jaundice and glandular fever. To the extent that this is a genuine reason, more detailed information about the implications of illness for future donation may be of help. However, many lapsed donors claiming illness to be a reason underlying their lapsing had, in fact, not bothered to seek advice, perhaps indicating that their reluctance to continue donating derived from poor commitment rather than the absence of factual knowledge.

Despite this, it is worth noting that some found they received contradictory information about when they could start donating again.

> "That's not very clear, when you can give blood and when you can't. I can't get that cleared up. The donor centre days, 'No, you can't yet'. My consultant say, 'Yes, you can'. They still keep sending me out letters every six months and I phone them up and ask but they don't seem very clear. The last answer I got was that they'll find out and phone me back but that was four months ago. If I wasn't going to pursue the matter I might just think, 'that's it', and then there's a donor lost which would be a shame." (Lapsed Donor)

It is also worth noting that people could get out of the habit if they attended a session and their offer of blood was refused, particularly if this was done insensitively.

> "I was put off, about four years ago. I was successful for the first year and the second time I went back it was discovered that I was anaemic so I had to get tablets." (Lapsed Donor)

> "I'm not sure how long it is (since the last donation). I came down once and they didn't take it and I never came back." (Lapsed Donor)

The refusal of blood was an issue of concern to many, and indeed was one of the reasons that could affect highly committed donors' future intentions. This was partly because the efforts (both physical and psychological) incurred in attending the session were wasted, and partly because an important reason for donating, self satisfaction through helping others, was not fulfilled. In part, too, the refusal could also imply a degree of criticism. Furthermore, this long-term effect of refusal could be exacerbated if insufficient reasons were given, and information not provided about if and when they could donate again.

> "I went back three or four times. Twice they refused because of my weight, twice it was due to the fact it wasn't six months after I'd had an operation. I didn't realise it was like that. I've more or less given up." (Lapsed Donor)

> "I didn't see the point in going back along if I was anaemic - whether I could afford to give it - they never said." (Lapsed Donor)

It is evident, therefore, that clinic staff approaches to potential donors who are refused is a critical and sensitive issue for those to whom it applies. The implications are self-evident.

> "I was really disappointed (refused as had no breakfast). They never took a sample - and I'd plucked up courage to go that time. I said, 'Well, leave it, I'll come back in the afternoon', but, 'No, no, no, you're here now' - that sort of attitude. And I thought, 'Blow you, I don't know whether I'll come back, here's me plucked up the courage to come.' I thought they could have been a wee bit more tactful." (Lapsed Donor)

In summary, many (although not all) lapsed donors appeared to have experienced weaker initial stimuli to donate than regular donors.

These factors gradually weakened over time, and interacted with negative ones that were maintained or even gradually increased, thus altering the balance of the attitude towards donation. Such donors did not usually make a conscious decision not to donate, but gradually drifted out of the habit, often giving rationalisations or excuses about why they missed the sessions.

> "I just don't go - probably laziness. When I was giving it I gave it when the Blood Transfusion Unit was coming here, because it was handy. I think the last couple of times I had a cold or something. I just can't remember." (Lapsed Donor)

The strategy used to encourage lapsed donors to donate again will depend on many of the theoretical considerations already discussed for non-donors. The decision to donate or not will be a function of the balance of positive and negative factors existing at any one time, and their relative salience. It is therefore possible that some people will have a particular combination of factors, and others, a different set. If this is the case (as indeed it is) then the practical implications for lapsing will differ for each group - an issue fully discussed in Chapter 8.

In the meantime, it should be noted that most lapsed donors had relatively weak initial reasons for donating, often responding to circumstantial pressures, such as from groups. In such situations, two strategies might be of help:

- First, and probably more practicable, would be to build up the strength of outside pressures to donate. Many lapsed donors had responded to outside stimuli initially rather than internal conviction, and some seemed willing to do so again. It may therefore be useful for the BTS to try to initiate more personal approaches to these donors. These could include: phone calls and personal letters reminding them of and inviting them to sessions; an appointment system which would make them feel more committed to attend; and encouragement to attend with friends, by prior arrangement.

Session staff could also make donating seem more personal, giving a friendly welcome, thanks and encouragement to return. They have an excellent opportunity to talk to people about the benefits of giving blood and might profitably use the occasion to make donors, especially potentially lapsing ones, more involved in the process. In this regard, a newsletter might also create feelings of involvement; in addition, it would allow the BTS to promote any factual information donors might lack.

- Second, it may be useful to try to stimulate lapsed donors' social conscience. However, this is a more difficult task, and will be dependent on the levels that initially exist. This is discussed more fully in Chapter 8.

6.6.2 Lapsed Donors' Attitudes to Previous Donating Experiences

Lapsed donors, as well as experiencing similar anxieties to regular donors before donating for the first time, often appeared to continue to feel anxious and distressed about aspects of donating blood when attending subsequent sessions. These anxieties and irritations were not deep-rooted, although more strongly felt than those perceived by most donors, and could probably have been overcome if the encouraging factors were strong enough. Except for specific examples of experiencing pain, they were not significant enough individually to cause lapsing. However, as has already been described (6.6.1), they could gradually accumulate and increase in relative importance over time, finally outweighing the (modest) encouraging factors the donor might experience.

It was noticeable that in comparison with donor groups, groups of lapsed donors were more likely to talk about aspects of blood donation sessions which they found unsatisfactory and irritating. By contrast, if regular donors mentioned these inconveniences, they tended to be tolerant and understanding of the organisational problems, dismissing them as unimportant in the context of the greater importance of giving blood.

These complaints have already been discussed in Chapter 4. They included the following:-

- Session Organisation. Lapsed donors objected to the inconvenience of the long waiting times they claimed they sometimes experienced. There were criticisms of the system whereby people had to keep moving through different stages, to be interviewed by different people before they could give blood. This was described as "like a factory line" or "musical chairs".

- Physical Discomfort. Most donors found the thumb prick uncomfortable but inconsequential, frequently laughing about it. Lapsed donors, however, reacted more seriously against it, often complaining about the discomfort. Lapsed donors also seemed more concerned about bruising and if severe physical pain were felt, this would often lead to a conscious decision not to return again.

- Large Halls. Lapsed donors seemed more likely to object to donating in some types of sessions, especially those held in large halls temporarily used for blood donation. Their large size could remind people about hospitals, particularly military field hospitals "like M.A.S.H". These also could highlight reservations about lack of privacy, and the likelihood of embarrassing situations occurring. The opportunities for potential embarrassment were especially felt by women, such as lying down beside men, or having to climb up onto high beds.

- Attitudes of Staff. Lapsed donors also tended to be more likely to react badly and be more critical of session staff (see Section 4.4. They were more likely than donors to feel they were more distant and "frosty", not paying enough attention to them personally as donors or thanking them for their efforts.

> "I know it's a very, very minor operation to have blood taken out, but I feel I would like to have a wee bit more attention than's being done - to make it more personalised, make me feel better." (Lapsed Donor)

The importance of a sensitive approach by staff if an offer of blood is refused has already been discussed in 6.6.1 and is further discussed in Chapter 8.

All these irritations and dissatisfactions might seem minor in themselves but become more important to the donor if he or she becomes disenchanted. They might well seem minor to staff and may indeed be 'objectively' minor compared with, say, organisational problems, but can assume quite disproportionate significance in the eyes of a sensitive donor. It is therefore important that those in actual contact with donors should be made well aware of these potential criticisms and their significance. It is vital that the initial positive stimuli to donate should be modified as little as possible by the experiences of donating, both through staff attitudes and the actual process itself.

It also appeared from the research that lapsed donors tended to continue to experience anxieties about subsequent sessions, unlike most other donors who found their anxieties reduced after their initial attendance. This could result in their continuing to require some effort to attend - "you steel yourself" was a frequent comment - and they could feel vulnerable and trapped once at the session. They could continue to experience minor fears such as "something might go wrong", but also reported some milder aspects of deeper rooted fears such as fear of needles and hospitals. While committed donors tended to overcome these apprehensions, their continued presence could become reasons for lapsing for less strongly motivated donors. Furthermore, it seemed that continued anxieties might make a donor more critical of session staff and organisation, and aspects of the session organisation could increase anxieties. Each could therefore potentiate the other.

For some or all of these reasons, lapsed donors tended not to find the procedure of giving blood enjoyable and beneficial, and did not perceive the rewards for giving blood that regular donors described (Section 6.4.2.3) even when attending similar sessions.

> "It's not pleasant to the mind even." (Lapsed Donor)
>
> "It's not that it's sore - it's just not a pleasant thing, not appealing, like." (Lapsed Donor)
>
> "It's basically associated with illness. You give blood to help somebody else who is ill." (Lapsed Donor)

This was further shown in some lapsed donors' negative reactions to the personality-type TV advertisements portraying giving blood as a happy pleasant activity (as discussed further in Chapter 7). They felt this was unrealistic, and that advertising should instead adopt more 'serious' approaches, such as the need for blood in illness etc.

> "It's not like that at all. It's not a laugh and a giggle. You come in and you do it." (Lapsed Donor)

The absence of positive benefit from donating, as well as the presence of fears and anxieties, tended to lead to commitment drifting away, with excuses not to attend becoming more and more easy to find. There was therefore often no conscious decision to stop, and indeed such donors might fully intend to donate again, but never actually did so unless personally prompted. In a few cases, however, the decision not to return derived from specific donating experiences. These were mostly concerned with pain on one or more occasions.

> "It's three years since I've been and I suppose it's been deliberate because I was in quite a lot of pain the last three times. Someone wasn't very careful and it hurt three times in a row. First, the needle went through the vein to the back and put pressure on the nerve at the back. That happened twice again and it put me off. I'm scared it might happen again." (Lapsed Donor)

> "I think people are always a wee bit apprehensive if somebody sticks a needle into you, although you're giving it for a good cause. You go on giving it till you hear of a bad experience, or you've had a bad experience yourself." (Lapsed Donor)

In summary, then, lapsed donors were relatively more likely than committed donors to perceive the experience of donating blood to be unpleasant. They made more criticisms of staff and session organisation than regular donors, who tended to dismiss many difficulties as irrelevant. Lapsed donors also seemed to feel relatively more anxious about giving blood itself, although not to any great extent. This anxiety tended to continue with experience, and did not diminish as it did with other donors, who usually gained in confidence at subsequent donations.

It seemed that the mild anxieties felt could potentiate criticisms of staff and session organisation. Equally, flaws perceived in the staff and organisation could exacerbate their anxieties. Given that lapsed donors often appeared to have weak initial commitment, it is important that staff are aware of these problems. A sensitive approach at all times, but especially at first donation, could make the difference between a donor continuing to donate or gradually lapsing.

6.6.3 Lapsed Donors Potential Willingness to Donate Again

The potential for increasing donations from previous donors was recognised by many lapsed donors themselves. Many claimed they would be willing to give again, and just needed a small 'push' to get them started. They felt that as they had overcome the major hurdle of the first donation and had no specific single reason for not donating, they might be persuaded to start again.

> "Because we've given blood there's more chance of getting us back. We'll go back with a wee bit of persuasion, more than those who have never given it." (Lapsed Donor)

> "I haven't given blood for thirty years and I really do feel ashamed. Every time I see one of those badges I feel ashamed that I don't give it regularly - and there's no reason why I don't. You've sold it on me now." (Lapsed Donor)

Many saw a personal appeal as possibly enough to trigger them back into activity. They managed to lose or forget about the standard reminder notes, but felt they could accept a phone call or a letter with a more personal appeal, or even a local representative calling at their house.

> "For lapsed people, the old personal contact would undoubtedly work." (Lapsed Donor)

These comments reinforce the analysis in Section 6.6.1 above. It seemed many lapsed donors experienced a weak commitment to give blood, although they felt goodwill towards the concept. Their first donation was often stimulated by pressure and encouragement from other people, rather than a personal decision that they should become donors. If that outside encouragement declined, then it was likely that they would lapse if they had not internalised any other motivating factors. However, it also seemed likely that they might be willing to respond to external stimuli again, even if they had perceived the minor irritations and anxieties described earlier (Section 6.6.2).

The interviews suggested that it would probably be best if this pressure came from acquaintances (as initially), but it seemed as if they might also be receptive to it from the BTS as well. This could be in the form of a personal appeal such as a phone call, letter or person-to-person request as just described. Lapsed donors would also like to feel involved in the organisation and to feel that their contribution was necessary. Disseminating information about the uses of blood and scale of local requirements might therefore be worthwhile.

It was interesting to observe that being asked by the BTS to participate in the research met with a co-operative response and indeed had already stimulated some people to go and give blood again. More intended to give blood having participated in the discussions, indicating the relevance of personal contact.

"The survey itself should produce quite a high turnout of us guilty types." (Lapsed Donor)

It is important that lapsed donors who do return should feel welcome, and that they should not find the experience stressful. Any previously experienced minor irritations and anxieties should be reduced as much as possible: if they recur, such donors may well lapse again, possibly for ever. It is therefore vital that lapsed donors are treated with extreme sensitivity.

In the final analysis, the original hypothesis that lapsed donors might be easier to recruit than those who had never donated at all would seem to be too simplistic. Some lapsed donors might respond to being re-recruited, primarily those whose initial stimuli had faded without any negative attitudes developing. Others, however, might have had relatively unpleasant donating experiences, and their negative views may be more difficult to change. The exact strategy to adopt will, as already observed, therefore depend on the relative balance of factors existing at any particular time, an issue more fully discussed in Chapter 8.

7.0 AWARENESS AND OPINIONS OF CURRENT PUBLICITY

A particular objective of the research was to assess donors', non-donors' and lapsed donors' awareness and opinions of current publicity on blood donation, and to relate this to their attitudes and motivations towards giving blood. In this way it was hoped to identify the most relevant publicity themes, if any, to present to each group and to examine the role of publicity within particular strategies for expanding blood donation among the public as a whole. This process was started in Chapter 6, where donor/non-donor motivations were explored, and continues in this chapter by examining awareness and opinions of current publicity. The final chapter attempts to synthesise common themes across the report as a whole, and highlights certain strategies for specific target groups where particular uses of publicity are outlined.

In detailed terms, this chapter explores the following issues:

- the measurement of awareness (7.1). This includes explaining and distinguishing between spontaneous and prompted awareness;
- spontaneous awareness of current publicity (7.2);
- prompted awareness of publicity as a whole (7.3), including specific awareness of
    - television advertising (7.3.1)
    - poster material (7.3.2)
    - session handouts (7.3.3)
    - leaflets (7.3.4)
    - newsletters (7.3.5)
    - Christmas cards (7.3.6).

Finally, the chapter concludes by discussing respondents' own spontaneous suggestions on useful approaches for encouraging blood donation (7.4).

7.1 Measuring Campaign Awareness

Measuring the public's awareness of any campaign is a complex issue, comprising at least two research options. The first involves simply asking people what they have seen on a particular topic, in this case blood donation. This spontaneous recall of material provides one assessment of awareness, but it does not necessarily measure the overall impact of a campaign, since the material people can recall without prompting is usually quite restricted, being largely a function of what they have seen most recently or is of high personal relevance. Relying on this measure alone can therefore be inappropriate or even misleading for certain types of campaign, such as those designed to maintain low but consistent background awareness over a long period of time.

For these reasons, a second method is also used, in which people are shown the publicity in question and asked if they recognise it. The drawback to this method, of course, is that some people will claim to be aware of material they have never in fact previously seen, for a variety of methodological reasons, such as genuine confusion or a desire to please the interviewer.

In commercial product advertising, most evaluation projects measure the public's awareness in both ways, and this was the procedure also used in this research. At suitable points during the discussion, spontaneous awareness was measured by asking respondents whether they had seen any publicity material relating to blood donation and the BTS, and where it had been seen. This is discussed in section 7.2.

After this, and always near the end of the session to avoid contaminating responses about other aspects of donating blood, prompted awareness of BTS campaigns was assessed. Respondents were shown a variety of publicity material, including posters (both general, and for specific purposes such as back-up material for campaigns or information about sessions) and other material such as personal stickers, car stickers, newsletters and Christmas cards. They were asked if they had seen these, and where. They were then

asked how they reacted to them, and how they thought other people might respond. Section 7.3 explores these issues in detail.

7.2 Spontaneous Awareness of Current Publicity

To provide one of the two complementary measurements of awareness, all respondents were asked whether they had seen any publicity material relating to blood donation and to describe what they had seen.

In general, awareness of efforts by the BTS to publicise donating blood was limited. Moreover, few respondents commented favourably on the publicity, with non-donors and lapsed donors in particular describing it as 'unimpressive'. If they noticed it at all, it was felt to have little impact or personal relevance.

> "I can't say I go a bundle on any of the publicity I've seen." (Lapsed Donor)
>
> "An advertising campaign would jolt people's memories a bit. There's no big advertising now." (Lapsed Donor)
>
> "From what's been said it doesn't seem they have a very good advertising agency." (Non-Donor)

Furthermore, it was often claimed that advertising was irrelevant to encouraging blood donation anyway, since the reasons for donation and non-donation were felt to be intrinsic to the individual, and therefore unaffected by external pressure.

> "I think if you want to give blood you'll give blood no matter who it is." (Donor)
>
> "You just sort of hear about it, you know. It's up to your own kind of conscience then." (Lapsed Donor)
>
> "I think if you're against giving, things on TV aren't going to change you." (Donor)

However, a great deal of care is required in interpreting the above comments about the effectiveness and relevance of the BTS's

publicity. In particular, care should be taken in assuming that the public's judgements automatically indicate actual effectiveness, for several reasons. Firstly, it is invariably the case that people will be critical of publicity on any subject that creates guilt or defensiveness. As relatively few of the public donate blood, it is therefore only to be expected that views as a whole will be negative.

Secondly, it is also the case in all areas of advertising research that respondents will claim to be unaffected by advertising, and indeed by any aspect of marketing. It is self-evident, however, that the reality is quite different, and that people do respond to advertising despite their claims to the contrary.

Thirdly, related to the above point, is the fact that the public are unaware of the objectives of advertising, and what it can and cannot achieve. There is frequently the somewhat naive expectation that it directly manipulates or persuades, often against the person's real motivations. In truth, no advertising can do this; indeed, it usually cannot directly initiate behavioural change at all. Instead, the effects of advertising are indirect - advertising says certain things about a product in particular ways, and it is the interaction of this information with other elements of the marketing 'mix', such as price, availability and product formulation, that determines behavioural change.

What matters in assessing advertising or publicity, therefore, is not people's overall judgements, which are often irrelevant, but their responses relative to its objectives. These objectives involve defining at least three components.

- target. Advertising is invariably not aimed at the public as a whole, but at particular sectors or groups within it. In this case, advertising could be targeted at donors v non-donors, but other groups might exist, eg primary school-children, session staff, doctors, politicians etc. It is therefore more relevant to ascertain the opinions of the groups for whom the publicity is intended, rather than those of the public as a whole or non-targeted groups.

- role of communication. Advertising does not necessarily attempt to achieve its objectives in isolation, but can also interact with other sources of communication. Thus, it can adopt a 'primary' role, such as through television, where it is the main focus of communication, or a 'secondary' one, where it acts as a back-up to other forms of contact (for example, a leaflet reinforcing personal discussion). Again, it is more relevant to assess opinions relative to these intended uses than in isolation.

- strategy. Advertising has certain strategic objectives. These can include creating awareness, maintaining awareness, promoting new knowledge, reinforcing existing knowledge, encouraging involvement and creating imagery, as well as influencing attitudes, values, expectations and behaviour*. Clearly, such objectives are set depending on what has been achieved before. Thus one campaign may attempt to promote knowledge to those unaware of it; another may reinforce existing beliefs; yet another may attempt to manipulate emotional imagery. Such campaigns can operate sequentially, or at the same time. Furthermore, strategy objectives may be directed towards existing consumers (eg donors) or potential ones (ie non-donors), again sequentially or concurrently. It follows, therefore, that assessment of advertising should be relative to these objectives, and not general. It also follows that if these objectives have not been specified, ie

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* There are many ways of categorising such strategic objectives, but a model that is often followed is the 'hierarchy of effects' model - see, for example, Lavidge and Steiner (1961), Journal of Marketing, Vol 25, No 3, 59-62. Briefly, this states that in responding to advertising, consumers go through certain stages, moving from awareness to involvement to knowledge/attitude change to persuasion. It is hypothesised that the further along this continuum, the more the person is likely to act as the advertiser intends. Equally, the further along the continuum, the more difficult it is to achieve intended objectives. Thus, the model states that it is relatively easy to create awareness, but difficult to induce change. This is the process of advertising that is implicitly followed in this report.

material produced with diffuse intentions for everyone in general but no-one in particular, then the material by definition is likely to be ineffective. This latter theme recurs throughout this chapter and is discussed in more detail below where opinions of the different types of publicity are outlined.

It is therefore more appropriate to assess advertising in detailed form relative to its objective, rather than in general - general comments may be misleading, or even irrelevant. These aspects are explored in the remainder of this chapter, but prior to doing this, certain points about the extent to which different types of material were recalled are worth noting.

Of all the publicity, people (particularly donors) were most frequently able to recall seeing notices giving information about the time and location of local donating sessions, although the particular details were often poorly remembered. These had been seen in buses, subways, shop windows, local libraries and advertisements in local newspapers. In some areas an announcement would be given from the local church pulpit or circulars were delivered to people's homes.

This local information is often printed on standard BTS posters, which can also contain additional messages promoting blood donation. It is worth noting that while the posters themselves were recalled, the additional specific messages were not.

