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THE SCOTTISH PUBLIC'S ATTITUDE TO BLOOD DONATION AND AIDS

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November 1988

This Unit specialises in health education, social marketing and social advertising research.

Principal sponsor: The Scottish Health Education Group

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INTRODUCTION

Acquired Immune Deficiency Syndrome (AIDS) has now become a major health concern in the United Kingdom arousing a wide variety of concerns, emotional as well as rational. So far, practising homosexuals and drug abusers remain the groups most at risk from contracting the HIV virus, the former through homosexual contact and the latter through exchanging blood when sharing needles. However, there is serious concern that the infection may spread to the wider community through heterosexual contact.

The possibility of the virus being transmitted via blood makes the AIDS issue a matter of great concern for the Scottish National Blood Transfusion Service (SNBTS) in their role of maintaining an adequate supply of uncontaminated blood. In relation to blood donation, two major problem areas exist; firstly, the danger of HIV infected individuals continuing to donate blood and secondly, the observed decline in blood donation levels which coincided with increasing public exposure to the AIDS issue.

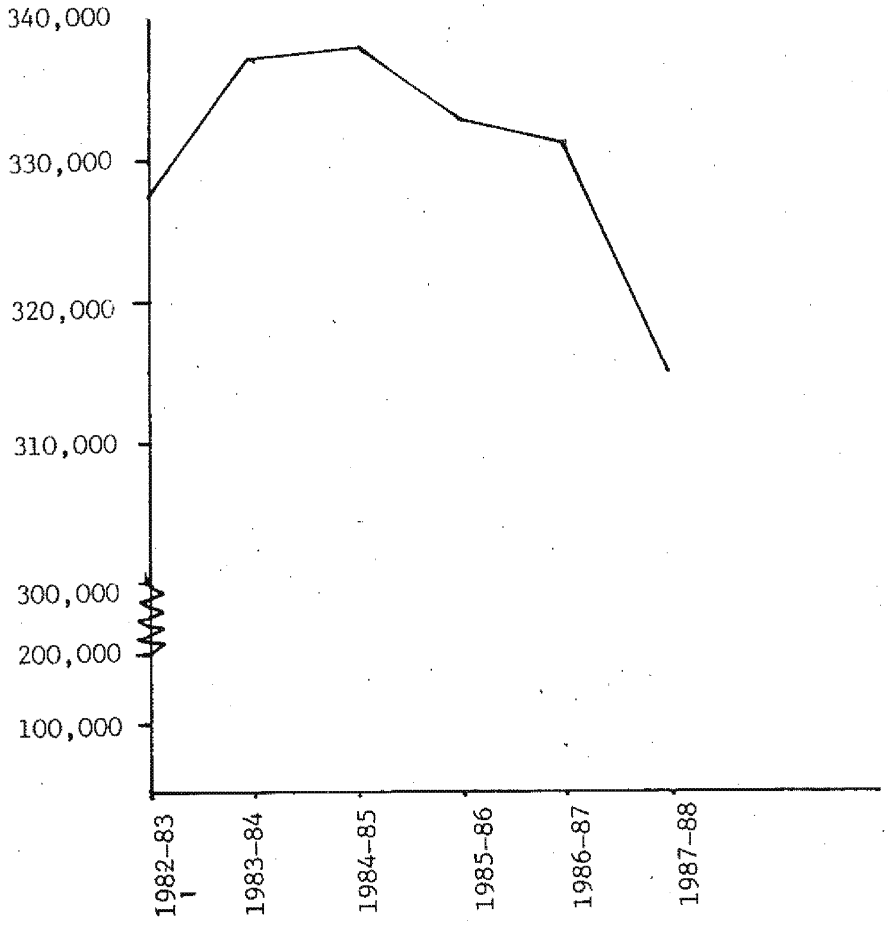
The SNBTS asked the Advertising Research Unit (ARU) to undertake consumer research on their behalf with a view to tackling these problems.

THE PROBLEM AREAS

The first of the two major problems identified by the SNBTS was the potential contamination of blood supplies by donors infected by the HIV virus.

The SNBTS response has been the development of a number of strategies, including the production of a range of AIDS-related publicity. This attempts to make potential donors aware of the problem of contamination, to encourage and enable them to check whether they are in the risk groups and ultimately to discourage donation among those at risk.

FIGURE 1: SNBTS BLOOD DONORS ATTENDED (1982 - 1988)



(1 April - 31 March)

The publicity primarily took the form of pre-donation printed material, namely AIDS-related additions to the pre-donation checklist all donors are asked to read and mailing information to existing donors with their call-up letters. Leaflets and other back-up material were also developed.