The next most frequently remembered type of publicity was television advertising, recalled by both donors and non-donors. Particularly mentioned was the campaign featuring celebrities - the Noel Edmonds and Sue Barker commercials were quoted most often, but the Spinners were also mentioned. All this material was recognised as an attempt to show people what a session was like, with the intention of helping them overcome their fears. However, the aspects best remembered were small details not actually relating to blood donation. They included Noel Edmonds saying, "It's what your left arm's for", Sue Barker dropping the tennis ball, the Spinners dancing in the street and people having a cup of tea.

> "There was an advert on television about six months ago, 'It's so easy to give blood' and there's a cup of tea and you see a guy lying there and they walk out and say, 'It's smashing' - that's advertising." (Donor)

Although detailed comments about the campaign are discussed later, it is worth noting that even at a spontaneous level, it was widely felt (especially by non-donors and lapsed donors) that the series did not always carry credibility.

> "It doesn't matter how easy Sue Barker or Noel Edmonds make it seem on the television. They don't show you what it's actually like. They make it seem nice and glamorous, but they don't show you the thing hanging down with the blood and the pack and weighing it out. It's interesting to know what actually happens". (Donor)

After the detailed session posters and television advertising, the next most frequently recalled approach was the distribution of stickers by BTS. These included both personal and car stickers. They were most frequently recalled by donors, although some non-donors mentioned seeing car stickers. The most useful aspect of this kind of publicity was thought to be in identifying donors so that non-donors could contact them for advice if they were contemplating giving blood. Finally, recall of poster material and leaflets (apart from those giving specific session information) was negligible, only two respondents spontaneously mentioning them.

Some generalised effects were recalled in less detail. The heart motifs which are used in varying forms were linked with donating blood - those most frequently recalled were the big red hearts used in posters and stickers, but also mentioned were the hearts filling with blood and the small BTS badge/heart often shown at the bottom of posters. The colours of red and white were also attributed to the BTS, as were slogans such as "Give Blood" and "Give Blood Today".

In summary, then, spontaneous recall of material was low, especially among non-donors, with few people able to describe it in detail. As discussed in section 7.1, spontaneous recall of

advertising is a stringent criterion of awareness, and recall on this measure alone is often low. Often the effect of publicity is to create a generalised undercurrent of awareness that cannot be attributed to any specific medium or campaign, but leads to greater recognition upon prompting. There was some evidence that this did indeed occur in this case, as prompted awareness levels were higher (see next section). At the same time, the spontaneous data provide little indication of recall of material designed with particular objectives in mind. There was little evidence of specific groups being aware of particular themes or messages, or messages recalled in one medium reinforcing or extending those in another. To that extent, the implication at a spontaneous level is of a publicity system that is generalised and lacking in objectives, rather than one targeted towards particular audiences with defined messages and strategies in mind.

7.3 Prompted Awareness of Current Publicity

Although respondents' spontaneous recall was limited, awareness increased with the introduction of visual prompts. Items shown were provided by the BTS and selected to illustrate a wide range of publicity material highlighting a variety of approaches in current use in Britain. The material used in the discussion is listed opposite and copies are illustrated in Appendix 6.

7.3.1 Television Advertising

Most people thought that television advertising was the most effective type of publicity. It was regarded as the best medium* for attracting attention, and making the message seem more real. Such was people's enthusiasm about the use of television for advertising that it was suggested that as well as standard advertising, the BTS should

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* This opinion is in fact technically correct, as commercial experience often indicates television to be the most successful primary advertising medium. However, as discussed in the previous section, its relative value will depend on the objectives of the campaign, and its target.

initiate the making of documentary programmes about blood donating and transfusion, with the primary purpose of persuading people to donate as well as giving information. It was felt that documentaries on other health problems had the effect of encouraging people to be sympathetic to the cause that was shown and that the BTS should not "miss out" on such an opportunity. Strategies suggested included 'purpose-designed' documentaries, the inclusion of blood donation information in general, health programmes such as 'Bodyline' and 'Medical Express', or the use of TV 'fillers'.

A few people, from both donor and non-donor groups, argued that television advertising should not be used because it was thought to be too expensive. These respondents further suggested that the money would be better spent on more posters and stickers which were seen to be cheaper. This relates in part to the general impression that the BTS had very limited funding (see section 3.2.3), implying that its resources should be carefully husbanded. However, a further implication was that it might be detrimental to the BTS's image to be seen to be spending money on expensive campaigns.

"BTS can't afford to pay fees to actors." (Non-Donor)

Clearly, the spending of resources is a matter for the BTS to decide, given its overall objectives. While it would obviously add little to the BTS's credibility to be seen to be wasting resources, the consensus was that it should use modern professional advertising, both to increase effectiveness and to counter its existing 'Cinderella' image. It was thus accepted that this would entail using resources in the way professional advisers recommended, and this might include television. The critical issue, therefore, is for the BTS to be seen to be effective and professional, rather than using the media the public would prefer.

As when testing for spontaneous awareness, the television commercials that were most extensively recognised after prompting were the three in the series featuring known personalities, ie Noel Edmonds, Sue Barker and the Spinners. These are also produced on posters, which were the prompts used. It is of interest that showing

any poster of one of the celebrities was sufficient to prompt comments about all three television advertisements, indicating that they were well linked in the public's mind.

All three were seen to be showing what it was like attending a blood donating session, giving people an idea of what they might expect to see and happen. They were felt to feature in particular how quick, easy and painless giving blood could be.

> "They show you how simple it is. There's a lot of folk who don't know how blood is taken from you." (Donor)

Many felt that this approach of showing a session could be helpful, and indeed there was limited evidence that it had some positive effect in attitudinal terms.

> "It's because he's a personality. Folk will think if he does it, maybe that's enough to get everyone to do it." (Donor)

> "Yes Noel, I'll be there the now!" (Lapsed Donor)

> "It's publicity to overcome their fear of what is going to happen to them at a session. I know it's been done partly - my wife has watched the Noel Edmonds type of advert and asked afterwards, 'Is it really like that - is that all that happens?', so it's had an effect. She just wants reassured and perhaps next time she'll come. Who knows." (Donor)

Moreover, most respondents liked and appreciated the generally cheerful approach taken by the personalities in illustrating their experiences.

> "They made one with the tennis player. It was comical. They put a bright side on the idea of giving blood. If she can come out laughing like that there's nothing to it." (Donor)

> "They're quite good. They joke to make people feel easier." (Donor)

This created a positive rather than negative impression, an approach now also widely favoured in health campaigns on other topics.

However, although the testimonial advertisements did attract the above favourable comments, certain weaknesses did emerge. In general terms, it was unclear whether they were intended to reinforce existing donors' motivations, persuade non-donors to give blood for the first time, or merely promote the general idea of giving blood. After discussion the consensus was that the prime target was probably non-donors, but the specific themes promoted, in particular claiming that donation was painless, led to respondents questioning whether this approach would actually be successful in practice (see below). Nor were the strategy objectives (as discussed in the previous section) particularly clear. For example, respondents were uncertain whether, in promoting blood donation to be painless, this was intended to provide factual knowledge where none existed before, counter 'myths' or reservations, or create positive feelings about blood donation in general.

In specific terms, too, certain reservations about both the message content and presentation method were expressed. These encompassed:

- the relative value of using a personality
- whether it should be said that giving blood was painless
- the general impression created

(a) Use of Personalities. While many people argued that one might stop and listen if a well-known personality was involved, a minority suggested that problems could arise.

Firstly, he or she might lack credibility. The claims that giving blood was easy, comfortable and painfree might easily reflect the arbitrary repetition of a script, done for financial reasons without commitment or belief. Alternatively, procedures might have been made artificially comfortable and attractive for the celebrity, unlike a real session. As a result, it was thought that an "ordinary" person might be more credible in claiming blood donation to be

pleasant and comfortable, although even here, expressing this for ulterior motives might still be suspected. This "ordinary" person for most people would be "just anybody" but a minority argued that he should be male and young. In addition, the value of using an ordinary person is also emphasised by the image of a typical donor as 'anyone', as described in section 6.3.1.

Secondly, it was felt that each personality might appeal to only limited sections of the community - if any particular celebrity was disliked, one might react badly to the message he (and the others) presented. In this context, Noel Edmonds and Sue Barker were seen to have more general appeal than the Spinners. It was also possible that the use of a personality tended to make him or her 'take over' the commercial, rather than promote the intended message. This seemed especially so of the Noel Edmonds scenario.

Thirdly, there was always the risk that a personality advertisement could become outdated or even disliked, which could reflect badly on the BTS. This was felt to be a particular risk with the Noel Edmonds commercial, which irritated a number of people.

> "They haven't updated it yet which I think it wrong. Young people now know what Noel Edmonds looks like and to see him appear with his long hair and bell bottom trousers! It dated the Blood Service that they couldn't come up with the funds to update their own image." (Lapsed Donor)

(b) Should Donation be Claimed to be Painless? Considerable reservations were expressed over whether the BTS should say that the procedure was painless. In general it was felt that if people were really afraid of pain, they would find it hard to believe anyone who said it did not hurt, whether it was a personality, an "ordinary person" or even someone they knew.

> "People are going to say, 'what qualifications do the Spinners have for giving a statement like that?' So they think it's easy - I still don't." (Donor)

> "It wasn't me lying there getting it done to my arm and I don't know for sure that it's not painful - it did not hurt him, but it might hurt me." (Non-Donor)
>
> "It's his opinion it's painless, other people have different opinions." (Donor)

Furthermore, the actual sequences in some of the commercials themselves reinforced this uncertainty about the procedure being painless. For example, Noel Edmonds was sometimes seen to collapse after donating, and the presentation of people lying down could also upset people, especially those who were scared of hospitals.

> "Not like Noel Edmonds, he collapsed after it." (Lapsed Donor)
>
> "I think all these pictures of people lying flat out is offputting because they're immobile to start with . . . it relates too much to hospital. People won't understand. They'll think, 'Is it that bad you've got to lie down?'" (Donor)

A further point raised was that there was always the risk that highlighting such an issue might be counterproductive, by raising a concern that did not previously exist. However, the consensus was that this possibility was unlikely, given the emotional nature of many people's fears, discussed in Chapter 6. Instead, a more relevant consideration was that the approach was negative rather than positive.

> "That's introducing a thought that might not have been in someone's head before. 'Why are they telling me it doesn't hurt?' It's a negative approach." (Non-Donor)

(c) <u>The General Approach of these Advertisements</u>. A small minority (primarily lapsed donors) thought the whole approach was wrong and that the emphasis should be on the need and uses for blood rather than how easy it was to donate.

> "See that advert (Spinners) when the guys come out jumping about with bowler hats on - saying they feel great after it. It was a bit like Monty Python with them dancing down the street after giving blood. It was like a bunch of old men making a fool out of themselves. They should make it more attractive. They should say, 'If you were in an accident, how would you feel if someone could save you?'" (Non-Donor)

> "That one of Noel Edmonds and the guys jumping down the street with the umbrella and things (Spinners), but it was never actually linked. They just went in and gave a pint of blood and things like that. I didn't actually think it was linked to the hospital and the operation and the life-saving it does." (Lapsed Donor)

This latter quote also illustrates the previously discussed finding (6.6.2) that many lapsed donors did not find sessions enjoyable and did not perceive a sense of reward intrinsic in giving blood. They therefore tended to be less likely to see any advantage in portraying donor sessions as being pleasant and enjoyable, and disliked the approach as a result. They also criticised the personalities for being too lighthearted, and as a consequence making the sessions seem unreal.

> "The advert with Noel Edmonds would tend to put me off coming rather than encourage me to come. It's no' like that at all. It's no' a laugh and a giggle. You come in and you do it but that advert doesn't particularly inspire me to come back down." (Lapsed Donor)

Again, this reflects the findings in Section 6.6.2 that lapsed donors tended not to find sessions enjoyable. Even so, while they themselves seemed unlikely to become convinced about this, the approach might still be a useful one, if it is intended to create a good general impression with non-donors, or remind donors who might be about to drift into lapsing that it can be enjoyable and rewarding to give blood.

The difficulty with this, however, is that there was no evidence from the research that this was actually achieved, or indeed was even an obvious objective of the campaign. Favourable opinions expressed

about the approach were not stronger among any one sector than another, nor was there any evidence of specific messages being communicated to any particular target. Instead, people were uncertain for whom the material was intended, although the eventual consensus was that it was probably for non-donors, and what the underlying strategy was. In other words, even at the prompted level, the campaign was essentially seen to be non-targeted. The implication, therefore, is while the approach might theoretically be capable of targeting particular messages to particular groups, this was not achieved in practice, and that clearer definition of objectives is required.

7.3.2 Poster Material

The group members felt that posters were the least useful method of communication used by the BTS, especially in comparison with television, although some posters were seen to be more effective than others. Significantly, BTS posters were noticed most by people already interested in donating.

> "I've seen that one, 'Don't let Blood run out'. I first noticed it when I gave blood, then I noticed all the posters." (Donor)

They had generally little impact and, as discussed in Section 7.2, they rarely left a lasting impression apart from conveying specific information about the time and place of donating sessions.

> "They don't make an impression on me. They don't hold your imagination or make you say you must do it." (Non-Donor)

> "There's plenty of posters about. You can go down and all you see is 'blood donor'. You just look at it and then turn round and see something else and you just forget about it. But if you watch a documentary or something on the telly you do sit down and you think about it." (Non-Donor)

The comments were applied to BTS posters, and also to posters in general. Such criticisms in themselves are not necessarily detrimental, but probably reflect their relative value as a

communication medium. They are not a primary persuasive medium but one of a number of approaches that reinforce the messages produced in other, more powerful media, such as television. They can enhance awareness and reinforce particular themes but should not in themselves be used as a persuasive medium. It is also vital that they should be accurately integrated into a campaign and not be produced in isolation, and that the campaign as a whole should have specific objectives, as already discussed. Respondents' comments about their success (or lack of it) should therefore be interpreted within this perspective.

Although spontaneous recall of the poster material was poor, except for the fact that they gave information about sessions, their use as prompts stimulated lively and interesting discussion about the relative approaches and messages. However, rather than summarise respondents' comments about each individual poster, it is more useful to highlight opinions about the different approaches the posters represented, and this is discussed below in sections 7.3.2.1 - 7.3.2.9.

7.3.2.1 The Heart Symbol

The heart symbol occurred in various forms. On some posters, it formed a major part of the visual image [eg "Please Give Blood" (H)] while in others it appeared as a small motif or badge, often near the bottom beside the BTS address [eg, "Give Blood Not Excuses"(B)]. Another use was in posters where hearts took the place of the letter 'O' and were seen to gradually empty [eg, "Don't Let Blood Run Out"(I)]. It was also used in personal and car stickers (M, N), and, as already discussed (6.4.2.3), on donor badges.

The heart symbol, often called 'the love heart', was well known and recognised as relating to blood donation. It was one theme that both donors and some non-donors were able to recall spontaneously, although not necessarily with details of the slogans. It was also thought to be an appropriate symbol for giving blood.

> "The heart's a good idea because it's associated with the heart, your heart is living and pumping."
> (Lapsed Donor)

Indeed, so strong was the association with giving blood that it was felt if the heart did not appear in any form on a poster, it would be harder for people to realise what it was about, as in the following comment about the cartoon poster "We can't get blood from a stone."

> "Maybe if it had the heart at the bottom you would look at it. I think if you have a symbol you should use it all the time." (Donor)

Despite this, however, the posters which featured large hearts ("Please Give Blood" and "Please be a Blood Donor") were not thought to carry enough impact to encourage people to donate, although the message was acceptable. This suggests that the heart's function is probably to reinforce other messages, rather than to promote donation on its own.

> "That big heart tells you what it's about - but you need a bit of impact to attract new people." (Lapsed Donor)

A query was raised as to whether the use of red colouring in association with the heart could potentially upset those who were squeamish about blood. In fact, however, most people felt the colour was acceptable and appropriate. As one self-confessed squeamish non-donor said:

> "No, it's a nice colour of red. It's not flowing stuff." (Non-Donor)

On the basis of these comments, and the comparatively high level of recall elicited, it would seem that this heart logo has been successful with both donors and non-donors in symbolising blood donation. However, it should be noted that it gives a very general impression of donation, rather than conveying any specific message. In addition, it was not seen to be targeted to any special group of people, although it elicited more recognition by donors than non-donors.

7.3.2.2 Arousing Guilt Feelings

eg "Give Blood, Not Excuses" (B)

eg "Do you have to wait for another disaster before giving blood?" (C)

The poster which was seen to make the strongest attempt to make people feel guilty about non-donation was "Give Blood, Not Excuses". This aroused quite heated discussion in both donor and non-donor groups, with opinion divided about its suitability.

A number of non-donors did actually react in the way the message intended, ie related it to themselves as people who were giving excuses. However, it is worth noting that they did not follow this with any actual or stated intention to donate.

> "It's right down to the person I am. It's telling you individually. They know there's people like me giving excuses." (Non-Donor)
>
> "That's what most folk do, give excuses. 'I would go but I need to wash my hair' or something like that." (Non-Donor)

This illustration of guilt being induced without the anticipated behaviour or even attitudinal change highlights one of the theoretical issues of social advertising, that there is little to be gained in raising people's level of anxiety and guilt without providing the means of resolving it. It is indeed the case that such anxiety can be resolved, but the usual means of doing this is to use easily applied arguments or rationalisations, such as disputing the message, denying its relevance or simply ignoring it. Only when these tactics are exhausted, and/or found to be ineffective, are the more involving mechanisms of belief/attitude change involved. The social advertiser's often desired change, behavioural change, is usually the last of all to be implemented, simply because of the commitment and effort involved.

This process has been illustrated in many areas of social advertising, smoking being the typical example. Here, smokers will adopt any number of rationalisations or counterarguments when faced

with guilt-inducing advertising, such as denying the personal relevance or claiming to have a grandfather who smoked till he was 102. A similar process almost certainly operates with blood donation - it is easier to resolve guilt by denying it, ignoring it, claiming to be too ill/too busy/too far away etc, than it is to change established habits, especially if emotional fears are triggered as a result.

This potential lack of success of stimulating guilt in isolation was illustrated from the same non-donor groups who related to the concept; despite identifying with it, they nonetheless reacted against it in several ways, including the following:

- some did not feel they needed to make excuses at all, accepting their apathy.

> "I don't see why people should feel guilty about not giving it." (Non-Donor)
>
> "I don't think I need an excuse not to go. I don't lose sleep over it." (Non-Donor)

- some others felt the approach would be self-defeating as people would not feel encouraged in a positive way to donate.

> "It's not the sort of encouragement to give." (Non-Donor)
>
> "It's moralising. You're getting at people. Even if it's true people would resent it." (Non-Donor)
>
> "It brings out your guilt. That stops your motivation." (Non-Donor)

There was a similar range of opinion expressed among lapsed donors, but a relatively larger proportion identified with the message that they were giving excuses. In the discussions in general, many lapsed donors felt guilty about not giving blood and often admitted that they did make excuses, as already discussed (6.6). However, this is not to say that inducing such guilt was effective, since in many cases it merely reminded them of the drawbacks (whether emotional or physical) of giving blood. At best, therefore, the approach is likely to be effective only for those 'drifting' into lapsing for no obvious

or overt reason, but who nevertheless have a conscience about doing so.

> "See how you're talking about getting at people's consciences. I think this one, 'Give Blood, Not Excuses' comes straight to you. That gets to you. If you're not giving it you've got no excuse for not giving it." (Lapsed Donor)
>
> "I think that would hit a lot of people - people who knew they were giving excuses. I think it would come home to them." (Lapsed Donor)

For others who lapsed for particular reasons, however, the approach did not always receive a positive reaction, since it reminded them of something they might otherwise have preferred to ignore.

> "However true these things are you don't like them thrust at you." (Lapsed Donor)
>
> "I don't think people like it, to be thought that they are giving excuses." (Lapsed Donor)

Finally, it should also be pointed out that despite the above reservations, it was recognised by some lapsed donors as an approach with considerable impact, however much this might have been resented.

> "It's more direct - you can't ignore it as much as the others." (Lapsed Donor)

Donors also expressed a range of opinion about this approach. Some were in favour of it:

> "If you were a non-donor it would make you think more rather than giving yourself an excuse from the top of your head, 'I'm in a hurry' or something." (Donor)

but, perhaps interestingly, the majority rejected it, primarily because it was felt to be a potential cause of anxiety and/or resentment.

> "That would intimidate me. That would put me in a position to give blood but you're not wanting people to feel forced." (Donor)
>
> "I can think of some people who would respond negatively to this approach. They would feel they were being got at by somebody up there." (Donor)

Some went even further in their criticisms, arguing that it was an inappropriate approach in relation to their feelings about blood donation and its voluntary ethos.

> "That one's actually contradicting the BTS itself because they're saying it's voluntary and if it's voluntary you don't have to give an excuse." (Donor)
>
> "The message is you're supposed to give blood and not excuses for not giving, as if it were a moral obligation. I think if people have got the moral part of it, that's not going to effect them and it might put a lot of people off." (Donor)

Another poster which some people thought was designed to induce guilt was the 'disaster' poster. Those who felt that it was intended to do this reacted with a similar range of feelings to those just described, but for the most part responses were slightly different, and are therefore discussed separately below (7.3.2.3).

In conclusion, it would seem that any attempt to stimulate guilt feelings deliberately is likely to be somewhat hazardous, as the mechanisms of resolving guilt are unpredictable. Moreover, it would only be appropriate for those who already acknowledged some obligation to donate, however small. As was discussed in Chapter 6, a significant proportion of non-donors - especially younger ones - were apathetic about blood donation, and for these the approach would probably be unsuitable.

Possibly more importantly, the reaction varied even among lapsed donors and non-donors who acknowledged some obligation to donate (and hence feeling some guilt). While some identified with the theme, a substantial proportion resented it, and would be more likely to be deterred than encouraged.

Any attempt to raise anxiety or guilt should always be accompanied by positive suggestions on how to resolve it, otherwise people will react in ways other than intended. In this case, positive concepts might include why there is a need for each person's blood, where to go to donate, the lack of damage to health entailed, and the welcome, care and support received at the session itself.

7.3.2.3 Use of Shock and Disaster - Showing a Need for Blood

eg Do you have to wait for another disaster before giving blood? (C)

eg Burns need blood (D)

The poster, "Do you have to wait for another disaster . . ." was thought to have the most impact and to be most effective of all those shown. It depicted a believable real life situation where the need for blood was very obvious.

> "I think this is the way to get home to people. Everyone thinks, 'Oh, it's never going to happen to me', but it's happening all the time - there's road accidents all the time." (Donor)

As discussed in Chapter 6, virtually all respondents, including both fearful and apathetic non-donors, and lapsed as well as current donors, claimed that if there were a disaster or an accident which led to an urgent need for their blood, then they would donate instantly, overcoming any fears or apathetic feelings.

> "See if a disaster happens, you've got plenty of volunteers, because they don't think about giving a pint of blood. They'd think about helping the bloke in the disaster, rather than think, 'I've got to have this needle in here, and a big tube'. They don't actually think about what they're gonna go through giving a pint of blood." (Lapsed Donor)

> "If I saw someone in an accident it would jog me and make me do it. For somebody who is concerned with the community, but doesn't like needles, the realisation that people could be dying would encourage me." (Non-Donor)

Furthermore, the approach was also thought to be useful because it said more directly why blood was needed, rather than just trying to encourage people to give blood.

> "The disaster one is prodding you into giving blood and graphically shows why it's needed." (Donor)

> "(It shows) people that are needing it - not dead healthy people giving blood - but people that actually do need it." (Non-Donor)

At first glance, it would seem that generating the concept of emergency need for blood would be a good stimulus to start donating. However, further discussion revealed that this approach is likely to be effective only if it is personalised, ie that the need is for their blood, not anyone else's. Otherwise, as for the situation inducing guilt discussed above, it appeared that in the absence of other reasons for donation, the most typical reaction among those resistant to giving blood would be to rationalise away the request, arguing that 'others can give it instead' or that 'it will never happen to me'. Again, therefore, this illustrates how difficult it is to persuade people to donate if they are challenged in any negative way, and that approaches that are positive and enhance self-respect are more likely to be favourably received.

As an illustration of this, it is relevant to note that non-donors were more likely not to identify with the scenario, although it caught their attention, thereby perhaps highlighting its somewhat threatening nature.

> "That's not me, so I don't relate to it." (Non-donor)

> "I don't relate to it. I look at it and think, 'No - that's a blood donor's poster'". (Non-donor)

In contrast, donors, and at a slightly less emotional level, lapsed donors, identified with it much more easily, reflecting the fact that they had already decided that their blood was needed and had given blood at least once.

"That's better, it would make you stop and think." (Lapsed Donor)

"More to the point than the Spinners." (Lapsed Donor)

"That could be any one of us." (Donor)

"It might be some of your own. What if you had to say there's not blood to give them." (Donor)

The fact that this approach was most favourably received by donors and to a slightly lesser extent by lapsed donors, and not by non-donors, does not necessarily detract from its value. As posters are a reinforcing medium rather than one of primary persuasion, it is quite compatible for donors to respond more positively if the objective was indeed to reinforce them in their intention to continue to donate. If, however, the intention was to persuade non-donors to donate for the first time, then the approach is much weaker.

One particular aspect which this poster raised was whether people who were already squeamish about blood and afraid of medical situations would find this type of picture anxiety provoking and would respond negatively as a result. The consensus was that the relative importance of this issue would depend on whether the poster is intended for non-donors or donors and with what objective. If it is targeted at donors then they have already shown an ability to overcome their fears and apprehensions about blood and so in general would not be deterred by this scenario. In fact, they did tend to feel that it was a useful approach and not too extreme - indeed, a few thought it could be more extreme.

"That's quite appropriate. That's OK because you know exactly what it is. You know there's an accident and they need blood and they'd like you to help. I think it's good." (Donor)

Some lapsed donors also approved the approach of portraying a situation of urgent need with which they could identify, and some liked the actual scenario. However, others suggested it could be just as effective if it were less dramatic and hence portrayed a situation which they would see as a little less threatening.

> "As long as it doesn't show all the blood - you don't see anything gory (disaster poster)." (Lapsed Donor)
>
> "It might be better if there was someone lying outside a car or something, maybe not as gory with blood pouring out of them but obviously looking as though they'd had an accident." (Lapsed Donor)
>
> "Even a man on the bed and his wife sitting beside him in tears. That gets to you." (Lapsed Donor)

Moreover, this request for a less threatening scenario was supported by some fearful non-donors, who reacted against the poster for this reason.

> "I don't like it only because I'm scared of that kind of thing." (Non-Donor)
>
> "That plastic bag puts me off." (Non-Donor)

This desire among some non-donors and lapsed donors for something a little less threatening, but its support among donors, tends to reflect the fact that those rejecting the approach experienced or anticipate experiencing fears and apprehensions about the process of blood donation, unlike many donors who see no reason for such concerns. Any approach reinforcing the negative, threatening reasons for donation merely highlights these concerns (or the lack of them) and hence is likely to be more effective in reminding donors or those who lapse for no ostensible reason, rather than fearful non-donors and donors lapsing for particular reasons. Possibly, however, there is a balance, where the threat could be modified without losing its impact for regular donors, but appears more attractive and less anxiety provoking for lapsed donors.

The "Burns need Blood" poster was also felt by some to be intended to shock. Although it attempted to indicate the concept of an accidental injury which would require an urgent supply of blood, it was thought to have much less impact than the accident poster. It was not immediately clear from the picture that the children, who looked well, were about to get burned, nor was it clear that if the children were burned, blood would be needed in treatment.

"Burns need blood, so what?" (Non-Donor)

"How do they use blood for burns? It doesn't make much sense." (Non-Donor)

As a result of these visual ambiguities, the poster did not shock, because the implications were hard to grasp, especially for non-donors. Alternatively, if it was not the intention of the advertising strategy to shock, but perhaps to provide an emotional platform with the concept of children needing blood, it was again not successful because the children did not appear to be in need of blood. (This is discussed in more detail below - see section 7.3.2.4)

As with the 'disaster' poster, some more squeamish people reacted against the thought of injury, and the idea of children getting burnt was upsetting.

"I don't like it. I think it's horrible, just horrible" (Non-Donor)

"But people don't like shocking adverts. It does get to them, that's why they don't like it." (Non-Donor)

Again, similar issues about strategy apply to this poster as for the 'disaster' concept discussed above. If it is intended to reinforce donors and perhaps remind apathetic lapsed donors (which would be its major value) then they are unlikely to be deterred by the dramatic aspects, and indeed might possibly respond even more. On the other hand, fearful non-donors and lapsed donors would not, and might even resent such an approach. Overall, however, the poster is likely to be less successful than the 'disaster' one, even among donors, because it is not immediately clear what it is about and its connection with a need for blood.

7.3.2.4 Use of Children

eg Burns need Blood (D)

eg You can save this little child from dying (Rhesus Leaflet) (L)

It was felt that posters featuring children in need could potentially be very effective. Their use could in theory generate a high level of emotional appeal, and stimulate feelings of involvement and care. This would be especially the case for parents, but was also thought to be appropriate for wider sectors of the public, including young people of either sex, and both donors and non-donors.

> "I think that would help you - make you go. You could just imagine there was a child and they're looking for blood and you would be able to help them." (Non-Donor)
>
> "Usually you've got to have kids to catch the woman's eye, because the woman, she's the family and she bullies the husband along. It's the woman they're going for really, not the man. It would go for the majority of women. (Donor)
>
> "I think the children would be the best approach. Especially if you've got children yourself, because you would do anything for them." (Lapsed Donor)
>
> "I think if they showed a child receiving blood it might get at the parents and bring it home." (Donor)

However, from the selection of posters used in the research as prompts, none was felt to utilise this potentially powerful concept in an effective way. The 'Burns need Blood' poster was regarded as lacking impact, both in terms of shock, as already discussed, and as a means of emotionally portraying the idea of children in need. In particular, it was commented that if children were to be used, they should look more obviously ill and in need of help.

> "I think from a mother's point of view, if you had a child that really looked ill, it might make mothers think." (Non-Donor)
>
> "That wouldn't persuade me, although I have children. If you had a pathetically ill child I might." (Non-Donor)
>
> "If you see something like those wee kids and you saw it from a bus you'd think it was for kiddies clothes." (Non-Donor)

Even the Rhesus baby looked healthy and active.

> "I think they should show tiny wee babies in incubators that need blood, and things like that, which make you realise that they're ill."
> (Lapsed Donor)

The above reactions indicate some of the practical difficulties in using the emotional appeal of children to urge people to donate. If the children seemed as healthy and fit as portrayed in these posters, it would be less likely that people would identify them as being in need of blood. On the other hand, if they seemed ill in order to generate a greater feeling of caring, then it might prove too upsetting to a wide range of people, and increase their anxiety level when thinking about blood donation. This in turn might run the risk of making them react negatively, and hence dismiss the appeal. Furthermore, in contrast with the shock posters just discussed, where squeamish non-donors were likely to be upset by the concept of an accident but donors tended not to be, in this case donors as well as non-donors were likely to be upset by the concept of children being burnt or ill. Although donors are more likely than non-donors to resolve this distress by donating, and hence the approach could still be a useful reinforcement, there is nonetheless a slightly higher likelihood that they would react against it in comparison with the shock poster previously discussed. There are thus likely to be practical difficulties in using the approach, although it has considerable intrinsic appeal, and its likely success will be very sensitive to the particular image depicted. This in turn means that considerable care should be taken to pre-test any material prior to its use to ensure that the desired emotional balance is achieved.

Again, it is necessary to decide whether the material is to be aimed at donors or non-donors, and with what objectives. In this case, the material seems more suitable for donors, particularly bearing in mind that posters are most useful as reinforcement material. This further illustrates the importance of the targeting of audience and objectives.

7.3.2.5 Use of Humour - Cartoon Effects

Examples - We can't get Blood from a stone (E)
- No vacation without Donation (F)
- Mobile donating bus poster (G)

A minority of donors felt humour should not be used at all for such an important subject as donating blood.

> "I think that's too funny." (Donor)

However, most people liked the more lighthearted approach.

> "I think they should keep it a light subject. There's no use being all serious about it." (Donor)
>
> "You'd probably need to see the funny side instead of thinking it was all needles and fainting and all the rest of it." (Donor)
>
> "It's like talking about death, isn't it? Death's a serious subject but you can joke about it." (Lapsed Donor)

It was also thought that cartoons might be different and more eye catching, and that they were a modern approach that might be more attractive to younger people.

> "It's a newer campaign." (Donor)
>
> "I think young ones would look at that more because it's a cartoon." (Lapsed Donor)

An added advantage in using the cartoon format was that it seemed to be more appealing to those who were made nervous by the shock posters. They appreciated the more neutral approach, finding the cartoon drawings easier to cope with than pictures of real people in need. However, even with such a concealed approach, occasional practical difficulties could arise. For example, the 'Blood out of a Stone' poster, despite being symbolic, occasionally triggered real fears through the drill being interpreted as a needle.

> "If it's needles they are afraid of, there's a certain similarity there - the pneumatic drill." (Lapsed Donor)

Detailed reactions to the individual posters were mixed. The 'Blood out of a Stone' poster was one of the few recalled without prompting, indicating that humour can indeed create impact. However, this impact was reduced by its not being easily related to blood donation, partly because it was so different from the others, but also because the heart symbol was not in evidence. This weakness in promoting the actual message in fact illustrates one of the problems of using humour in social advertising: while it can be an effective means of attracting attention, the need to be different from what is expected (which is what underlies humour) often obscures the message being promoted.

Another cartoon poster, 'No vacation with Donation' provoked little response from the groups. It was thought its actual message was too obscure and that it gave the effect of poor production. The poster, including a picture of a mobile donating bus, while primarily designed to give information about local sessions for the mobile units, also used humour, albeit a little obscurely ("Fare 1 pint - Adults 18-65 years). However, it was argued that it could easily be taken to be advertising something completely different, such as a jumble sale or more frequently, a coach tour. As a result, it was felt that even people who would be interested in donating might not stop to look at it.

> "That bus just looks like a coach trip." (Non-Donor)

> "If you don't take in the writing you'd think it was a bus tour or something - you don't bother reading it." (Lapsed Donor)

In other areas of social advertising, the use of humour, including cartoons, has had some success in recent years, eg SHEG's Dying Scotsman campaign. As an integrated part of a campaign it can help create positive images by including a sense of fun without trivialising the subject. It can also be more successful than a more 'heavy' approach inducing fear or guilt, or showing unpleasant events

such as disasters. In the present case, however, reactions to its use were sometimes inconsistent. It was appreciated by some (both donors and non-donors) but not by others. Unfavourable comments were especially expressed by some donors who thought it would have little effect because it did not show cases of need, and by a few who felt it trivialised something that was very important to them.

> "I don't think a cartoon would have much effect. I think it's better to have something like an accident that you can relate to." (Lapsed Donor)

Once more, this highlights the importance of targeting - the humorous approach appears more likely to appeal to certain groups rather than others. In general, its appeal seems to lie among donors who feel giving blood is fun, and non-donors who have no strong objections to donating. Again, however, the success of this approach will also depend on its objectives, and in particular whether it is intended to persuade non-donors to donate for the first time, or remind donors of the need to continue. These issues are more fully discussed in Chapter 8.

7.3.2.6 Using the Word 'Please'

Examples: Please give blood, it won't hurt but it could save a life (H)

Please be a Blood Donor (Glasgow Donor Centre) (J)

Don't let it run out - be a Blood Donor, Please (I)

Opinion varied on the importance of using the word 'please'. Some donors and lapsed donors felt it was a useful addition, and occasionally suggested it should appear on other posters. The phrase 'Please Give Blood' was particularly liked.

> "I like the 'Please give blood', because people have logical reasons why they don't give blood and very personal reasons. I certainly wouldn't like to intimidate anybody into giving blood if they didn't wish to give blood. I always like to be asked. I don't like people telling me what to do." (Donor)

> "It makes it sound friendly." (Donor)

> "'Please give blood'. The words are just simple. You couldn't make it more simple than that." (Lapsed Donor)
>
> "You could use the slogan, 'Please give blood' on photographs." (Lapsed Donor)

A smaller number of non-donors, however, argued that the more polite 'please' would make little difference in terms of encouraging non-donors to donate and in fact might possibly reduce the impact.

> "You don't ask the public to do something - you tell them to do it." (Non-Donor)
>
> "You either do it or you don't do it." (Non-Donor)

In the event, the actual posters using 'please' which were used as prompts in the research had little impact and aroused much less interest in the groups than those previously discussed. However, this was probably related to their visual presentation and execution rather than the use of the 'please' concept.

While they seemed quite pleasant, giving no offence, and in the case of Glasgow donating centre poster, informative, they did not seem to have any obvious strength.

> "You could walk by that 100 times a day and you wouldn't notice it. Or you'd think, 'I'll need to give blood some day' and just walk past it." (Lasped Donor)
>
> "It's all right for somebody who is in the habit of giving blood, but it wouldn't do anything for a new donor. You're just saying, 'Please give blood', but somebody who's never been before will want to have some reason to give blood." (Donor)

However, because the idea of using 'please' was commented on favourably by the majority of people, the use of the word itself is probably worthwhile. On balance, it seems to project attractive images about the BTS and people who give blood, promoting both as pleasant, polite and friendly. Overall, therefore, it helps to reduce any undercurrent of coercion to which non-donors might be sensitive.

7.3.2.7 Claiming That it Doesn't Hurt

Examples - Posters from TV personality advertisements, eg Noel Edmonds (A)
- Please give Blood - It won't hurt but it could save a life (H)

This topic has already been discussed in relation to television advertising (Section 7.3.1) and the same feelings were expressed when used in posters. In summary, it was felt by most donors and non-donors that the concept of pain was better not mentioned, for a number of reasons:

- Giving blood could actually be painful on some occasions; people who experienced discomfort might therefore feel let down by such a claim, and perhaps extend their distrust to other aspects of the BTS.

  "If someone said it won't hurt at all and you came and it did hurt you wouldn't be very chuffed." (Non-Donor)

- It might introduce the previously unconsidered concept of pain.

  "If anyone says they're not going to hurt me I always feel they're going to." (Non-Donor)

- It was likely to be an unproductive message because fearful non-donors would not be convinced until they had donated themselves.

  "To me the only way to get rid of the fear is to go in. Nobody's going to tell me it's not going to hurt until after the first time." (Non-Donor)

- Donors were aware of whether giving blood could be painful or not from their own experiences and did not need to be informed. It was thus essentially irrelevant for those who had not experienced pain, although not counterproductive, but potentially irritating for those who had.

Overall, it was accepted that, depending on the target group and the advertising strategy, a variety of more positive images and approaches would be more useful.

7.3.2.8 Use of Personalities

The posters used as examples were all taken from the television advertising campaigns, so the range of comments were the same as discussed previously (section 7.3.1). This can be summarised as follows.

- Using a personality could attract attention and could make the material more memorable.

- A personality might lack credibility, describing a false situation because he or she had been paid to do so. An 'ordinary' person might be more suitable in this regard.

- Donors and potential donors might relate better to the experiences and opinions of an 'ordinary' person, bearing in mind the widely felt concept that a donor could be 'anybody'.

- The personality might be disliked by some sectors or become outdated, or lose credibility during the course of a campaign. All could detract from the message presented.

- Using a personality might be seen to be squandering limited BTS resources, if it was assumed that he or she was being paid.

7.3.2.9 Giving Information

Example: If you have had chickenpox or shingles . . . (K)

It was frequently mentioned by both donors and non-donors that there was a need to know more about the process of giving blood, the conditions/restrictions preventing donation, and what blood was used for. This was the only poster available as an example which attempted

to fulfil some of this apparent need and interest. It was immediately recognised as having too much information for an 'impact' poster but was felt to be potentially successful as a handout. It was also suggested that it could usefully be shown in a waiting room, especially at a doctor's surgery or health centre/clinic, where people had time to read it and were preoccupied with health matters. This idea was also reinforced by the poster's particular design, where the black background and yellow spotted chicken in cartoon format were felt to be eye catching and intriguing.

In practice, it did highlight a use for blood of which very few people were aware. In fact, people thought that if they had had chickenpox or shingles that they should actually postpone donating for some unspecified time until they felt their blood was 'clear' of the infection, similar to the way they felt they should act after any infectious illness.

> "I didn't realise that. When you go to give blood they ask you if you've been in contact with any infectious diseases. If you're a member of a family who has maybe had chickenpox or shingles you wouldn't go. I would think having been in contact with someone, then I shouldn't go along."
> (Lapsed Donor)

Other misconceptions about eligibility to give blood such as described in section 5.5 might also be suitable subjects for information posters, especially perhaps the poorly understood fact that people can donate blood after recovering from some forms of jaundice. Again, the primary appeal of such posters is probably for donors or those on the point of donation, once more highlighting posters' reinforcing rather than persuasive role.

7.3.2.10 Conclusions - Poster Material

Overall, this research indicated that respondents felt most of the posters to have little value in terms of attracting non-donors to give blood, although some might be effective for small sections of the community. They were, however, seen to have some value in giving

information to those who were actually looking for it, ie donors, or those who had already decided to donate.

> "Overall they (the posters) don't do anything for me, they don't make me want to go and give blood. They bring you around to thinking about it - but not for long. I'd forget about it until I saw another one." (Non-Donor)

> "I think there's a place for all kinds (of posters). It's a question of keeping people's awareness up, but the disaster one had most impact." (Donor)

In evaluating the above conclusion, it is important to reiterate the point made in an earlier section (7.2) of this report that consumers are unlikely to have the understanding or experience to judge what is effective in advertising and what is not. As a result, their comments of the overall effectiveness of posters are their opinions, not necessarily a statement of fact. Nevertheless, their views in this case were compatible with the theoretical role of posters, which is primarily to reinforce rather than to persuade. A particular demonstration of this is that donors tended to be more positive about the content than were non-donors, and also spontaneously recalled the material to a greater extent.

This theoretical role of posters in reminding specific groups about particular issues cannot be overstated. While many of the posters used were experimental, in the sense of illustrating themes rather than being designed for the particular groups with whom they were researched, they nevertheless demonstrated as a whole the relatively poor targeting of blood donation posters in terms of audiences, messages and objectives. It is therefore vital for future development that these targeting objectives be clearly specified in advance, and material designed with these particular aims in mind, rather than produced generically and linked to objectives retrospectively. Within this overall aim, it is clear that some groups will be more important to approach than others, and the nature of these and the optimum communication strategies to use are discussed in Chapter 8.

7.3.3 Session Handouts

Examples: Personal Stickers (M)
Car Stickers (N)
Calendars (O)

These were received at sessions, and were well remembered by most donors who saw them as a reminder to themselves and others to continue to donate. They were also regarded as a form of thanks from the BTS, and to a lesser extent, as a type of 'free gift' in return for giving blood. Non-donors also had some awareness of this type of material but in their case the car stickers had had a relatively greater impact than the personal stickers or the calendars.

> "These things help it stick in your mind. (Donor)
>
> "If you're walking along the street people see it and think about it more." (Donor)
>
> "I think things on cars. I might think, 'Yes, I'll maybe give that a try'". (Non-Donor)

Both donors and non-donors felt it was worth distributing such handouts with easy to recognise BTS symbols, especially the heart logo. There was an implication that they increased awareness by widespread display, although it was not thought that people would donate because of them.