However, a small number of sero-positive donors had been identified, who subsequently turned out to be members of the risk groups as defined by the SNBTS material. This suggests that current strategies may not be completely effective and there was a need for research to determine the causes for this.

Two possible explanations were suggested. Firstly, that the message may not be getting through sufficiently well - people may be unaware of or misunderstand the relevant publicity.

Secondly, that some people are deliberately ignoring or defying the publicity, perhaps using blood donation as an opportunity to get tested for AIDS. Researching the latter area would involve interviewing sero-positive donors and it was felt that ethical considerations made a separate exercise untenable, given the importance of structured and positive counselling for these people.

Thus, this area of the research concentrated on the former option, that the message may not be getting through sufficiently well. The overall objective was to examine perceptions about AIDS and blood donation, both in general terms and in relation to SNBTS strategies in dealing with the issue of AIDS and blood donation.

The second problem area concerns the steady decline in donation levels observed since 1983-84 from a hitherto satisfactory level to a level which gives serious concern about the ability of SNBTS to meet demands for Factor VIII and albumin products (Figure 1). Not only has there been an overall decline in donations but there has been an even more pronounced decrease in the numbers of new donors attending, culminating in a fall of 18.49% between 1986-87 and 1987-88 (Table 1).

The watershed period of 1983-84 coincides with the increasing prominence of a number of AIDS-related phenomena. The first SNBTS messages asking donors at

TABLE 1: NEW WHOLE DONORS BLED - SNBTS

	1983	1984	1985	1986	1987	1988
Numbers bled	42,975	47,269	45,267	41,146	41,803	34,073
Percentage change	0	9.99	5.33	-4.26	-2.73	-20.71

risk of HIV infection not to give blood were issued in 1983-84, with subsequent extentions as knowledge accumulated. In addition, since 1985, donors have been required to consent to their donation being tested for HIV antibodies. Furthermore, over this period, there has been mass publicity from Government and other media sources about AIDS, highlighting blood as the major medium for transferring the virus.

Thus it seemed probable that the decline in donor attendances might be related to an association between AIDS and blood donation. It was hypothesised that the main effect was that potential donors were afraid of contracting AIDS through blood donation. Additional research was therefore conducted to assess the extent and salience of this and other fears about AIDS and blood donation.

THE RESEARCH METHODS

Alternative research methods were used to study the two problem areas. Firstly, qualitative research methods involving small group discussions, primarily with blood donors, focused on the contamination issue. Secondly, quantitative research methods using an Omnibus survey focused on the extent and salience of fears about catching AIDS from donating blood, or receiving blood among the public as a whole. These methods are now discussed separately.

The Qualitative Research

The primary function of the research was to provide an in-depth understanding of respondents' perceptions of a number of issues. Thus, the emphasis was on exploration and probing. It was therefore decided that a qualitative group discussion procedure should be used, rather than a quantified approach using standard questionnaires. This method is commonplace in market research and overcomes many of the disadvantages of questionnaire methods. It involves bringing together, in an informal setting, groups of 6 to 8 respondents who are carefully selected in social demographic terms, and asking them to discuss in depth areas of interest, under the direction of a group moderator.

The resulting procedure has many advantages and stimulates a wide review of the issues. Areas are discussed and explored rather than (perhaps standard) answers being given to specific questions. This method is eminently more suitable for using indirect, projective interviewing techniques, rather than more directive questioning methods that may be superficial or inappropriate for complex attitude research. Respondents select their own priorities in exploring the subject, thereby ensuring that the areas covered do not simply reflect the biases of researchers. Topics can be explored by a variety of questioning techniques, and can be repeated, if necessary, to assess consistency of opinion. Complex attitudes such as imagery can be examined since complicated questioning procedures are feasible. The lack of formality reduces any potential embarrassment when discussing delicate topics such as AIDS and sexuality.

The main disadvantage of group discussions is that statistical estimates of population prevalence are not possible as the research sample is usually smaller and selected differently from one for quantification procedures. In this instance, however, it is felt that the advantages of qualitative methods greatly outweigh this disadvantage.

In selecting respondents to interview in qualitative research one does not necessarily select a sample 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 prevalence. This is achieved by structuring or 'quotaing' the sample by factors known to be important in shaping relevant attitudes and behaviour.

Such factors 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. For this research it was felt that three variables were important, namely, donor status, demographic characteristics and geographic location.