> "They get a wide range of advertisements." (Donor)
>
> "They're advertising blood - I suppose it helps." (Donor)

It was also argued that the more these were displayed, the greater would be the feeling that 'everyone gives blood', which would be a useful impression for the BTS to create, especially for groups of acquaintances. A further advantage was that if a donor was using a BTS symbol in some way, then perhaps those who were considering giving

blood could ask that person for advice. Bearing in mind that many donors do not wish to 'preach' to non-donors at random, this in effect facilitates the introduction of personal persuasion, since the non-donor himself has expressed an interest in donating blood. Throughout the research, and from all the experiences described, it was apparent that personal contact and support is of prime importance in persuading people to donate blood and therefore strategies which might facilitate this are important.

> "If someone's wearing one and you're thinking of giving blood, you could go up to them and ask them how it was rather than just going along scared stiff." (Donor)

> "Folks'll stop you and ask, 'What's these?'" (Donor)

> "Maybe if they are actually sitting in the car and they say, 'Oh, did you give blood?' and you start talking about it." (Non-Donor)

> "If somebody says to you, 'What day is it?' and you take the calendar out, and they'll see it." (Non-Donor)

One suggestion made was that donors might feel proud to display the fact that they were donors. This, however, was not a generally reported feeling, although it applied more in relation to metal badges.

> "It might give you a bit of an ego trip to have it stuck on your car." (Lapsed Donor)

The car stickers were most popular, because they were more substantial and permanent than the small personal ones. Many donors did not like to wear the personal stickers for the reasons discussed below, but found the car ones acceptable.

> "It's less embarrassing than wearing a sticker - they don't look so bad on the window. It's better there than on your jacket." (Donor)

Feelings were much more mixed about the personal stickers. In general they were liked, implying that they gave a nice, cheerful

image to blood donating. However on prompting, a number of people (both donors and non-donors) said they would not actually like to wear them, for a variety of reasons.

- A lot of men thought they were 'cissy' or 'just stupid'.

- Women especially felt they might mark their clothes.

- They were seen to be very impermanent, and got tatty quickly or had to be taken off to clean the clothes.

> "You stick them on your jerseys and the next thing they get washed and they'll come off." (Donor)

It was thought they might appeal to young people, especially if they were jokey or gimmicky, but had little real appeal to other sectors despite generating a good friendly feeling about the BTS.

> "The ones you have a gimmick on you'll get young people or someone like myself wearing." (Donor)

> "Is there not one - Kiss Me I Gave Blood Today." (Donor)

Young girls were seen as the group most likely to wear them, especially in a workplace situation, where they could contribute to any group feeling being generated.

> "In your work you would (wear it) - I can imagine all the young girls." (Lapsed Donor)

> "When I was young it was, 'She's got a badge, I'm going to get one too.'" (Lapsed Donor)

While most donors said they would not actually wear them, many did display them rather than just throw them away. Examples were given of sticking them onto purses, handbags, tool boxes or locker doors. The end result of this might be just as effective, and should be borne in mind in designing them.

A further distribution was through donors taking them home for their children to wear, suggesting that there may well be some potential in designing some of the stickers with appeal to children in mind. An example of this quoted was a sticker saying, 'My Daddy Gave Blood Today'.

> "Stickers have no effect. It's the children who appreciate them more than anyone." (Lapsed Donor)

The potential of this lies, of course, not only in giving something that is appreciated (as already discussed in Section 6.4.2.3), but also in making children aware of the idea of giving blood and/or the BTS.

> "If it's on badges (BTS symbol) the children will wear them, so in the long run they'll be associating with it." (Lapsed Donor)

A more indirect (and possibly less morally acceptable) function would also be in stimulating children to remind their parents to donate again, similar to the situation that sometimes occurs in anti-smoking, where school education about the hazards of smoking sometimes leads children to try to correct their parents' behaviour.

> "If you can get the children interested in giving blood, they they'll get the mother and father to give a pint of blood." (Donor)

To counteract the problem of their impermanence, it was suggested that metal, enamel or plastic badges could be considered instead. It was also agreed that these should be of high quality to give a better impression of the BTS.

> "Surely they would be better if they were metal badges and you wore it on your jacket and it would be there all the time. These things come off very quickly." (Donor)

> "I'll wear a metal badge, not a sticker." (Non-Donor)

The slogan "Blood Donors Love Life" appeared on a variety of the handouts, usually superimposed on a red heart. This was well recognised by the public, especially by donors but also by non-donors. The immediate reaction was that it was 'good' or 'nice' and 'appropriate'.

> "That's it in a nutshell." (Non-Donor)

However, on prompting, people often found it hard to explain what it meant to them. Non-donors especially had very little appreciation of any specific message. Lapsed donors and donors made some attempt to describe the ethos it implied, but still found it difficult. Interpretations varied in emphasis, from blood donors enjoying life themselves to blood donors giving life to other people.

> "They appreciate it (life) so they give blood more so it will go to someone it will help." (Lapsed Donor)
>
> "Blood donors are giving life, it's not that they're fit and healthy." (Donor)
>
> "They promote life by giving blood." (Lapsed Donor)
>
> "Obviously if you're giving blood you're giving someone life." (Lapsed Donor)

Moreover, some donors and lapsed donors felt it to be weak and ineffectual, promoting an unattractive image of blood donors as 'nice', 'goody-goody' people.

> "Blood donors love life sound like a 'wishy washy' thing to do and sounds like a 'nice thing' to do, rather than an essential thing to do which I hope it is." (Donor)
>
> "Sweet - rubbish. There's nothing catchy about the phrase." (Lapsed Donor)

Overall, however, most people interviewed liked the sound and impression of "Blood Donors Love Life" slogan. The fact that they could not readily explain what it meant is not necessarily detrimental since it did seem to convey a good feeling to most people. However, a

more straighforward slogan might be even better recalled and internalised.

In the final analysis, the handout material with BTS symbols seemed to enjoy a degree of success. Because they are widely displayed they generated feelings of awareness about blood donation even among non-donors as well as the donors who had been given them. Their display had the added advantage of making donors available to answer questions from interested non-donors, as well as generating the feeling of 'everyone gives blood'. Their continued use should therefore be encouraged, particularly bearing in mind their relatively low cost in comparison with some other forms of publicity.

7.3.4 Leaflets

The researchers had not been given any BTS leaflets, and so these were not used as prompts in the discussions. Their availability was only twice mentioned by donors with little recall of content apart from the fact that they were felt in general terms to be informative. Some donors and non-donors did suggest that they should be made available, either at sessions or distributed around houses just before, but were obviously unaware that such material already existed.

> "They should have a supply of them where you give blood and I would read them." (Donor)

This poor awareness seems unfortunate in view of the previously discussed lack of knowledge about blood among both donors and non-donors (Chapter 5), and the actual requests for information from all sectors, especially lapsed donors (Section 6.6). It is particularly regrettable because some of the existing leaflets provide in detail much of the information that was requested.

> "I've been a number of times and seen leaflets sitting on the table. One day I took them and I got an awful lot of information. In other words I think the information is available, but I think as soon as you go there they should give you a leaflet. Even if you go no further at least you've got this bit of paper." (Donor)

It is unclear from this research why people were not aware of the leaflets available. No obvious reason emerged, and further research would be necessary to clarify the issue. Several possibilities were suggested, including:

- Poor Distribution. If leaflets are usually only displayed at donation points, non-donors are by definition unlikely to be exposed to them, even if they are considering donation. In this case, alternative locations that could be considered might include doctors' waiting rooms, medical aid points, factories/offices/canteens, libraries, playgroups/community centres etc. However, in view of the anti-medical concerns many non-donors appear to hold as reasons for not donating, it might be more useful to consider non-medical locations such as community centres rather than medical ones. Alternatively, house to house distribution in selected catchment areas might prove advantageous, as might direct mail facilities such as the GPO's Home Delivery Service or commercial equivalents. It was also suggested that donors could take a supply to give to interested non-donors when talking to them about donation. However, this may well be a somewhat idealistic strategy in view of many donors' concern about being seen to 'evangelise'.

An alternative strategy suggested to improve distribution was that leaflets could possibly be better distributed within the sessions themselves, being available for reading both while waiting to give blood, and also at the rest points afterwards. Some degree of personal distribution could also be of value, with staff actually offering leaflets to donors. A particular advantage of this strategy was felt to be the potential availability of staff to respond to queries about the leaflets' content, or discuss the issues raised. This would combine the proven benefits of interpersonal persuasion and reinforcement with the backup material in the leaflet to take home. In this regard, the rest period after giving blood might be the most useful distribution point.

- Poor Design. Leaflets are extremely sensitive to graphic design considerations, especially in creating the image that the content is attractive and worth considering. In this regard, many

currently used in social advertising do not fulfil adequate design standards, particularly if they are in any kind of competitive situation. As a result, many tend to disappear without trace or impact, even though they may well be delivered to their intended audience. Particular issues that should be considered are attractive outer pages, clear and logical text of the correct reading age and difficulty, and the appropriate emotional tone, especially in the language used and/or lifestyle depicted.

- Poor Print Volume. In practice, leaflets tend to have a short life, being highly disposable. Because of this, there is often a high turnover relative to impact of even the best designed leaflet. A high print volume in addition to wide availability is therefore required to achieve the desired effect, and it may be that this is not being achieved.

- Poor Information Source. It was suggested that the reasons for the leaflets' poor impact might reflect the inadequacy of this mechanism as an education strategy, rather than anything to do with their poor distribution, design or print volume. In other words, it was felt that the means itself of promoting information in this way could be inappropriate (or might be used incorrectly) even though it might appear a correct strategy at face value. The reason for this was that it was felt unlikely that education on and retention of complex issues could take place through reading leaflets alone, unless there was an extremely high degree of involvement or interest. In particular, it was argued that without personal reinforcement, the material could easily be read and understood, but forgotten with the passage of time, particularly as the topic occurred relatively infrequently. The implication, therefore, is that leaflets should be used as a back-up for other means of education or communication, such as interpersonal discussion, rather than relying on them as the sole means of achieving this.

7.3.5 Newsletters (P)

In the groups, respondents also discussed the concept of a newsletter as a means of publicity. To help them, a particular example was used as a prompt. This was 'Donor News' , issued by the Edinburgh and South East Scotland BTS. In the event, no-one in any of the groups, either in the South East or elsewhere, recalled having ever received any kind of newsletter. However, the concept elicited favourable comment by the majority, although with some reservations.

The idea seemed to appeal more to donors than non-donors. Perhaps interestingly, it also appealed more to lapsed rather than regular donors, possibly reflecting the former's greater need for involvement with the BTS to persuade them to continue donation. By contrast, regular donors claimed not to require this stimulus to continue, arguing that the motivation already existed. It was also noticeable that the idea was more attractive to women than to men. The former claimed that they would be more likely to read it, welcoming the magazine type format with its short factual articles as well as 'gossipy' sections about people involved in blood donation.

> "I think a lot would sit and read it."
> (Lapsed Donor - Female)
>
> "Do you think you would actually read it cover to cover?" (Lapsed Donor - Male)
>
> "Things like that bore me." (Non-Donor - Male)

A newsletter was seen to have a number of particular advantages.

- It could provide information. As mentioned previously in relation to leaflets, donors and lapsed donors in particular continually requested more information about blood. While a newsletter might not be the best theoretical medium for providing this, it might in practice convey relatively more information than some other means because the format and content were interesting.

"I think they should send those out more. You'd know more about what was happening to your blood - where it's going and what it's doing." (Donor)

"That'll be the facts and figures I'm looking for." (Lapsed Donor)

"Because then you know where your blood's going and what's happening to it." (Lapsed Donor)

- It would be in a magazine-like format which it was felt some sectors would find more interesting and readable. As already mentioned, this was especially true of females and lapsed donors. In this sense, the material was seen to be more accurately targeted in design terms, following the style that in practice appeals to many people, especially young, working class women.

- It could create a greater sense of involvement with the BTS, through reading about other people's experiences. It could also convey more particular information about the need for blood, and how this was being met. Moreover, it could also present a cheerful, friendly image of blood donors and the activity of giving blood. As already indicated, this type of approach could provide greater encouragement to donate, especially for lapsed donors. In their particular case, it was thought that simply receiving such material without any overt pressure to donate might convey the BTS's interest and involvement in them as individuals, especially if it were implied that they were considered part of the 'family' of donors.

"I'd read it to see what was going on."
(Lapsed Donor)

- It was thought that if it was delivered to one's own home, more time would be available to read it, and it might therefore be more likely to act as a reinforcement.

"I think it's a good idea. You're more likely to read it if it's in your own house." (Donor)

- It could be a useful back-up reinforcement to help donors in the delicate task of encouraging non-donors. It was not overtly designed to try to persuade people to donate, but instead provided a positive, cheerful image of the BTS and blood donors, implying that giving blood was an attractive activity to be involved in.

> "They could ask you to read it and then circulate it with friends. Rather than browbeating them into going, just say, 'Well, here's some information' and let them read it when they get time. It would also be a good thing to leave in factories in the canteen areas. Our own work puts out a monthly magazine and it's amazing how many people lift it up and read it." (Lapsed Donor)

The main reservations about the concept of newsletters were:-

- They might not be read, but just put aside and eventually thrown out. This was primarily a male rather than a female viewpoint, and reflects the fact that men were much less attracted to the magazine type format than were women. However, it is also general experience in social advertising that such handouts can often be discarded, unless well designed and containing material that interests the reader as much or more than what is otherwise available. It is also important that they are sent only to people interested in reading them. As indicated, this would be primarily donors and lapsed donors, but consideration might also be given to sending it to females only, who react best to the small magazine-type format.

- The second criticism relates to the first, and is that it might be an expensive project considering that there might be a potential risk of lack of impact. Again, this was a male comment, stimulated by the fact that they thought it would have little effect. This concern about cost was apparent in considering a number of publicity media, but in each case cost effectiveness would be a management decision with the aid of

research. In this case, females thought the approach more successful and thus, by implication, worth some expenditure.

Overall, therefore, considerable interest was shown in the concept of a newsletter, with positive responses in particular from donors and lapsed donors. It was seen to be a medium for conveying information but also a potential means of generating a sense of involvement and pleasure in the activity of donating. The magazine format was of interest and home delivery would be appreciated. It also might give an interesting, positive perspective to any non-donors considering donating.

However, in the final analysis, it would have to be considered whether or not a newsletter would actually be read, and if it would be cost effective. The BTS would need to ensure there was accurate distribution to those who would most appreciate it, and the content would have to be competitive with other reading material available.

7.3.6 Christmas Card (Q)

This example of publicity material was again issued by the Edinburgh and South East BTS. It was sent to donors suggesting that they continue to give blood as a Christmas gift, as well as conveying thanks and best wishes from the BTS. This was one of the most positively received forms of current publicity discussed in the research, with the idea generally warmly received by donors since it conveyed in particular the feeling that the BTS appreciated and cared about donors.

"It shows that you are appreciated." (Donor)

"It makes you feel proud, proud to be a blood donor." (Donor)

"Really good - you think, 'Oh, I must go and see them next time.'" (Lapsed Donor)

"If they take an interest in you - you'll take an interest in them." (Donor)

However, as some respondents pointed out, cost effectiveness would be a major consideration. While the cards would undoubtedly increase morale among donors which might be reflected in continuing donation, this might be a minimal effect. It was claimed that regular donors would usually donate anyway and it might not be a sufficiently strong reminder to lapsed donors, especially as it would probably not be received just before a local donating session when it would have most effect. It was also felt that the feelings of involvement and interest in the BTS it conveys could be generated in other more effective ways as described in previous sections, such as staff attitudes, personal reminders and personal invitations to sessions.

Overall, the continued use of Christmas cards and their likely success should be judged against their objectives. If a priority is to strengthen the morale of donors then they may be a helpful tool, but if other objectives are defined then the sending of Christmas cards might be a pleasant but expensive luxury. On balance, their continued use should probably be encouraged, but they are likely to be most effective as part of an integrated campaign.

7.4 Further Ideas from the Groups to Encourage Donation

As the discussions progressed, both donors and non-donors showed a great deal of interest in the problem of how to encourage people to start and to continue donating blood. This degree of concern about the problem again indicates the supportive way people felt about giving blood. As well as giving reactions to existing publicity, they spontaneously made a variety of suggestions about other possible strategies, and these are discussed in the following sections. Three issues are explored in detail:

- increased advertising campaigns (7.4.1);
- encouraging and facilitating increased personal persuasion (7.4.2);
- providing more information about blood donation (7.4.3)

A discussion of the common themes underlying these suggestions is given in Section 7.4.4.

7.4.1 Increased Advertising Campaigns

Some people felt that since current publicity seemed to lack the power to urge people to give blood, then increased publicity would automatically help. It was argued that this should comprise a more extensive range of bigger and better posters, television advertisements, eye catching stickers and slogans, and publicity through TV documentaries.

> "It's not really advertised. They should advertise it more and then more people would do it." (Non-Donor)

> "People forget about it. They forget the service exists. They never think about it. If they had a reminder that there was such a service there every six months and actually had an advertising campaign then people might be more likely to get started on a regular basis." (Lapsed Donor)

This type of comment commonly occurs in group discussions with the general public about advertising campaigns. It should not be interpreted literally as a request for more advertising but as another way of stating that there is poor awareness about the topic. In this case, discussants are really saying that awareness of the BTS, the need for blood, and how to donate etc should be given greater public visibility. How this should be achieved, of course, is a matter for the BTS and their advisers to decide.

Some suggestions were made for some different approaches to be incorporated into the publicity used. Most frequently mentioned was material that featured real, 'ordinary' people who had been helped as a result of receiving blood, preferably with a before-and-after effect. This was sometimes compared with kidney campaigns showing people who had been helped after a transplant. It was thought this approach might bring home more vividly that giving blood really did

help people. As already discussed, a real person would have more credibility than a celebrity.

This approach would, it was felt, help reinforce donors in their intention to donate. It would also have the added advantage of giving the impression of recipients thanking people who gave blood. Although most donors would give blood without thanks, a 'thank you' from the BTS and their staff did help morale, and thanks from a recipient would be another factor, albeit a small one, that might tip the balance for a donor about to lapse.

The continued use of personalities was also mentioned, but with a request to feature people who would be more interesting to more people. However, as discussed earlier (7.2) this use of personalities has many pitfalls and should not be undertaken lightly. Suggestions included pop stars for 'young people' and sports celebrities such as well known snooker or football players. Mention was made as well of the use of Jim Watt in anti-smoking posters. It was also felt there could be more 'local' heroes used, especially Scots for Scotland.

In suggesting alternative strategies, respondents mentioned other examples of social advertising that they had found memorable. The following were highlighted:-

- Road safety topics.

> "Ads like, 'Think twice, think bike'. That sort of thing with tomato ketchup are strong. Something of that kind to bring it home." (Lapsed Donor)
>
> "You notice those ads on telly with the wee girl running out in front of the car. They're effective." (Donor)
>
> "Have you seen the one with the motorbike? That gets you. It's short but puts over it's point really good. That guy doesn't say much really - it's more action. It gets you thinking." (Non-Donor)

- The Jimmy Saville TV series on safety which highlighted dangerous situations and showed children who had been involved in accidents.

> "Can any of you remember the programmes with Jimmy Saville with regards to the health? It showed you a few things which got right to the point. There was one with glass doors. I had a glass door, but I changed it as a result of seeing that. There was one regarding ovens as well." (Lapsed Donor)

- Help for Cystic Fibrosis.

> "I saw a good poster. It showed a wee boy in a wheelchair. It said, 'You can walk away from this poster - he can't', so it made me think a wee bit. That shocked me. Often you just walk by posters." (Non-Donor)

- Appeals for kidney donors.

> "That kidney advert. It shows you before they couldn't do this, they couldn't do that, couldn't have a family, and then a wee while after she had the kidney, and that makes you think." (Non-Donor)

All of these involve approaches already discussed. They use real, 'ordinary' people as examples, often children or young people with whom one can readily sympathise, portraying them in situations that one is encouraged to identify with. The successful use of this emotional involvement strategy is demonstrated by the fact that they were memorable and that they raised the level of awareness of these topics. However, with the exception of the Jimmy Saville series, no mention was made of changes of behaviour.

Some further ideas were suggested, each by only a few people. One young non-donor who said he did not know any donors suggested a function every year, where donors could meet other donors, and gain encouragement from them. It could also be seen as a thank you from the BTS.

> "They should try a function once a year for blood donors - maybe for younger people with a disco unit. Everybody would have something in common. (Non-Donor)

Another suggestion was that pens with details about sessions and BTS slogans might be more welcome handouts than current stickers or calender cards.

In conclusion, several strategies to increase the effective use of advertising were suggested. All have indeed been successfully used in the past, but their potential should be interpreted within the previously made point that consumers do not in general have the understanding or capacity to decide what is effective advertising and what is not. In essence, the above suggestions really highlight campaigns that have created some kind of impact among certain people, but they may or may not have been effective in terms of the objectives set for them. As discussed earlier, impact is only one objective of advertising, and the audience among whom it was created may or may not have been as intended. The important issue therefore is as already mentioned: it is important to set objectives for advertising and use strategies that achieve these, rather than select what seems to be intuitively appealing approaches and look for objectives to fit them.

7.4.2 Encouraging and Facilitating Increased Personal Persuasion

In contrast to bigger and more varied publicity, the importance of smaller scale exercises, ideally involving personal or one-to-one contact, was stressed by a number of discussants. Such contact could be through a friend or acquaintance, or perhaps from BTS staff or volunteers.

The following possibilities were suggested, and are discussed below:

- a friend encouraging someone to donate;
- personal invitations to donate by telephone or letter;
- leaflets through the door prior to a session;

- personal calls at homes prior to sessions;

- talks to small groups including school children;

- invitations to sessions without donating, to meet staff and observe the situation.

However, persuasion by advertising and personally by individuals were not seen to be mutually exclusive processes. It was recognised, although not widely, that seeing some form of advertising which was then followed by personal contact (or less commonly, vice versa) was probably what most people experienced in practice. It was thus implied, correctly, that successful advertising could raise people's level of awareness of the topic, but that the decision to donate or not depended on wider considerations, as discussed in Chapter 6, and that these would be facilitated by personal contact and discussion.

> "All advertising is to increase awareness. If you've never heard of blood transfusion before you're much more likely to be cautious. If you've been subjected to a successful campaign, then when the crunch comes when your neighbour or whoever says, 'Are you coming down?' you're much more likely to respond." (Donor)
>
> "I haven't given blood for three years and I'll pass these adverts in the street and I don't feel guilty about it. It's not until someone comes along and asks you." (Lapsed Donor)
>
> "If you had seen any advert for the blood donors and you were absolutely on your own, nobody to go with, you wouldn't go." (Lapsed Donor)
>
> "When you first go, you go because someone's taken you there, a friend, or you know someone who has given blood, not particularly because of adverts." (Donor)

It was within this context of the interaction of publicity and personal persuasion, therefore, that the following suggestions on increasing personal persuasion were made.

Personal Contact Through a Friend/Acquaintance. Most people felt that a friend who was already a donor was probably the most powerful

agent for encouraging donation. It was recognised that a donor already had personal conviction that giving blood was worthwhile and necessary, which could be passed on to a non-donor, either through verbal persuasion or by personal example of donation. He or she was also able to answer individual queries about sessions from experience, and as someone known to the non-donor, would have higher credibility in comparison with a stranger or publicity material. Finally, it was noted that a donor could also give a potential donor reassurance by accompanying him to his first session, which is often the major hurdle to be overcome.

It was suggested, therefore, that perhaps existing donors could do more to encourage non-donors. Theoretically, at least, this is an approach with considerable potential.

> "Perhaps we should make more of an effort each time. Take somebody new along each time. We could encourage more people to come along." (Donor)

> "I've worked with guys and I've discussed it with them - 'Come on, try it'. After the first or second time, they just say, 'I'll do it then'. They feel some sort of responsibility towards it so they go and give blood each time." (Donor)

> "The majority knows someone who has needed blood and if someone approaches you face to face it makes you think, 'Right enough, maybe I should do something'". (Donor)

Even non-donors thought this could potentially have a valuable effect.

> "Is it just that we can keep avoiding it or because nobody's actually said to you, 'Linda, please go and give a pint of blood.' Perhaps it's not personal enough." (Non-Donor)

Moreover, personal persuasion and reminders to donate were also seen to be very important to lapsed donors as something that would help them go back to donating again, as already discussed (6.6).

Some donors felt they would be happy to encourage people to give blood, and would make a point of mentioning it, both to people they

met socially and people at work. Others, however, were more reticent, and felt that donating was an activity which each person should decide for himself. As a result, they argued that attempts at persuasion might be resented, and be seen as 'preaching'.

> "I don't argue with anyone who doesn't give blood - I just accept that they don't. It's not my right to argue with them to that extent." (Donor)

> "I wouldn't canvas for the BTS." (Donor)

However, on further discussion, the consensus was that donors could probably be encouraged to persuade non-donors without creating antagonism. Provided the potential problems are borne in mind, the BTS could thus suggest to donors that this is a valuable approach, and, as long as overt preaching is not encouraged, could advise donors to be aware of making use of possible opportunities and interest from non-donors. In fact, most donors seemed willing to talk about donation to anyone who showed an interest, and it might be useful for them to have more information and leaflets available to facilitate their efforts.

Personal Invitations by Telephone or Letter. For individuals not exposed to personal persuasion from a friend or acquaintance, it was felt that the BTS could consider approaches that attempted to simulate this. In this regard, personal invitations by letter or postcards were suggested as potentially useful means of jogging people's memories, although they ran the risk of being easily put aside and forgotten if one wished.

> "The letter is a good idea. It does jog your memory. If you are really keen on going it's enough to jog your memory." (Lapsed Donor)

The success of such an approach would obviously also depend very much on the content. It is important that the correspondence is personalised, using the individual's name and address, and that it should appear bright and friendly, rather than anonymous and clinical. It is also important that accurate records should be kept about when letters have been sent out: some people who received them close

together tended to resent it, feeling they were part of an anonymous system harassing them. Other isolated complaints were made of invitations when the individual's donation had already been refused because of ill health, or they had already contacted the BTS to say they could not attend. Clearly, these practical issues should be continually borne in mind.

> "It's offputting getting letters too often - you feel pinned down. I got two in two months. They just say if you'd like to come along. I don't think they should pester you - it puts me off going." (Donor)

It was also suggested that a useful policy might be to telephone people (mostly previous donors) just one or two days before a session was held, and invite them to attend. Of all the strategies suggested, this was thought to be the most productive one that the BTS could initiate if it could be afforded. It would be a personal approach, and would also require the potential donor to make an immediate, conscious decision about whether to attend.

> "The only time I've refused a phone call is when I've had a cold. I've disregarded the reminder (letter) quite often. If the cost of a phone call is going to get a pint of blood I would say the personal touch works." (Donor)

> "I think if you got a phone call in the morning it would be more effective than a letter. I'm not organised and that would be better for me. If I'm walking past it I'll go. I just forget about it." (Lapsed Donor)

This approach appealed especially to lapsed donors who, as discussed earlier (6.6), often did not make a deliberate decision to stop, and were basically willing to donate again. They did not fear the unknown or need company for reassurance, but still needed a 'push' and felt they would be receptive to a telephone prompt. This reinforcement strategy would therefore be worth BTS consideration, especially with lapsed donors.

> "I think if they gave you a phone call and invited you to come down, you'd feel obliged to go." (Lapsed Donor)
>
> "They could give you an appointment - just like the doctors. At least you could say, 'yes' or 'no' at the time. You'd be more likely to say 'yes' because of actually speaking to someone and if you felt you had an appointment to go. Rather than just knowing that they're there that night and you think, 'Well, maybe I'll go along', and you never do." (Lapsed Donor)
>
> "Maybe after a year and a half a phone call to say, 'Is there a problem?' Just to jog your memory." (Lapsed Donor)

It is worth noting that while people were willing to receive a telephone call from the BTS, it was felt unlikely that they would take the initiative themselves and phone to find out about donating blood. This procedure is suggested in the national advertising, in order to encourage people to find out more, but from this research it seems unlikely that this would actually happen in practice. This would imply that the major points of information for donors (or non-donors) should be included in the text of any advertising material itself, and that campaigns should not rely on any subsidiary strategy like this to communicate their intended messages.

> "Like that one on the TV that comes on, 'Ring the Blood Transfusion Service now.' You never think, 'I must do that now.'" (Donor)
>
> "At the most you think, 'Well, I must go next time they are in Forfar' - you never go and phone." (Lapsed Donor)
>
> "You'd be using your own phone and it would cost you." (Lapsed Donor)

Door to Door Leaflet Distribution. Another suggestion was that it might be useful to consider door to door distribution of leaflets to all houses, including donors and non-donors, especially prior to a local session. Some people said they read "everything that comes throught the door", although others disagreed, arguing that a leaflet would be more likely to be put aside with other unsolicited material. The latter result is probably more common, and care should be taken in

considering their use on a regular or widespread basis. They may, however, be more appropriate for particular audiences, such as in smaller rural communities, or if designed for particular objectives, for example, to trigger lapsed donors' interest. Again, this highlights the need to define objectives and determine the most suitable communication medium relative to these, rather than vice versa.

Door to Door Canvassing. A representative canvassing round private homes was also suggested. It was felt this would be beneficial since it would provide someone on the spot to answer any queries. However, on balance it was thought that it was more likely to be resented as too much of an interruption and intrusion. Essentially, the suggestion represented a request for personal contact, rather than specifying a viable means of achieving this.

It was noticeable, however, that where an active local volunteer was known and could be identified, even by non-donors, this increased the general level of awareness of blood donating, with beneficial results. This stimulating effect was especially apparent in rural areas and some workplaces where personal contact is easier. The BTS could therefore usefully encourage any donors who showed an interest in this way, giving them posters and leaflets, and keeping them up-to-date with publicity campaigns and technical developments in blood donation. The volunteer would then become known as someone who would be able to answer questions about donating and reassure people. They could also remind people (both donors and non-donors) about imminent sessions, and might themselves attend as support.

A further suggestion was that such people could call at the door on the day of the session and offer transport, rather like polling day.

> "If people went around the doors it would jog the donors to go and give blood if they forget, or if they feel they can't be bothered going tonight. You could say, 'We've got a car and we'll give you a lift along.'" (Donor)
>
> "I think transport would help, especially with the colder weather coming along." (Donor)

Small Group Talks/Discussions. It was often suggested that it would be useful for BTS representatives to talk to small groups of people about blood donation and the BTS. These could include church groups, workplaces, voluntary organisations, school children etc. This would have two benefits: the sense of personal appeal, and the wider dissemination of information and awareness about the BTS. It was felt that even the group discussions held for this research, which deliberately made no conscious attempt to persuade people to donate, were enough to make people think about the topic, and perhaps decide to take action. (Whether donations actually followed in practice would be interesting to know, but would require further research.)

> "Being spoken to and having this discussion I feel I should do something and go and give blood." (Non-Donor)
>
> "I think I should go. There's a little thing there but I don't give it a lot of thought unless, like tonight, we're talking about it." (Non-Donor)
>
> "Maybe as a result of this evening I'd feel more tempted." (Non-Donor)
>
> "I've got no reason for not going, just laziness, that's all. I will go. Next time I see it I'm going to go and do it. I've decided. (Non-Donor)

The advantages of talking to groups of school children were also mentioned, and respondents were surprised this was not done, to their knowledge. It was suggested that school leaver groups would be important contacts as they would soon be old enough to donate. A possibly even more important group was felt to be younger children, since early education would lead to growing awareness of the need for blood donation.

> "Do they ever have campaigns in schools, for sixth formers or anything like that? That would be a good idea because at that age a lot of people are quite willing to do it, especially if there was a group of them. They could get them as they're leaving school, when they get all their careers stuff." (Donor)

"If people were taught more about it, maybe sixth formers at school, or just before they leave school, and whoever was responsible for that area visited the school to tell them about the BTS." (Donor)

"It might be an idea to get a unit along to show them what happens. They do all this type of thing in schools now, especially with the children who don't do exams." (Donor)

"I think they should even show films in junior schools, to 11 year olds just before they change schools. If you can see the birth of a baby at 10 years old they could see films about blood." (Donor)

Invitations to Attend Sessions, without Donating. A different but frequently suggested approach was to encourage non-donors to observe blood donating sessions, without having to commit themselves to donate. It was felt this procedure would allay a lot of fears, especially fear of the unknown. It is worth noting, however, that this suggestion was primarily made by donors and lapsed donors, rather than non-donors themselves.

"Mount a campaign for a prospective donor to come with a donor, maybe three of four times, just take him along, see how it actually happens and where it's actually done. Even if he doesn't give a pint at the first visit or even the fourth or fifth, just let him come in his own way. I think that's the only way you're going to get through to people is if they actually see it." (Donor)

"What would encourage me would be if they took me on a Saturday and let me see round the place first. I'd go if I was allowed to see what happened." (Non-Donor)

"I think if someone went along to watch, they'd feel, 'If everyone else is doing it then there's no reason why I can't." (Donor)

"It helps if you see someone who's just getting up or going out. It's fine. You think, 'Oh, they're discussing the weather or shopping or something.'" (Donor)

It was also suggested that children should be encouraged to attend with adults, for similar reasons. Some young people in youth

organisations had in fact helped at sessions, serving teas etc, and found this helpful when they were considering donating themselves.

> "I think it would be a good idea for children to see." (Donor)

> "Our wee girl likes to go along. She's actually quite squeamish, but she doesn't mind going along to that. She's a nurse for a fortnight after. I wonder if it would encourage children in the long term. They'd be more familiar. They could make it more attractive in the hall for the likes of families to go down." (Lapsed Donor)

In this regard, the provision of creche facilities was also suggested. This would enable children to observe sessions, and have an added advantage in making it easier for their parents to attend.

> "I think it would be a good idea to have a creche unit there." (Donor)

> "A creche would be good because it's not everybody who's got someone to watch the children all the time." (Donor)

However, while attending sessions might help some non-donors and is possibly worthwhile for the BTS to suggest to donors, it is unlikely to reassure those who experience extreme fears about blood donating, especially in relation to medical situations. In observing sessions, they are probably likely to perceive many of their preconceptions as actual realities, especially the hospital-type context and people looking unwell. They would therefore be exposed to an anxiety provoking situation without any of the rewards of having actually given blood.

> "I went and helped with the Girl Guides. I remember someone came up and said, 'Look, it's not painful', and they're shaking. When the needle goes in they change colour." (Non-Donor)

> "That would frighten me, watching people with bags filling with blood." (Donor)

This was further illustrated by one lady who had taken her teenage daughter who 'hated hospitals' to observe a session; having seen it, her daughter was adamant she would never give blood in the future.

> "My daughter's terrified to go, she's 17. She came with me once and it put her off. She's got a fear of hospitals. She spent quite a long time in hospitals when she was younger and that's probably put her off. I think it was the actual blood that put her off, seeing the blood. I was sorry that I'd done it. She might change her mind if she goes to college and there's a unit and they all go in together and feel brave." (Donor)

7.4.3 Providing More Information about Blood Donation

Requests for more information were frequently mentioned throughout the discussion groups. Specific information requested included many of the issues outlined in Chapter 5, such as the uses to which blood could be put, and the actual amounts that were needed. Both donors and non-donors felt ignorant about these subjects and argued that giving people a fuller picture would be more fruitful than simplistic approaches which merely asked for yet more blood.

However, it was also noticeable that committed donors were prepared to donate without much knowledge about what happened to their blood, giving blood for other reasons.

> "You've started me thinking tonight along lines I've never thought of before. I'm willing to give blood, but I've never thought where it goes and how many uses it has." (Donor)

> "It is of interest what's happening to your particular pint. I would never stop just because I didn't know what was happening to it. It doesn't matter to me that much. I feel I want to do it." (Donor)

This group do not therefore actually require further information to make them donate, but they would nonetheless benefit from the extra feeling of involvement, and reinforcement of their ideas that blood is necessary. This is likely to be especially the case for donors who might potentially lapse.

It was felt by some groups that if people could be convinced there was still an unmet need, which does not always come across strongly with current publicity, then they might be more likely to donate. This was especially so of lapsed donors, many of whom had not actually decided to give up donating, but had just not got round to doing so again.

> "It obviously has a lot of uses that we know nothing about. If you knew how important it was it would maybe spur you into giving."
> (Lapsed Donor)

> "Maybe if they gave you more figures and said, 'Glasgow needs so many pints a day.' All these campaigns tell you nothing. They just try to remind you to give blood. You always think someone else will give it." (Donor)

> "Another problem is that you don't ever hear of someone dying because there wasn't blood available. So therefore people think there's enough and it doesn't really matter if I don't give it." (Lapsed Donor)

For non-donors, giving more information would probably not encourage most of them to donate. In particular, those with high levels of fear would not respond to such an approach, because their fears are too overwhelming. However, it might conceivably influence the mass apathetic non-donor, who has not really thought about donating blood at all, although it should be noted that the experience in most other areas of social advertising is that information alone does not usually initiate behavioural change. (The reason for this is that people usually act for more complex reasons involving fairly deep motivations and inhibitions.)

A few people argued that adding complexity in the form of more detailed information to the request to donate might actually be damaging, rather than productive, in that they felt that many people who donated thought only about the more dramatic aspects of blood transfusion and saving life. The knowledge that it was being used to treat other, less exciting ailments might be less motivating, and potentially counterproductive.

> "You think you're saving life because you're giving it. You don't want to hear about parts of blood." (Lapsed Donor)

However, this seemed a minority view. Many more people were interested in finding out more about blood, often questioning the interviewer and other group members. While wider dissemination of information would thus seem a popular approach, it would, of course, have to be considered by the BTS in the light of their campaign strategies, the objectives set, the images to be conveyed, and the nature of the target audience. However, it might help recruit some less fearful non-donors, and also retrieve some lapsed donors. Furthermore, offering more information to donors would have two other potential benefits. Firstly, it might prevent some from lapsing by making them more aware of the need for blood and more involved in the BTS; and secondly, the better informed donor would find it easier to persuade and reassure non-donors.

It was felt that the extra information could be given in many forms, most of which have already been discussed in earlier sections of this chapter. Posters and TV advertising were not considered by the discussants to be particularly appropriate, as the former lacked impact and the latter lacked detail. Television documentaries, however, were thought to be important, being watched with interest by many people. Other possibilities were talking to groups, including school children, and perhaps showing films about sessions. In some areas, local newspapers printed articles about blood donating as well as advertising sessions and reporting the amounts donated, to good effect.

> "The local paper tells you the amount it's gone up by and they're very pleased with the interest shown." (Lapsed Donor)

Blood donating sessions themselves were obvious centres for distribution, although only those already interested in donating would be exposed to this. Suggestions included:

- Leaflets to take away or read during sessions, as already discussed in Section 7.3.4. It is interesting that this was often suggested as a new approach but as mentioned earlier, leaflets are currently available and put out during sessions.

- Continuous slide or video displays which could be watched after donating. However, it was agreed that the whole tea/rest area should not be exposed to this because some donors still felt squeamish about giving blood, and might not like to be exposed to more explicit information about it.

> "I think when you have tea at the end some video type of things could be shown about your blood while you're sitting there for ten minutes waiting for your alloted time to pass." (Donor)

- An enquiry table where someone was free to answer questions about blood donating, for both intending donors as they came into sessions, and those who have already given blood. This was suggested as it was sometimes felt that the nurse at the bedside was too preoccupied or not sufficiently knowledgeable to help.

In conclusion, the further dissemination of information about blood donating, as suggested by the discussants, would probably have a beneficial effect in terms of maintaining and possibly even marginally increasing the levels of donation. It might help to persuade apathetic non-donors and some lapsed donors to donate, and probably would also reinforce donors' motivations. The approach might also be viewed positively by young people, who might be more enquiring about aspects of donating blood.

It is important to note, however, that the total impression given within the strategy chosen to promote information should not be too 'heavy' and dull, especially if the material is designed primarily for young people. The presentation of information is thus critical, as is the understanding of its role as reinforcement material, rather than as persuasive in its own right. All the ideas mentioned by discussants are probably worth considering on a small scale,

especially those involving local involvement such as newspapers, letters, local talks and newsletters. All could create small scale changes which might help tip the balance in some people's decision to donate or not to donate again.

However, in considering the feasibility of presenting further information to the public, the prime importance of personal interaction should not be forgotten. As discussed in the introduction to this section, personal persuasion is likely to be more effective than impersonal advertisements or handouts. In the same way, personal presentation of information will be more effective, since it will probably come from a source with higher credibility, and will relate specifically to the enquirer.

7.4.4 Common Themes Underlying Respondents' Suggestions

In certain respects, many of the above suggestions in Section 7.4.3 from respondents to expand blood donation might appear simplistic and impractical, and hence might be viewed as inconsequential to future decision making. However, it should be noted that their value lies not so much in specific terms as in the concepts being expressed that underlie them. Certain themes recurred throughout this section, and it is these rather than specific examples of them to which attention should be paid. Among the more important would seem to be the following:

- there is clearly a need for greater awareness and public visibility of blood donation and the BTS. This is particularly illustrated in the perceived need for more extensive media campaigns, especially through television. While this specific suggestion is probably impractical in terms of resources available, the theme underlying it, public visibility, can be achieved through alternative strategies. These might include increased PR activity; greater involvement in general health activities, such as SHEG's Health Weeks; competitions for school children; involvement in local community events, especially in rural areas; and increased use

of 'free' media, such as TV programmes, editorial press articles and radio broadcasts.

In this context, it should be noted that in the last five years or so, the Scottish Health Education Group has, as a matter of policy, deliberately and successfully pursued such a strategy to raise the public visibility of health, by linking it to as many diverse media and sources of activity as possible.

- related to this, there is clearly a widespread demand for increased contact with the BTS, and emotional involvement in it. This request comes particularly from donors, and is critical for some lapsed donors. In many ways, the BTS is in a unique situation in social advertising, since the value and benefits of the 'product' it promotes are accepted without question, and many people wish to be emotionally involved in it. This is in contrast to virtually all other health issues, where there are considerable benefits in not acting as requested.

Such involvement could be pursued in many ways, but is possibly likely to be achieved best by linking it to wider public visibility as discussed above, especially if emotional values of 'goodness' and 'it's what everybody does' are promoted as well.

- again as a related theme, it is likely that increased response will be achieved if this is pursued as an integrated strategy involving personal contact reinforcing basic messages and visibility promoted through the media. It is evident from Chapter 6 that the motivations underlying donation are complex, and personal contact, and in particular discussion, are often critical at certain points in the decision-making process. In this regard, the suggestions made highlighting the role of 'opinion leaders', usually committed donors, and their importance and involvement in the process of encouraging donation should not be underestimated. There thus may be

considerable potential in identifying such people and targeting much of the back-up and more technical material towards them.

- another theme underlying the suggestions made was the request for further information. In practice in social advertising, this request is always made, and care should be taken in interpreting its importance. It is, for example, naive to assume that people change their behaviour and habits, particularly those that trigger deeper emotions in any way, simply on the basis of increased information. The issue really has to be interpreted within the context of the extent of the information lacking, and its nature and importance.