TABLE 2: QUALITATIVE RESEARCH - SAMPLE STRUCTURE

Selection Criteria		No of Groups
Donor Status:	Current Donors (<2 years)	12
	Lapsed/Ex-Donors (2+ years)	2
	Non-Donors	2
		16
	All donor groups contained a mix of donor centre, community session and workplace donors	
Age:	18 - 24	10
	25 - 44	3
	45 - 65	3
		16
Sex:	Male	8
	Female	8
		16
Social Class:	ABC1	8
	C2DE	8
		16
Location:	Glasgow	6
	Edinburgh	6
	Aberdeen	4
		16

Donor Status: In this instance, current donors (defined as those who had donated within the past two years) were of greatest interest. They are most likely to have come across SNBTS publicity about AIDS and represent the main target for such material. However, it was also thought valuable to interview a small number of ex/lapsed donors (those who had given blood, but not for at least two years) and non-donors to check for variation in response. For this research each donor group contained a mix of donor centre, community session and workplace donors.

Demographic characteristics: As in market research in general, demographic characteristics, namely, age, sex and social class, were felt to be important. Male and female and middle and working class respondents were interviewed separately and in equal proportions, as AIDS was felt to be of equal relevance to each of these groups. However, the relevance of AIDS was expected to vary with age. Most notably younger people are more likely than older people to be in the 'at risk' groups. Particular emphasis was therefore put on younger people with ten of the sixteen groups being made up of 18-24 year-olds.

Geographic location: There was some feeling that perceptions about AIDS are likely to vary in different parts of Scotland. Thus AIDS as an issue might be more prominent in Edinburgh, nicknamed the 'AIDS capital of Europe,' than in Aberdeen where so far no sero-positive donors have been detected. On the other hand, at the time of the study much media coverage had been given to a patient in Glasgow contracting the virus from a blood transfusion. Thus the research covered all three cities.

In summary then, the research sample was structured as in Table 2. A detailed breakdown of the composition of the groups is provided in Appendix 1.

Normally group discussants are recruited by trained market researchers contacting members of the public at random and inviting respondents who fit the quota requirements to attend the discussion. This procedure was used to recruit the non-donor groups. However, because donors are a small section of the population, a different approach was used. In this case, the Regional Donor Organisers provided lists of names and addresses of donors who fitted the sample requirements, chosen at random from existing records. The names were initially screened by SNBTS staff to ensure as far as possible that there were no unusual medical or social conditions which might make an approach difficult.

Each person on the list was sent a standard letter about the research by the Regional Donor Organisers. The content was previously agreed and a copy is contained in Appendix 1. 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 SNBTS as soon as possible.

The lists, modified by the very few refusals which were received, were forwarded to market research recruiters working in the appropriate areas. They contained information about age, sex and donor status, but recruiters still had to confirm this information and determine the social class of respondents. They then invited appropriate respondents to participate, giving details of time and place.

These procedures were followed for donors in all three types of session: workplace, donor centre and community.

The group interviews were deliberately loosely structured giving respondents considerable flexibility in determining the priorities for discussion. However, to ensure all the relevant subject areas were covered, a brief on the possible content areas was discussed and agreed with the SNBTS. This is given in Appendix 1 and highlighted such aspects as, general perceptions of AIDS and blood donation including knowledge of the disease and processes of transmission and risks from AIDS to donors; the media treatment of AIDS and blood donation; and detailed response to the SNBTS strategies relating to AIDS and blood donation.

Each group discussion was led and directed by experienced personnel. Three moderators were involved, two female and one male. The majority of interviews were held in the homes of the market research recruiters, in order to provide

TABLE 3: QUANTITATIVE RESEARCH - SAMPLE PROFILE

		Unweighted	Weighted
Base:		976	976
		%	%
Sex	Male	48	47
	Female	52	53
Age	15-24	18	21
	25-34	26	18
	35-44	18	16
	45-54	13	14
	55-64	12	14
	65 +	14	17
Class	AB	11	15
	C1	21	21
	C2	31	29
	DE	37	35

an informal and relaxed environment. However, in Aberdeen accommodation in the donor centre was used because this was more convenient for donors.

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. The 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 £5 were given to all respondents.

The main findings from the qualitative research are described below in Section 1.

The Quantitative Research

Quantitative procedures were used to assess the extent of fears about catching AIDS from donating or receiving blood. In this case statistical estimates of prevalence were needed and a quantitative method, using a large representative sample and a structured questionnaire, was more appropriate than a qualitative approach. An 'Omnibus' survey provided the most economical means of collecting the data as only a limited number of questions were involved. An 'Omnibus' is a regularly repeated survey conducted by some commercial agencies on a range of topics. Questionnaire space and data processing facilities are sold to interested clients on a cost per question basis. The Omnibus survey is conducted in the home by experienced market research interviewers, using face-to-face personal interviewing.