  In the present case, there does seem to be a significant lack of detailed information about the requirements for giving blood, and especially the exceptions and conditions, which specific information may help to remedy. In this regard, the BTS should review its current strategy for promoting specific information, particularly in relation to the comments on leaflets outlined in Section 7.3.4.

- finally, all the above suggestions highlight the complexity of the blood donation 'market', and in particular the extent to which different groups respond to different messages in different ways. It is <u>not</u> the case that generic strategies can be used that will apply equally to different people with different attitudes, and this is probably the critical weakness that has occurred in the past. Instead, particular approaches will have to be developed for particular targets and objectives. Some of these have been outlined in passing throughout this chapter, but more formal consideration of the topic follows in the next chapter.

8.0 BLOOD DONATION SEGMENTATION

8.1 What is Segmentation?

One of the principles of marketing is that the market for a product does not consist of identical individuals buying exactly the same brands for exactly the same reasons - one cannot describe a particular individual and say that he typifies the market as a whole. Instead, most markets are complex and comprise a number of subsections or 'segments', each of which can be uniquely defined. Thus one segment may contain individuals who, for example, hold a particular range of attitudes, buy certain brands but not others, are young, male and upmarket, shop in particular ways, have certain attitudes towards money etc. Another sector may be quite different - it may comprise people who are older, buy different brands for different reasons etc.

Furthermore, because each group is uniquely defined, and acts for particular, distinctive reasons, it is likely that each will respond differently to external pressures, such as advertising. One group may respond best to advertising that is emotional or personally involving. Another may demand more detailed, factual advertising. Yet another may reject mass advertising altogether, preferring alternative communication approaches, such as through interpersonal discussion.

Typically, any market will comprise seven or eight relatively large segments, each of which will contain individuals who are more or less similar in certain ways. A further principle of marketing is that, even if all groups are broadly equivalent in size, they will differ in importance in marketing terms. One sector may contain most of the company's main purchasers; these will be important to retain, and will therefore demand certain resources. (These may be modest, as all that is necessary is to retain their existing interest or commitment, rather than persuade them to act differently). Another may contain individuals who may be relatively easy to convince, for whom conventional advertising may be appropriate. Other sectors may be virtually unapproachable - they may contain competitive buyers who are relatively well entrenched, requiring disproportionate effort and resources to change, with perhaps only modest success. The essential

marketing principle is that efforts (both management and financial) should be directed or 'targeted' towards the most responsive sectors. Conversely, they should not be directed towards sectors that are difficult to persuade, even though they may be relatively large in size, or intuitively interesting.

Similar principles apply to the marketing of social and health concepts. There is no such thing as a single 'public', all of whom think similar things and respond to advertising in the same way. Any social market can be segmented in exactly the same way as a product market. Several subgroups will exist, each of whom can be described uniquely, will respond to particular communication approaches, be more (or less) easily persuaded etc.

The objective of social marketing segmentation is exactly the same as for product marketing - to identify those groups with the greatest potential, either in retaining their co-operation or in persuading them to act differently, and to optimise the resources spent. Equally, groups that are highly resistant to persuasion should also be identified, so that they can be avoided, or approached through some longer term strategy. Essentially, the emphasis is to move away from a generic strategy covering everybody, towards directing a particular strategy at those likely to be most receptive. Contrary to what much of social advertising may imply, and as demonstrated by much of the existing BTS publicity (see Chapter 7), there is no point in trying to cover the world if most of it is unresponsive.

There are many ways of describing the segments in a social market. The objective is to describe each group as comprehensively as possible; usually it is more meaningful to do this by describing more complex dimensions such as attitudes, values and expectations, rather than choosing behavioural criteria which may be too simplistic. In the present case, for example, donor v non-donor is a type of segmentation, but is inadequate because it implies that there is a single type of non-donor (and also a single type of donor).

The method chosen here is to divide the market into groups on the basis of both their attitudes and behaviour towards giving blood, and

to describe each group in these terms. There then follows some implications for procedures at clinics - how people in each group should be treated, important weaknesses in existing procedures, perceived fears, etc. Some segments will also contain lapsed donors; the reasons for their lapsing are related back to their initial attitudes and motivations, and procedures to overcome their reluctance to continue giving blood discussed. Finally, comments are made on the importance of each group in policy terms, the general marketing strategy to adopt, and the role of communication within this.

The research identified five important sectors of the blood donations 'market'. A summary of their characteristics is given in Table 1 opposite, together with an outline of the implications for staff/clinic procedures, and publicity/marketing strategies.

8.2 Important Blood Donation Segments

Group 1: High Commitment to Giving Blood

The first group comprises those who have a high commitment to giving blood. It consists mainly of established donors who give blood regularly or intermittently, but also includes certain types of lapsed donors. The group's essential characteristic is that it contains those who are committed to the idea of giving blood, and who have overcome or tolerated any fears or reservations about the donating process. This is not to say that when they give blood, they find all clinic procedures pleasant or even acceptable, but most will be tolerated for the sake of the blood given, although they are regretted for the sake of others who may have similar experiences. Basically they have a high threshold for judging any single procedure unacceptable enough to warrant lapsing on a permanent basis, although their threshold may be triggered by the cumulative effect over time of minor but regular irritations.

Those with a high commitment towards giving blood would seem to be of no particular age or social class group, but instead are characterised by quite highly developed values of responsibility, not only towards others, but towards themselves as well. There is a recognition that society has a responsibility to provide services or

facilities for those in need, and that in the case of blood, this cannot be provided by any state system, only by individuals helping others. However, although the basic responsibility for giving blood lies with the individual, an essential precondition for this is that the state should provide all necessary facilities for the actual donating process.(Indeed, this recognition of need for adequate facilities for giving blood was observed across all groups, even among those most resistant towards giving blood. There was no indication at all among all respondents interviewed that providing facilities for blood donation was seen in any way as a waste of public resources. In fact, the converse was often noted: a significant proportion of those interviewed observed that the BTS appeared to be the 'Cinderella' of the NHS, for no apparent reason.)

For this group, therefore, giving blood fulfils a social requirement, but the benefits of donating extend beyond this. It is also intrinsically rewarding: the individual feels good, through having his or her needs as a responsible member of society satisfied. Indeed, this requirement to act as one 'should' often predominated members' own descriptions of their motivations: they frequently claimed to give blood because it was 'good to do so', or that it was 'like being a Samaritan', or even that it represented 'good British behaviour, the British way of life'. Even the word they used to describe donation, 'giving', reflected connotations of responsibility and self-sacrifice.

These feelings of responsibility might suggest that it would be relatively easy to persuade this group to continue giving blood. They are intrinsically motivated, and as already discussed, they have a high threshold for unpleasant clinic procedures. Nothing would be further from the truth, however, simply by virtue of the fact that their feelings of responsibility are often latent rather than overt. They thus require considerable triggering, particularly in maintaining them over an extended period of time. Once the process of actually donating is started, then the basic feelings are satisfied, but for many donors, they are not strong or overt enough to counter a whole host of circumstantial factors preventing their donation.

Thus although members in this group are basically motivated to give blood, and no 'serious' reasons theoretically exist to prevent this happening on a regular basis, some drift away because there is an absence of an overt trigger or cue to remind them of how they feel about giving blood. Those who do drift away, however, tend to experience minor feelings of guilt, though these are often relatively latent.

The triggers that might remind them of their feelings towards donation would appear to take three forms - physical, personal, and mass-media. 'Physical' triggers refer to some environmental or circumstantial event which reminds the person of his/her responsibility to give blood. These can be of various types. At one extreme lie isolated but extremely involving incidents, such as a major disaster, the accident at work of a friend or colleague, illness among the close family, a personal experience of requiring blood etc. At the other extreme occur more typical physical reminders of blood donation, such as being aware of a blood donation session, passing a mobile unit, or even walking past one of the mobile centres.

Physical triggers would, on their own, appear to have limited potential in reminding people of their intrinsic commitment to give blood. Personally involving accidents, although powerful in their own right, are relatively infrequent; more common cues, such as passing a mobile unit, often lack impact, competing with and blending into their surrounding environment, sometimes even to the point of not being seen. For example, there was little evidence that walking past the St Vincent Street Centre in Glasgow on its own triggered blood donation, although its central location was important once the decision to give blood was made.

Instead, more powerful triggers would seem to lie in the area of personal contact. This incorporates three dimensions. Firstly, there is the extremely important aspect of the extent to which personal contact at the clinic encourages future donation. This is not merely through ascertaining that procedures are painless and/or pleasant, for example, but also entails ensuring that comments made by staff at the session itself are helpful and rewarding, such that the donor leaves the clinic feeling that something worthwhile and responsible has been achieved. In this regard, all the potential problem areas of donor

treatment by staff discussed in Chapter 4 are critical. A particularly sensitive issue is the extent to which anyone 'rejected' as a donor, particularly on some temporary medical grounds, should not leave the clinic feeling let down or uninformed about when he will be welcome to donate again.

A second dimension of personal contact is the extent to which donors seek or obtain reinforcement from other donors. One of the tangential findings of the research was the extent to which the research process, particularly the group discussions, triggered the desire to continue giving blood. Often, it transpired that those who had lapsed (or potentially were going to lapse) did so simply because they were drifting out of blood donation, for no apparent reason other than that there seemed no overt reason to continue. In some cases, the process of the group discussion was claimed to reverse this trend, though whether it did so in reality would be a matter for future monitoring. While the practical consequences of this finding may be unclear in that it is unlikely to be cost effective in conducting group discussions for this reason alone, the principle could be incorporated into other approaches. For example, it could be suggested in leaflets or posters that donors would find it useful to talk to other (established) donors about blood donation.

It probably has to be recognised, however, that no matter how effective these two forms of personal contact are likely to be, they are not likely on their own to continue to motivate donation. The time between any two donating sessions, for example, is so extensive, and the circumstances so complex, that it would be unrealistic to expect people's interests to be maintained from one session to the next without some form of additional trigger. There is therefore a strong case for the third type of personal contact, issuing a reminder nearer to the donating session itself.

It is evident from this research that this reminder should incorporate two principles. Firstly, it should build upon the positive experiences generated in the actual donating session itself, such as the personal contact/discussion that reinforced feelings of responsibility/help. Secondly, it should be personalised, indicating that the BTS are talking to the donor as a person, rather than a

xeroxed facsimile of him. Ideally, the contact should be by telephone, but in its absence, some indication of the personal relevance of the request would be advantageous. Possibly this could be combined with some form of mass communication such as a leaflet explaining the process of giving blood [incorporating the information donors request on technical issues (see Section 7.4.3)], or a newsletter giving up-to-date data on sessions, the need for giving blood, BTS structure and news, current developments, etc.

The third type of cue is some form of mass communication, such as through advertising. Theoretically the requirement is to provide reinforcement of the donor's relatively high feelings of responsibility, and concepts such as heightening of self-esteem, being positive, and thinking of others are all likely to be of relevance, although this should not extend towards promoting 'goody-goody' connotations. The essential element in such an approach is that it should be 'personalised': it should create images of 'you and me', not feelings of servicing an anonymous impersonal system.

It would appear from the research that several advertising platforms or concepts already exist promoting these images. For example, 'love-life' is positive and emotional; showing accidents and/or disasters reinforces the need for blood; and using children enhances feelings of involvement and care. It might therefore seem as if ready made cues are available through existing mass communication material, and all that is necessary to increase donation among this group is to expand their regular use. Unfortunately, however this would be an erroneous conclusion.

The difficulty is that one would be using such publicity for reminder objectives, and the typical medium for achieving this, posters, is probably ineffective in this case. Typically, posters are displayed either at or near to the point of donation itself, by which time the decision to return is already made, or in situations where they lack impact, such as in amongst many others on a general noticeboard. Furthermore, it is (theoretically) difficult for any poster to create feelings of empathy or deep involvement on its own: even though it may contain the correct message, it seldom presents

this with the impact necessary for involvement to occur. Instead, posters usually reinforce the messages from other media, such as TV advertising.

In the present case, it is likely that the only traditional mass media channel that could be used effectively to trigger the need to continue donation is television advertising. This is probably impractical, however, as one normally uses this medium for wider objectives, and using it for this objective alone would be a disproportionate use of resources.

In the final analysis, it has to be recognised that this group essentially has the basic motivation to continue to give blood, and that all that is required is a minimal strategy to reinforce this motivation, not one to initiate it or overcome reservations. It is therefore likely that traditional mass media approaches will be unnecessary, although in no way counterproductive. Instead, the optimum communication approach probably lies in personalising the request to give blood, although certain forms of mass communication (such as newsletters) may prove beneficial if presented at the same time. It should also be noted that general staff attitudes at the clinic are crucial in maintaining involvement. Particular requirements are the need to emphasise the social benefits of giving blood, and sensitivity in rejecting donors.

Group 2: Marginal Commitment to Giving Blood

The second segment to be identified consists of those with a marginal commitment to giving blood. They have minor latent feelings of responsibility and may have considered giving blood, or even done so in the past (but no more than once or twice). For those who have tried, their reasons for lapsing are not usually associated with a bad clinic experience, although this can occur occasionally, but more because there appears to be no particular reason to return. This is not to say that they become disenchanted with the need for blood donation once having given, but rather that there seems no particular reason for them to become personally involved. Often, the attractiveness of giving blood is the novelty of experiencing

something new, and this, by definition, no longer occurs once the event has been experienced.

Other characteristics of this group are that they are often young, modern in outlook and often socially committed in other ways; and that they are often pleasant and co-operative people. Nor do they have any particular fears of blood donation, such as fear of needles, though there is often a minor generalised fear of the unknown.

The group's essential characteristic is that their need to give blood on a regular basis is not established on any deep, personally involving basis. They therefore differ from group 1 in that, while the latter have basic motivations that can become latent and consequently require triggering, group 2's motivations are intrinsically not well enough established in the first place, although they do exist to a slight extent. A consequence of this difference is that when group 1's lapsing is pointed out to them, this can create feelings of guilt, unlike those in group 2 whose feelings of responsibility are not well enough developed for guilt to occur.

Because the members of this group have no specific fears about giving blood, and also because feelings of responsibility already exist, albeit to only a minor extent, they comprise the 'market' segment with greatest potential in expanding blood donation. There is considerable scope for an integrated 'campaign' along traditional lines persuading this type of person to become more involved in giving blood.

It is essential, however, that the approach should be integrated. By definition, a 'campaign' does not merely comprise mass advertising (in whatever form) but integrates and reinforces the objectives of advertising with other 'sources' of influence, particularly interpersonal contact. It is vital that whatever is said by the advertising is captured and reinforced by those having personal contact with potential or actual donors. Here, all the observations about the potential effectiveness of group pressure discussed in Section 6 will be of particular relevance. Another critical aspect of this will again be the clinic staff's treatment of donors, this time

in the initial donating session. It is crucial that particular care and sensitivity is shown towards first time donors, and time devoted to discussion and contact. Equally, those who are involved in organising sessions, for example in workplaces, would benefit by being told in advance the nature of any proposed campaign and its objectives, or given information packs about it, so that the campaign messages can be reinforced.

Other more obvious dimensions of 'integration' should, of course, not be ignored, such as the need for material in one medium to reinforce that used in another (for example, posters reinforcing television advertising); the use of badges for first time donors (as discussed in Section 6.4.2.3); consistent copylines across a range of material and back up promotions; inclusion of campaign details on session stickers which are inserted into the BTS registration card; integration of graphic design, colour, etc. Local involvement should also be encouraged, such as the featuring of local sessions and facilities in national campaigns.

It is also vital that the correct mass communication strategy is used. The essential objective is to increase feelings of responsibility among a target group who are relatively young, co-operative and modern in outlook. Such an audience typically responds best to social advertising that is positive, attractive and modern in emphasis, inviting participation in an activity that is socially the 'in' thing to do and which captures some kind of community spirit and involvement. A typical example of such an approach is the Glasgow Marathon, which careful SHEG backed promotion established as a community event that was challenging and enjoyable, inviting involvement among both participants and observers alike.

A key characteristic of this approach is that all elements that suggest officialdom, and order involvement through creating guilt, should be avoided at all costs. In this regard 'heavy' factual strategies using fear or showing unpleasant events such as disasters, are taboo. There is nothing in the history of social advertising in the last decade or so to suggest that people who are modern and positive in outlook, and who like to be part of an enjoyable community

spirit, respond to sombre threatening messages - the typical reaction is to quickly rationalise away any threat, and/or make it clear to the source where his message really belongs.

Instead, successful social campaigns aimed at this group have emphasised positive images, often highlighting movement, lightness and a sense of fun, without trivialising the subject or creating 'goody-goody' images. Creative strategies have included using humour, peer group and/or 'hero' figures, and emotional music and images. However, the current movement is towards using emotional music/images, and away from peer/'hero' figures. Peer group figures, although potentially powerful, are often difficult in practice to create with the necessary levels of involvement; hero figures often lack credibility - even though the audience may identify with them, it is often difficult to convey the impression that the person really believes what he or she is saying, and is not participating for ulterior motives, such as money. There is also the danger that 'status' figures may lose their audience appeal rapidly. Often this occurs during the life of the campaign, but even if it does not and occurs later on, it can still have a dramatic effect on long-term impact. An example of this was SHEG's use of the Bay City Rollers in an anti-smoking campaign - their credibility was maintained throughout the life of the campaign, but their later involvement in alleged drug abuse did little to enhance long-term anti-smoking messages.

Four further points should be noted about this strategy. Firstly, it will not be successful using only back-up media such as posters and leaflets; they cannot create the necessary involvement. Instead, primary media will be required. In this case, however, this is likely to be cinema rather than television, because of the age profile of the potential audience. This should make the campaign less costly in resource terms, although restricting it to the cinema alone will not allow any secondary target, such as those in group 1, to be exposed to the material as they would be if TV were used.

Secondly, related to the above point, any successful approach will demand greater resources than are available to the BTS at the moment. It should be recognised that one cannot persuade audiences

that are in any way resistant without using the techniques that are most appropriate for the intended objectives. It has been repeatedly demonstrated in social marketing that, in terms of resources, one cannot make a silk purse out of a sow's ear - the more persuasive the objective, the greater the resources demanded. For example, posters are not equivalent in terms of impact to television or cinema advertising. Ultimately this is a management decision, and really reflects the extent to which increased response is considered necessary, or even desirable.

Thirdly, there is no evidence from this research that any material produced for this group should directly emphasise that the procedure is painless. Specific fears of this nature existed only at a very marginal level, and there is the risk that concentrating on this aspect would sensitise the audience to a drawback that did not previously exist. In this regard, the Noel Edmonds/Sue Barker strategy is probably inappropriate, as it emphasises this single aspect too strongly. [Indeed, the approach is probably inappropriate for various reasons for all segments (see below), except for regular donors who presumably are not the primary target of the campaign]. Instead, the topic should probably be approached indirectly through giving general reinforcement that clinic procedures are nothing to fear, as part of the strategy of resolving the minor generalised fears of the unknown that exist.

Fourthly, the approach will only be successful in enhancing feelings of responsibility that already exist to at least some extent. It is extremely unlikely that any campaign could induce such feelings where none exist before, and quite improbable that it could counter negative feelings of irresponsibility, at least in the short or medium term. Ultimately, the achievement of these objectives lies in wider social education, particularly through the schools. It is noteworthy that no-one in the interviewing recalled any school education on blood donation, an omission which seemed inexplicable to the respondents.

Group 3: Minor Specific Fears

Group 3 is similar in many respects to group 2, but there is one crucial difference: it comprises individuals who have specific fears about giving blood. These are not particularly strong, and do not automatically preclude giving blood, but are extensive enough to make donation unlikely. Thus essentially they not only lack impetus, as do group 2, but have additional particular reasons for not giving. Chief amongst these are the fear of pain, of needles, and of perhaps being ill or sick during or after donation. They are thus extremely sensitive to clinic procedures, and of those in this group who have previously donated, many will have chosen not to return because of specific clinic experiences. In reality, many of these may have been objectively trivial, but their importance heightened by the person's basic reluctance to be committed to giving blood in the first place.

This group is a potential target, but a relatively resistant one. It will require all group 2's procedures for increasing motivation but in addition some strategy will be necessary to overcome specific fears. It is unlikely that this latter objective can be achieved through the mass media, by, for example, a Noel Edmonds type of campaign (which seems to be intended to achieve this).

The reason for this is that such fears are often emotionally based. Objectively they are often trivial, but nonetheless real and involving. Unfortunately, a Noel Edmonds type of approach can only present objective, rational arguments, not emotional ones. Only the individual can judge whether pain is likely to be experienced or not, and an external figure has little authority in commenting on this through rational, logical argument. The probability, therefore, is that this type of approach is likely to be ineffective or even be counterproductive, since it may heighten the possibility that there is indeed something to fear. In fact, this type of approach may be making one of the classic errors in communication strategy: one cannot counter emotional fears simply by pointing out that they do not exist.

Instead, it is likely that such fears will only be lessened by personal contact, reinforced by clinic procedures. In this respect,

the optimum strategy is likely to be to encourage such people to attend with a friend, and to ensure that they are sensitively treated in the clinic itself. To that extent, it is critical that first time attenders are identified as such, and treated with particular care.

Group 4: Strong Fears of Needles/Procedures/Illness

The fourth segment essentially comprises the first type of non-donor whose reluctance to give blood is related to strong emotional fears. These can take any of several forms: fear of needles, of clinic procedures, of being reminded of a hospital context; of associating blood transfusions with illness, etc. Their fears are strong, and though they may wish to be helpful and/or experience guilt in not donating, they will not do so. In many respects, they are similar to those who attend clinics, doctor's surgeries, even the dentist only as a last resort.

There is only minimal potential in approaching such a group. Their fears are so strong that they probably reflect to some extent generalised personality characteristics, rather than specific fears about blood donation. They are in no way amenable to a mass media approach which would only confirm all their worst reservations. In the long term they may be captured by continual, consistent promotion that creates the 'norm' that giving blood is painless and innocuous, rather than the present norm which is the reverse. However, this is such a long-term objective that for all intents and purposes, little effort should be devoted towards them, other than by encouraging donors to talk through their fears with them whenever the opportunity arises.

Group 5: Extreme Emotional Fears - Giving Away the Self

The last segment contains the second type of non-donor whose lack of co-operation reflects deep-seated emotional fears. These are individuals who have an extreme emotional fear of giving blood, because in deep psychological terms it entails giving away an essential part of the individual. Emotionally, it is equivalent to giving away part of one's life, draining its core component.

These fears only emerged upon deep probing in the interview, and were not spontaneously or, occasionally, even consciously expressed. Because they are so deep seated, it is unlikely that any communication strategy would have any impact. There seems virtually no potential in approaching this group.

Conclusion

This analysis has revealed five sectors of the blood donation 'market'. Each differs in its importance for future strategy, as do the appropriate communication approaches necessary for each. Group 1 comprises those with a high commitment to giving blood, based on intrinsic feelings of responsibility. However, they require to be reminded of this through various 'triggers', the most important of which is personal contact. The group requires only a minimal reinforcement strategy since the basic motivation exists.

Group 2 has no particular fears about blood donation, and minor latent responsibilities which need to be enhanced through an integrated campaign. This needs to be modern, positive and involving, part of a community spirit that regards blood donation as the 'norm'. It is likely to involve positive, modern, imagery based promotion that reinforces and integrates with personal communication. Correct clinic strategy is also vital.

Group 3 is similar to group 2, but its members have in addition minor specific fears about blood donation. These are likely to be resolved through personal discussion and contact, and through attending clinics with a friend. People in this group are extremely sensitive to clinic procedures and have to be treated with great care.

Groups 4 and 5 comprise non-donors whose non-participation in blood donation derives from strong fears about the process. These are emotionally based, and unlikely to be amenable to short-term strategies.

APPENDIX

APPENDIX 1

Group No	Age	Donor Status	Sex	Social Class	General Public/ Workplace	West/ East	Urban/ Rural	Location
1	18-24	D	M	C2DE	General Public	West	Rural	Dalry
2	18-24	D	M	ABC1	Work Place	West	Urban	Marland Ho (G)
3	18-24	D	M	C2DE	Work Place	East (S)	Urban	Feranti (E)
4	18-24	D + ND Conflict	M	C2DE	General Public	West	Urban	Bishopbriggs
5	18-24	D	F	ABC1	General Public	Aberdeen	Urban	
6	18-24	Lapsed/ Ex-Donor	F	ABC1	General Public	West	Urban	Bishopbriggs
7	18-24	D	F	C2DE	Work Place	West	Urban	Playtex (Port G)
8	18-24	Friendship D	F	C2DE	General Public	East (N)	Urban	Dundee
9	18-24	ND	M	ABC1	Work Place	West	Urban	Rolls Royce (EK)
10	18-44	Lapsed/ Ex-Donor	M	ABC1	General Public	West	Rural	Dalry
11	18-24	ND	M	ABC1	General Public	West	Rural	Inverkip
12	18-24	ND	M	C2DE	Work Place	East (S)	Urban	Feranti (E)
13	18-24	D + ND Conflict	F	ABC1	General Public	East (s)	Rural	Jedburgh
14	18-24	ND	F	ABC1	General Public	West	Urban	Jordanhill
15	18-24	ND	F	C2DE	General Public	West	Rural	Inverkip
16	18-24	ND	F	C2DE	General Public	West	Urban	Linwood
17	25-44	D + ND Conflict	M	ABC1	General Public	Inverness	Urban	
18	18-44	Lapsed/ Ex-Donor	M	C2DE	Work Place	West	Urban	Wills (G)
19	25-44	Lapsed/ Ex-Donor	M	C2DE	General Public	East (N)	Rural	Forfar
20	25-44	D	F	ABC1	General Public	West	Rural	Oban
21	25-44	D	F	ABC1	Work Place	East (S)	Urban	Standard Life
22	25-44	Lapsed/ Ex-Donor	F	C2DE	General Public	West	Rural	Oban
23	25-44	ND	F	C2DE	Work Place	West	Urban	Wills
24	25-44	ND	M	ABC1	General Public	West	Urban	Jordanhill
25	45-65	D + ND Conflict	M	ABC1	General Public	West	Urban	Coatbridge
26	45-65	ND	F	C2DE	General Public	East (N)	Urban	Dundee
27	18-44	Lapsed/ Ex-Donor	M	ABC1	General Public	East	Rural	Forfar
28	25-44	D	M	C2DE	General Public	West	Urban	Coatbridge
29	18-44	Lapsed/ Ex-Donor	F	ABC1	General Public	West	Urban	Coatbridge
30	18-44	Lapsed/ Ex-Donor	F	C2DE	General Public	East (S)	Urban	Edinburgh

APPENDIX 2

BLOOD TRANSFUSION SERVICE - ATTITUDES TO DONATING BLOOD

General Public Recruitment

Target Group .....

I'm working with Strathclyde University doing research for the Blood Transfusion Service. I wonder if you can help me, by answering a few questions.

1 How old are you?

..... years
(record age if given)

☐ 18-24 years
☐ 25-45 years
☐ 45-65 years

2 Sex

Male | Female

IF INAPPROPRIATE CLOSE INTERVIEW

3 Have you ever given blood?

(includes contact day)

No Non-Donor | Yes

IF NO EITHER CLOSE INTERVIEW OR GO TO (7)

4 Approximately when did you last give blood? (including contact day)
.....

☐ < 2 years — Donor
☐ 2 - 4 years — Lapsed
☐ 4 ≥ years — Ex

5 Where have you mostly given blood?

General Public | Workplace

6 Can you tell me what work Head of Household/you do?

Occupation .....

Assign

A	C2
B	D
C1	E

ABC1 ☐ C2DE ☐

IF INAPPROPRIATE CLOSE INTERVIEW

We would like to get together a small group of people like yourself to talk to each other and to one of our interviewers about health and blood donation. Your views and opinions would be very useful. This will be quite informal and confidential. We will pay you expenses for attending.

Name	Address	Phone:
.....	.....	Work .....
	.....	Home .....

When unable to attend

When able to attend

APPENDIX 3

Dear

Attitudes to Donating Blood

We are presently conducting a survey into donor recruitment, and why others do not donate blood. The project is being conducted by the Advertising Research Unit of the University of Strathclyde with our support. Your views as a donor would be useful, and it is hoped to obtain information that will identify areas where our service could be improved, and also ways of attracting new donors. All information associated with the reserach study will be treated in the strictest confidence.

Your name has been chosen at random from our records as a possible participant in the survey. Should you not wish to participate, please let us know by return of post, sending your letter (no stamp required) to Blood Transfusion Service,

If we do not hear from you we shall pass on your name to the Advertising Research Unit and you may be approached in the next few weeks or so. We are having to supply more names than will be necessary, so even though you are agreeable, you may not be approached at all. If you have any queries please contact me at the above address.

May we take this opportunity to thank you for your past help and support of this Service.

Yours sincerely

THIS LETTER WAS PRINTED ON HEADED NOTEPAPER FOR EACH OF THE FIVE REGIONS

APPENDIX 4

BLOOD TRANSFUSION SERVICE - ATTITUDES TO DONATING BLOOD

Workplace Recruitment

Target Group .....

I'm working with Strathclyde University doing research for the Blood Transfusion Service. I wonder if you can help me, by answering a few questions.

1 Do you work in this building? [No] [Yes]

Location .....

IF NO CLOSE INTERVIEW

2 How old are you?

..... years
(record age if given)

☐ 18-24 years
☐ 25-45 years
☐ 45-65 years

3 Sex [Male] [Female]

IF INAPPROPRIATE CLOSE INTERVIEW

4 Have you ever given blood? [No Non-Donor] [Yes]

(includes contact day)

IF NO EITHER CLOSE INTERVIEW OR GO TO (7)

5 Approximately when did you last give blood? (including contact day)
.....

☐ < 2 years [Donor]
☐ 2 - 4 years
☐ 4 > years

6 Where have you mostly given blood? [General Public] [Workplace]

7 Can you tell me what work you do?

Occupation .....

Assign

		ABC1	C2DE
A	C2		
B	D		
C1	E		

IF INAPPROPRIATE CLOSE INTERVIEW

We would like to get together a small group of people like yourself to talk to each other and to one of our interviewers about health and blood donation. Your views and opinions would be very useful. This will be quite informal and confidential. We will pay you expenses for attending.

Name	Address	Phone:
.....	.....	Work .....
	.....	Home .....

When unable to attend

When able to attend

APPENDIX 5

Psychologist's Brief

The main objective of the research is to provide detailed information about the motivation of blood donors in Scotland. This information would initially be used to enable the preparation of recruitment and publicity campaigns which would be suitable for the target group (previously defined as 18-24 year olds) and which might also be suitable for potential donors outwith this group, ie 25-44 year olds and 45-65 year olds.

As stated above, loosely structured group discussions will be conducted, and as a result there will be no rigid format. The following outline should therefore be seen more as a check-list of areas that need to be covered rather than a rigid interview sequence. It would be expected that similar areas could usefully be covered in groups made up of donors and non-donors.

The interviews will move from more general areas to specific issues, following the priorities of respondents. In detail, care will be taken to cover the following areas:

1 Attitudes to health concepts
2 General attitudes to the Blood Transfusion Service
3 Perceptions about donating blood

1 Attitudes to Health Concepts

This will cover general points about group members' attitudes and behaviour with reference to their own health. It will include establishing whether they feel they can, by their own actions, have any influence on health. Topics which should be covered could include their attitudes to health enhancing activities, such as dietary habits, fitness and uptake of preventive medicine facilities (such as screening). Attitudes towards activities which might harm health, such as smoking and alcohol abuse, will also be

examined. The general nature of their life styles, with special consideration of possible differences in values between different social class groups, will be established, and their degree of innovativeness will be explored.

This part of the discussion will act as a 'warm up' period for respondents, allowing them to relax and get used to the interview situation. It will also provide a useful context against which to judge later contributions.

2 General Attitudes to the Blood Transfusion Service

It would be useful to assess general awareness about the BTS as an institution, and how it relates to other institutions. For example, is it a voluntary organisation, a government organisation or part of the NHS? Is it locally organised or on a Scottish or UK level? This would also include a consideration of its image, and of its attempts to appeal to the public with publicity material and recruitment campaigns.

Projective techniques could be used to explore the image generated by the BTS itself. A variety of aspects could be considered such as feelings towards the buildings in which sessions are held, the staff, both those at centres and the recruiters, and the equipment used. Consideration should be given to possible regional variations of its image.

Respondents will also be asked to express their attitudes to publicity and recruitment. This would initially be unprompted, but it would be useful to give prompts in the form of examples of publicity material used in Scotland and possibly England. It is expected that the BTS would provide any publicity material they would consider suitable for such evaluation.

From these discussions it is hoped to make recommendations about the optimum communications strategy for BTS. While respondents' attitudes to different approaches may have already

become apparent, they could usefully be reviewed at this point. For example, should mass campaigns be developed or should the emphasis be on public relations with communication to small groups or individuals? Should it be on a formal or informal basis? What medium should be used, eg posters, TV and radio advertising, stickers, badges or leaflets?

3 Perceptions about Donating Blood

Finally, the discussion will concentrate on perceptions about actually giving blood.

i) Factual knowledge

The level of knowledge about giving blood could be assessed. For example, what is the blood used for? How frequently can an individual donate blood? Where can blood be given? How long might a session take? What side effects could be experienced? If publicity material is to be used for evaluation (see 2 above) the knowledge level should be established before these prompts are seen by respondents.

ii) Why an individual might choose to give blood, or not to give blood

All discussants, whatever their donor status, would be asked to generalise about possible motivations and demotivations of both donors and non-donors, as well as discussing their own experiences and feelings. Projective techniques could be used here, for example, asking interviewees to describe a typical donor or non-donor. It would be expected that a number of "rational" beliefs might be elicited, but it will be important to probe further and establish any underlying emotions and impressions about which even the respondents might not be aware.

Inhibiting factors would be especially important to analyse. For example, fear can derive from a variety of stimuli, and operate on a number of different levels eg physical fear, perhaps of needles, or emotional fear, perhaps from feeling vulnerable in the donating situation. Since individuals sometimes act in spite of fear eg attend the dentist, this is an important area for consideration.

iii) Why an individual who has once decided to give blood might continue to donate, or might stop

In terms of ensuring a steady supply of blood, this consideration might be almost as important as establishing the initial motivations for giving blood. Similar techniques of discussion will be used as in 3(ii) above.

While some lapsed or ex-donors might appear in the non-donor groups, it is hoped to interview some groups made up exclusively of these categories.

APPENDIX 6

Material used as visual prompts to publicity.

Posters

A Noel Edmonds - Giving Blood is Painless, Doesn't Take Long and Could Save a Life (Related to recent television advertisement)

B Give Blood Not Excuses.

C Do You Have to Wait for Another Disaster Before Giving Blood.

D Burns Need Blood.

E We Can't Get Blood From a Stone.

F No Vacation Without Donation

G Mobile Donating Bus Poster.

H Please Give Blood - It Won't Hurt But It Could Save a Life.

I Don't Let It Run Out - Be A Blood Donor Please.

J Please Be A Blood Donor - Glasgow Donating Centre.

K If You Have Had Chickenpox or Shingles . . .

L You Can Save This Little Child From Dying (Rhesus).

Personal Stickers

M (Be Nice to Me, I Gave Blood Today.
(
(Blood Donors Love Life.
(
(Are You A Blood Donor.

Car Stickers

N (Give Blood.
(
(Blood Donors Love Life.

Pocket Calendars

O Blood Donors Love Life.

P Newsletter

Q Christmas Card

"Giving blood is painless, doesn't take long and could save a life."

Noel Edmonds: Disc Jockey and Blood Donor.

Please give blood.

A PERSONALITY POSTER - NOEL EDMONDS

NBTS 1144A3
Prepared by the Department of Health and Social Security and the Central Office of Information 8/80

Printed in England for Her Majesty's Stationery Office by UDO Litho Ltd., London
Dd. 8202860 Pro. 16187

Give blood. Not excuses.

B GIVE BLOOD, NOT EXCUSES.

Call 01-200 0200 day or night.

NBTS 1167A
Prepared by the Department of Health and Social Security and the Central Office of Information 12/80

Printed in England for Her Majesty's Stationery Office by Stewkley Press, Milton Keynes.
Dd 8202410 Pro 15535

do you have to wait for another disaster before giving blood? DONORS ARE NEEDED NOW

C DO YOU HAVE TO WAIT FOR ANOTHER DISASTER BEFORE GIVING BLOOD?

NBTS 1154/A3
Prepared by the Department of Health and Social Security and the Central Office of Information 10/77

Printed in England for Her Majesty's Stationery Office by UDO Litho Ltd., Lon
Dd. 8299206 Pro. 18800

GRO-A

BURNS NEED BLOOD

D BURNS NEED BLOOD

NBTS 1172
Prepared for the Department of Health and Social Security by the Central Office of Information
Printed in England for Her Majesty's Stationery Office by Colibri Press Ltd. Dd 8333053 Pro 18735

WE CAN'T GET BLOOD FROM A STONE

PLEASE GIVE US A LITTLE OF YOURS

E WE CAN'T GET BLOOD FROM A STONE

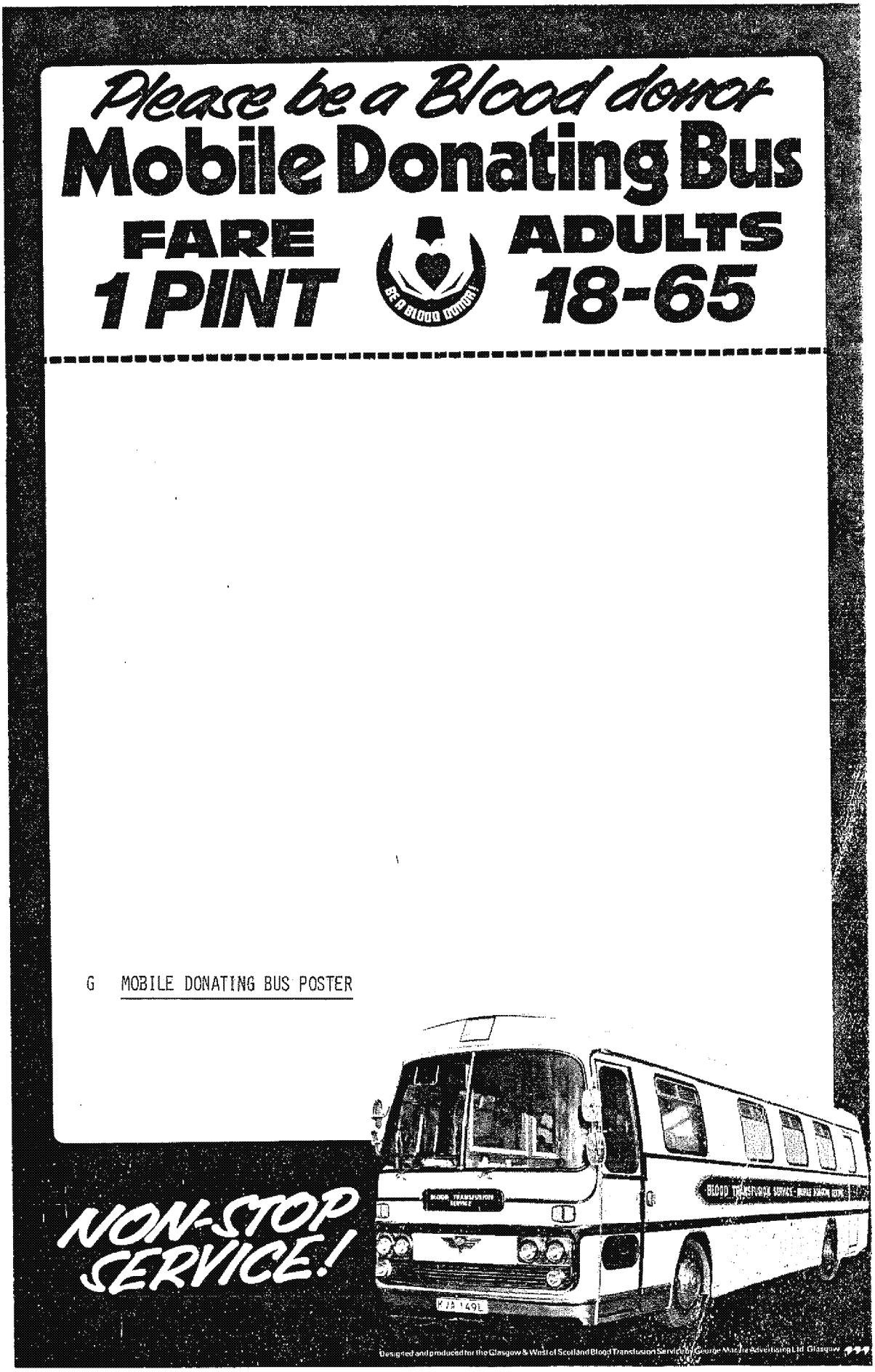
Printed in Scotland for the Scottish National Blood Transfusion Service by John Swain & Son (Edinburgh) Ltd.

Please give blood before you go

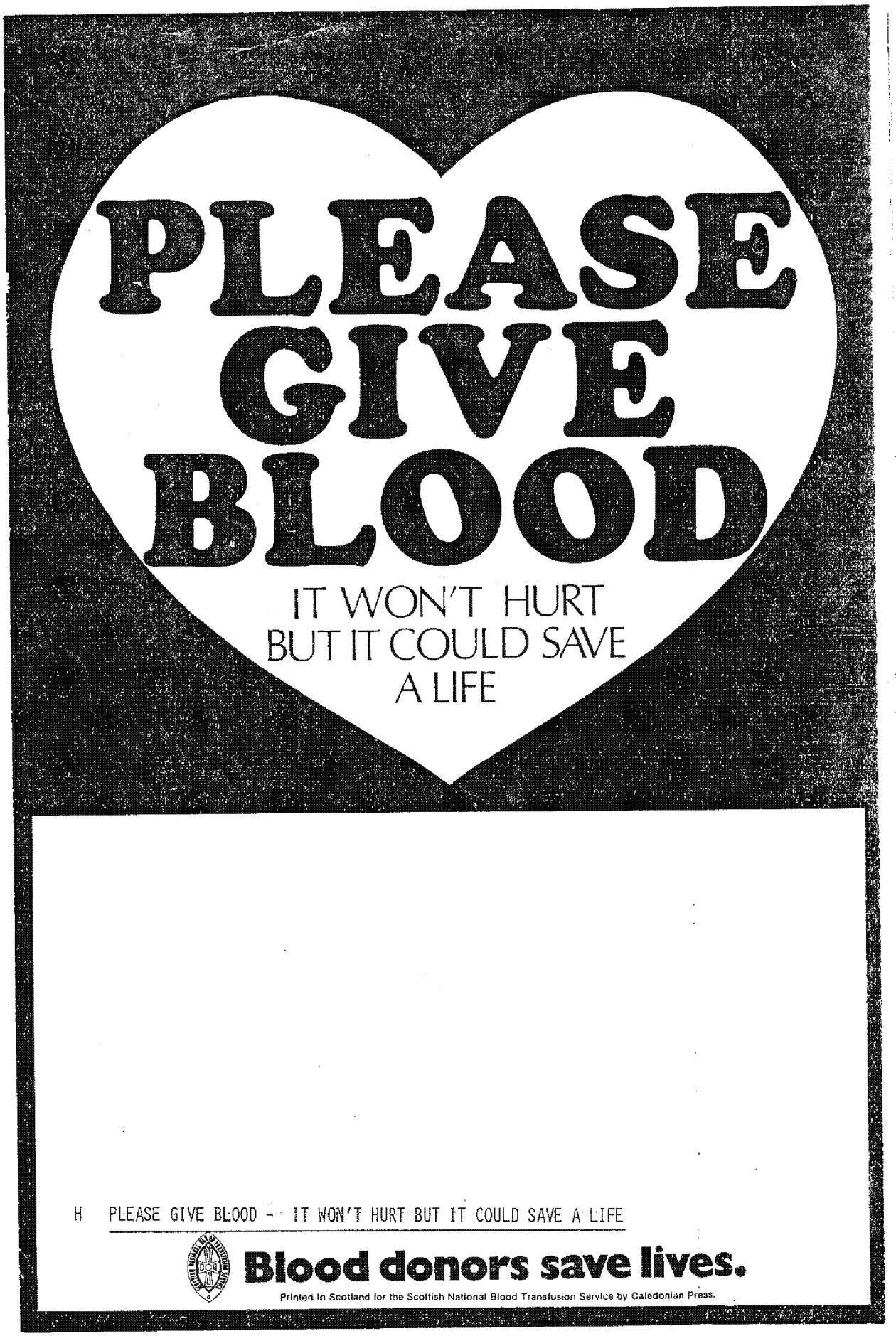
F NO VACATION WITHOUT DONATION

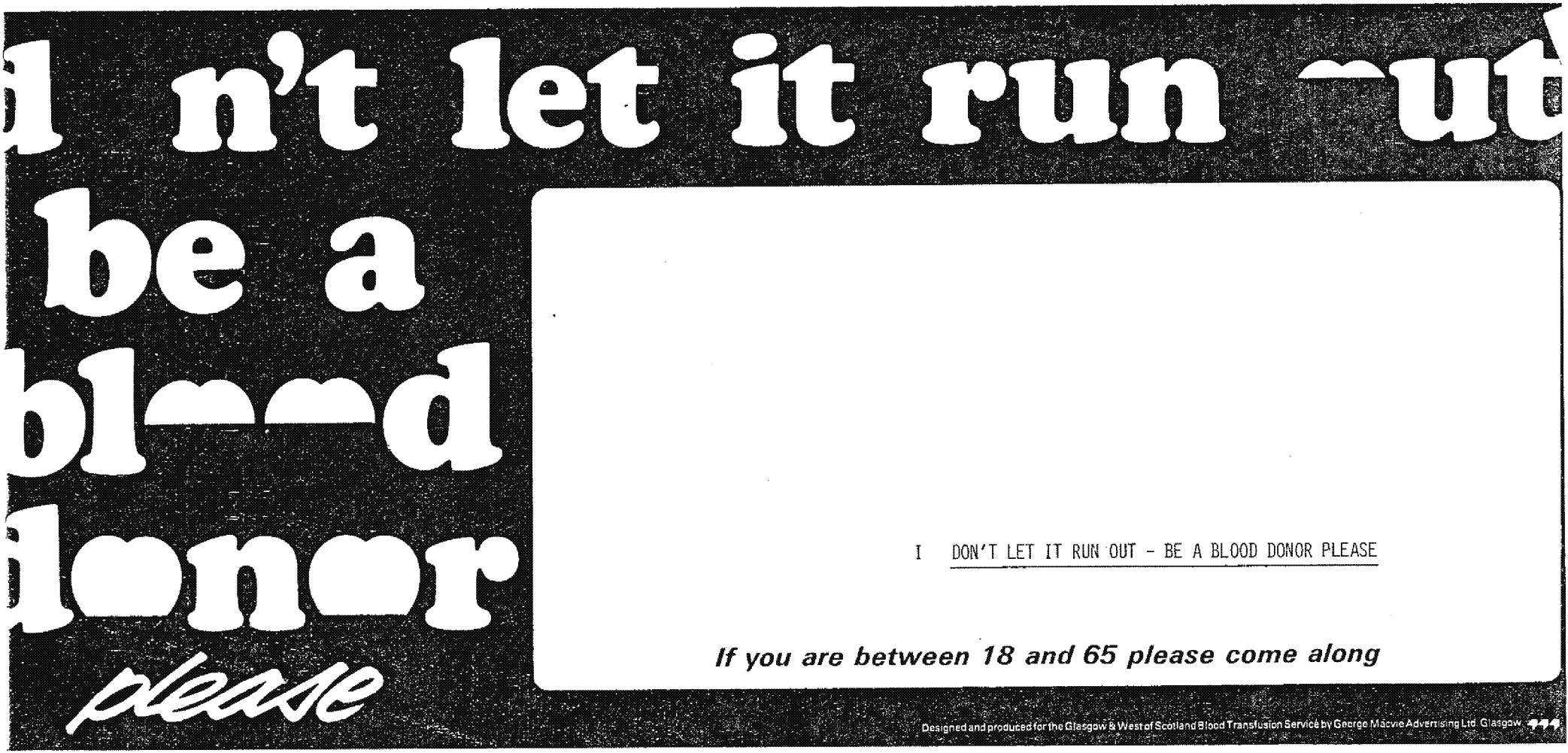
NBTS 1169

Prepared by the Department of Health and the Central Office of Information 1982. Printed in England for Her Majesty's Stationery Office by Alpine Press. Dd 8298689 Pro 18104



G MOBILE DONATING BUS POSTER


PLEASE
GIVE
BLOOD
IT WON'T HURT
BUT IT COULD SAVE
A LIFE
H PLEASE GIVE BLOOD - IT WON'T HURT BUT IT COULD SAVE A LIFE
Blood donors save lives.
Printed in Scotland for the Scottish National Blood Transfusion Service by Caledonian Press.



PLEASE
BE A BLOOD DONOR

Glasgow Donating Centre

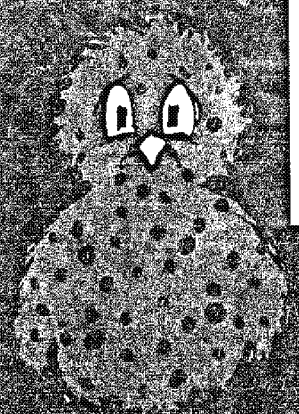
80 ST. VINCENT STREET

MONDAY to FRIDAY 9.30am-4.30pm
SATURDAY 9.30-11.30am
WEDNESDAY OPEN LATE TILL 7.30pm

J PLEASE BE A BLOOD DONOR - GLASGOW DONATING CENTRE

If you are between 18 and 65 please come along.

K IF YOU HAVE HAD CHICKENPOX OR SHINGLES . . .



if you have had

within the past 5 weeks

Chickenpox and Shingles are caused by the same virus — HERPES ZOSTER. Persons who have recently had Chickenpox or Shingles develop antibodies against Herpes Zoster virus. These antibodies, present in the plasma of the blood, reach a peak about three weeks after the infection and then gradually subside.

This information is important because these antibodies are needed in the treatment of certain children whose resistance to infection is low. Chickenpox can be fatal in such children. Treatment with plasma containing Zoster antibodies can prevent these disasters.

That is why people in the recovery phase from Chickenpox and Shingles are needed as blood donors.

If you have had either recently you can help. Please call the Blood Transfusion Service, or mail the prepaid card.

If you know someone who has had Chickenpox or Shingles please give them the postcard and ask them to call us. We'll take care of the rest.

please donate your blood.

80 ST. VINCENT STREET GLASGOW Tel 041 226 4111

Designed and produced for the Glasgow & West of Scotland Blood Transfusion Service by George Mayne Advertising Ltd. Glasgow

GRO-A is a Rhesus baby.

Until a few years ago she might have died or been permanently crippled.

Now, thanks to blood donors whose blood contains special protective antibodies, her mother has received treatment so that the baby can grow up a healthy child.

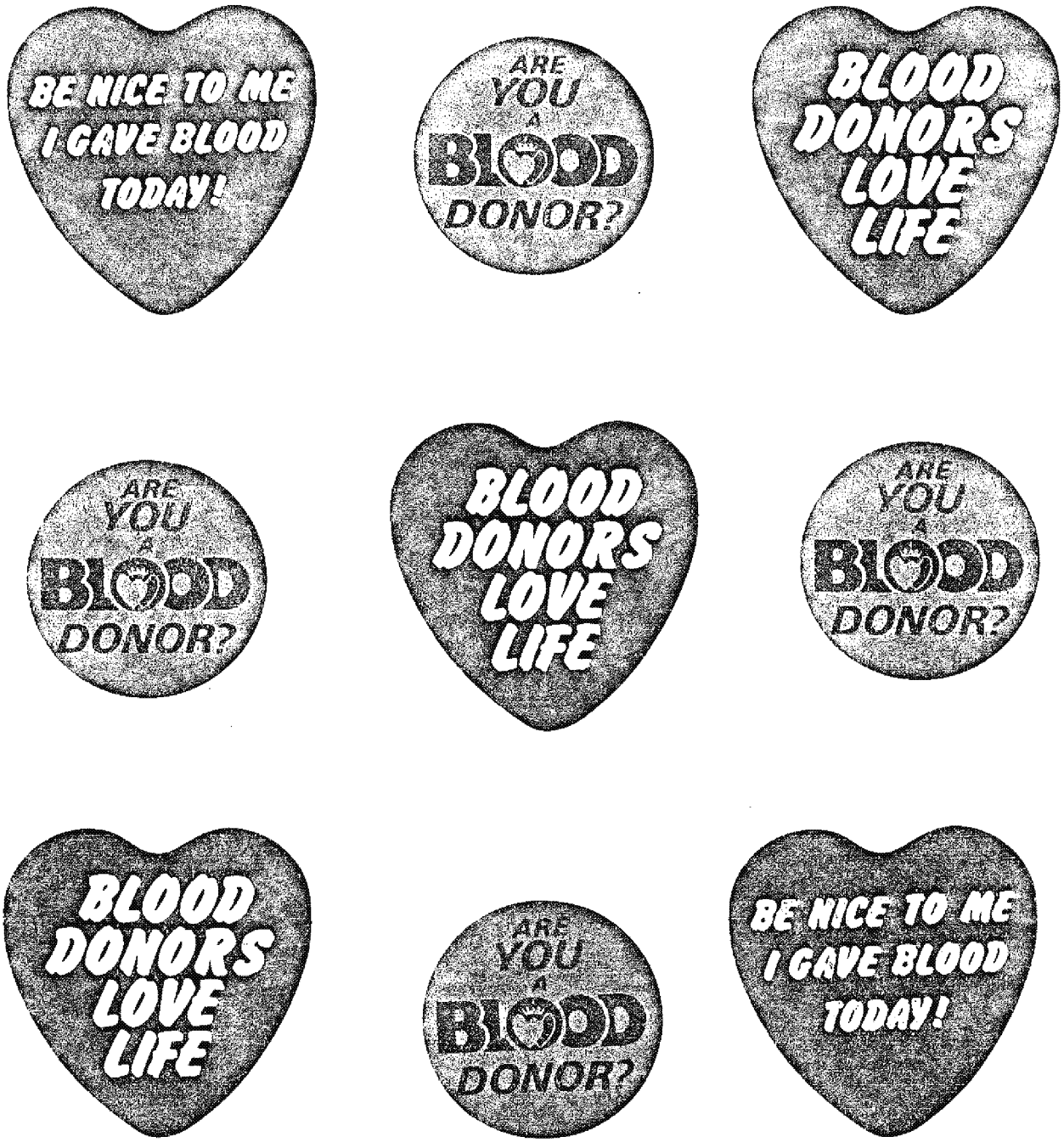
GRO-A

u can save
s little child
m dying.

Supplies of blood are continually being used up, that's why we need people like you to come and give blood at the address below. Your blood will save a life.

BLOOD TRANSFUSION SERVICE DONOR OFFICE , LAURISTON PLACE, EDINBURGH.

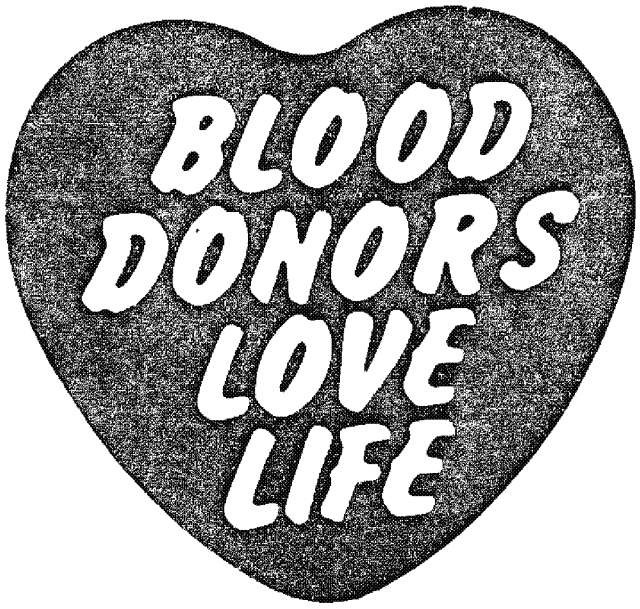
L YOU CAN SAVE THIS LITTLE CHILD FROM DYING



M PERSONAL STICKERS

BE NICE TO ME, I GAVE BLOOD TODAY
BLOOD DONORS LOVE LIFE
ARE YOU A BLOOD DONOR?

ring
'Blood Transfusion
Service'



N CAR STICKERS

GIVE BLOOD
BLOOD DONORS LOVE LIFE

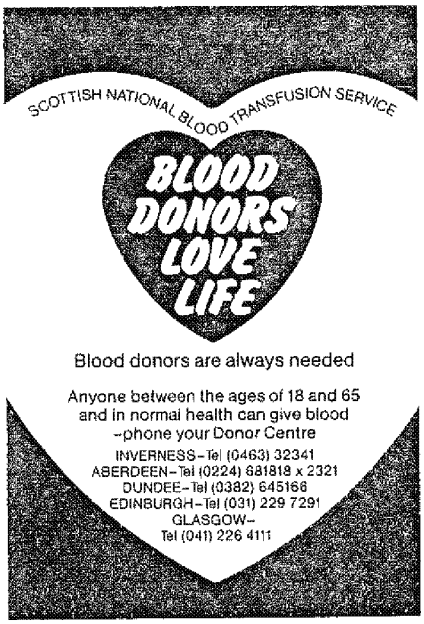
Calendar 1983

JANUARY	FEBRUARY	MARCH
S 2 9 16 23 30	6 13 20 27	6 13 20 27
M 3 10 17 24 31	7 14 21 28	7 14 21 28
T 4 11 18 25	1 8 15 22	1 8 15 22 29
W 5 12 19 26	2 9 16 23	2 9 16 23 30
T 6 13 20 27	3 10 17 24	3 10 17 24 31
F 7 14 21 28	4 11 18 25	4 11 18 25
S 1 8 15 22 29	5 12 19 26	5 12 19 26

APRIL	MAY	JUNE
S 3 10 17 24	1 8 15 22 29	5 12 19 26
M 4 11 18 25	2 9 16 23 30	6 13 20 27
T 5 12 19 26	3 10 17 24 31	7 14 21 28
W 6 13 20 27	4 11 18 25	1 8 15 22 29
T 7 14 21 28	5 12 19 26	2 9 16 23 30
F 1 8 15 22 29	6 13 20 27	3 10 17 24
S 2 9 16 23 30	7 14 21 28	4 11 18 25

JULY	AUGUST	SEPTEMBER
S 3 10 17 24 31	7 14 21 28	4 11 18 25
M 4 11 18 25	1 8 15 22 29	5 12 19 26
T 5 12 19 26	2 9 16 23 30	6 13 20 27
W 6 13 20 27	3 10 17 24 31	7 14 21 28
T 7 14 21 28	4 11 18 25	1 8 15 22 29
F 1 8 15 22 29	5 12 19 26	2 9 16 23 30
S 2 9 16 23 30	6 13 20 27	3 10 17 24

OCTOBER	NOVEMBER	DECEMBER
S 2 9 16 23 30	6 13 20 27	4 11 18 25
M 3 10 17 24 31	7 14 21 28	5 12 19 26
T 4 11 18 25	1 8 15 22 29	6 13 20 27
W 5 12 19 26	2 9 16 23 30	7 14 21 28
T 6 13 20 27	3 10 17 24	1 8 15 22 29
F 7 14 21 28	4 11 18 25	2 9 16 23 30
S 1 8 15 22 29	5 12 19 26	3 10 17 24 31



0 POCKET CALENDARS

BLOOD DONORS LOVE LIFE

DONOR NEWS

OPEN DAY

On Monday, 21st March the Blood Donor Centre did not close its doors at 5 p.m. as usual. The reason for the late opening was an Open Day where local organisers and other friends of the Blood Transfusion Service were invited to look around the new premises. Around 100 people, coming from as far as Le[illegible] and the Borders and including the Lord Provost, braved the terrible Arctic weather. Regrettably some who had intended to come had to cancel because of the snow. Those who persevered were warmly welcomed by Mairi McLeod Thornton, the Organising Secretary and Dr. Brian McClelland, the Regional Director.

Girls from the Donor Records Office escorted the visitors on a tour of selected laboratories. Mike McGuinness, John Donaldson and Hugh Purcell explained how the ante-natal laboratory, (known as Immunology I) screens mothers in the region to help prevent rhesus baby problems. Then visitors moved on to the tissue-typing laboratory where Charles Darg told them about the cross-matching procedure for kidney donors which ensures those who need kidneys receive suitable ones with the greatest speed. Andy McGowan, another scientific officer, showed how another laboratory investigated patients suffering fro[illegible]ecurring infections because their immune systems which fight disease were faulty in some way. He also discussed the methods used to produce the substances needed to group blood. Most visitors were surprised at the wide range of activities going on in the Blood Transfusion Service laboratories.

Sister Mary Gresham demonstrated the new OSM2 machine which double checks the haemoglobin levels of borderline cases electronically making sure they are healthy enough to give blood. In the 'withdrawal area', where the donors actually give blood visitors admired the comfortable new beds which allow donors to sit up should they prefer it.

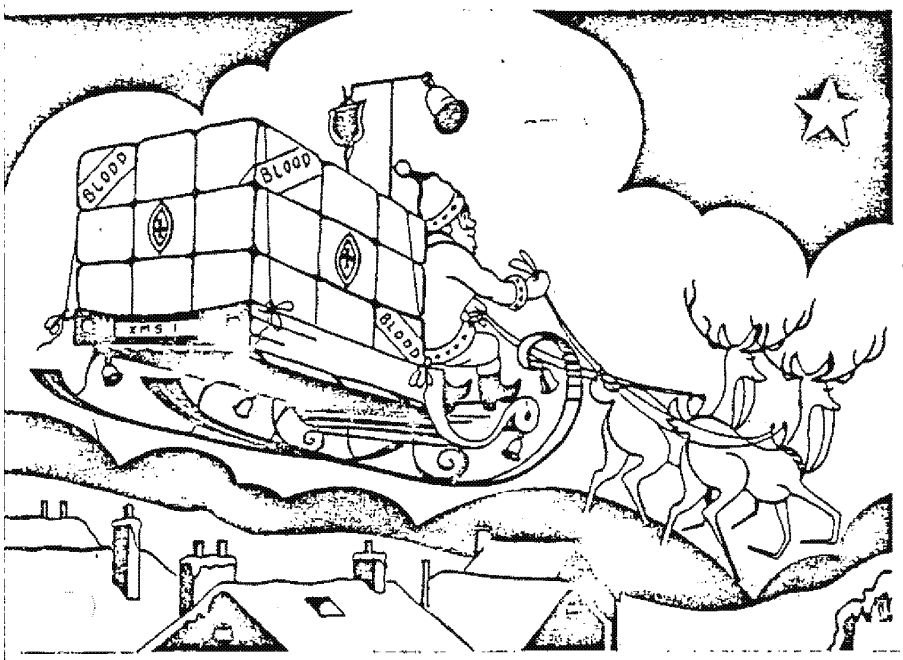
Sister Wye explained 'plasmapheresis' by which vitally needed plasma is extracted from a blood donation and the red cells returned to the donor so enabling the donors to donate plasma more frequently.

Back in the reception area there were other interesting things to look at as well as refreshments and snacks. A display showing the way the Blood Transfusion Service has developed since 1929 attracted attention as staff and visitors had fun spotting themselves in photographs of earlier days. In another corner Elaine Brown showed how donors records are maintained and how address labels for 'sessions' are produced by microprocessors. One visitor was surprised to realise that all the labels weren't stuck on by hand!

Harry Bethel explained how the new bar code reader which is just being introduced [illegible] it impossible for a pack of blood to be mis-labelled. People lingered over the wine and quiche to chat to old friends and make new ones. In many cases it was great for both staff and visitors to match a face with what had previously been a voice at the end of a telephone.

We hope our new poster and handbills go down well with all organisers and donors. The Organising Secretaries of the Blood Transfusion Service throughout Scotland feel that changing the design every so often attracts the attention of new donors. Regular donors tend to notice Blood Transfusion Service posters whatever the design. So far the reaction to their humorous tone and multi-coloured print has been a very positive one says Liz Cross, Publicity Officer for the B.T.S. in this region. They were considered especially appropriate by the organisers at the recent blood donation session at the National Coal Board.

P NEWSLETTER



Christmas is a Time for Giving

Give Blood

SCOTTISH NATIONAL BLOOD TRANSFUSION SERVICE

Merry Christmas and a Happy New Year

From The Director and Staff

Edinburgh and S. E. Scotland Blood Transfusion Service

Q CHRISTMAS CARD