A total of 976 respondents were interviewed throughout Scotland. The sample was designed to represent the general population in terms of sex, age and social class and where necessary was weighted for analysis purposes to match JICNARS population estimates from the National Readership Survey of January - December 1983 (Table 3).

Using this method, data were obtained on the occurrence of blood donors in Scotland together with the public's perceptions of off-putting aspects of giving blood, as well as a measure of fears of catching AIDS from blood donation and receiving a transfusion. These findings are described in Section 2 of the report.

TIMING

The research was approved at the end of August 1987. The Omnibus survey for the quantitative research was conducted over the period 19th - 24th November 1987. Organisation of the qualitative research, however, was more problematic. All but two groups comprised donors and so there needed to be a high level of input from Regional Donor Organisers in identifying suitable respondents. The first group discussion could not be held until November 1987 and further organisational delays meant that the last one was not completed until March 1988.

A verbal presentation of the findings, with accompanying notes, was made initially to the SNBTS National Organiser on 28th March, 1988 and again, in a revised form, to a meeting of national staff, including Medical Directors and Regional Donor Organisers on 19th May, 1988. An article based on the research was then written and submitted to the BMJ for publication.

This report provides a detailed breakdown of the findings in three sections:

- Section 1.0 discusses the findings of the qualitative research
- Section 2.0 discusses the findings of the quantitative research
- Section 3.0 summarises the main findings from both projects and discusses their implications for the SNBTS

MAIN FINDINGS

The two research projects are discussed separately.

The qualitative research, which was concerned primarily with the risk of HIV positive donors continuing to give blood, is covered in Section 1. The quantitative research, which examined whether fear about AIDS would discourage donation, is covered in Section 2.

Inevitably there is some overlap in the findings. For example, both projects examined off-putting aspects of giving blood. Where relevant such complementary findings are cross referenced.

1.0 QUALITATIVE RESEARCH

The findings in this section of the report are divided into two main areas:

- Basic perceptions of blood donation and AIDS (1.1)
- Perceptions of SNBTS response to AIDS (1.2)

1.1 BASIC PERCEPTIONS

Basic perceptions in four related areas are discussed:

- Blood donation (1.1.1)
- AIDS (1.1.2)
- Blood donation and AIDS (1.1.3)
- Blood transfusion and AIDS (1.1.4)

1.1.1 BLOOD DONATION

In 1984 the ARU conducted a detailed examination of the Scottish public's attitudes to blood donation. The current research is much more specific, and limited to those attitudes which have direct relevance to the AIDS issue. However, this first section comprises a brief over-view of general attitudes to donation in order to set the context for the AIDS-related findings. Three areas are therefore covered:

(i) Factors encouraging and discouraging blood donation
(ii) The concept of 'handing over' blood to SNBTS
(iii) Respondents suggestions for improvements

(i) Factors Encouraging and Discouraging Blood Donation

This issue was examined in great detail in the previous research (1). It is interesting to note that perceptions have changed little in the intervening four years. Thus as before a number of encouraging and inhibiting factors can be identified. These will be highlighted individually below, but it is important to remember that they interrelate. Any or all of them may be experienced by each individual but with varying salience and their relative importance can alter over time.

This dynamic interaction between encouraging and inhibiting factors should always be borne in mind when analysing donors' and non-donors' motivations. Thus the individual can be seen as occupying a continuum of commitment which 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.

It should also be noted that many reasons, especially for non-donation, can be rationalisations. The reason given can mask a deeper emotion and could be overcome in other situations, especially for personal benefit.

Encouraging Factors: The majority of groups were made up of current donors and so the range of encouraging factors were described more fully than the inhibiting factors. The fundamental impression that emerged was that for regular donors giving blood is a warm and rewarding experience and that they generally perceive themselves to be responsible citizens, doing the 'right thing' for the community. The encouraging factors are of two types. The first are initial stimuli to donate and are most important in encouraging people to become donors in the first place. The second are factors that encourage continued donation. The two types are described separately.

Initial stimuli: The initial stimuli identified in the previous research are still apparent. They fall into four main categories.

Firstly, group pressures often stimulate an initial donation with a group of people giving blood together, projecting a feeling that 'everybody does it,' both encouraging and supporting their companions, for example at work or at college.

> "We saw one of the posters at the college last year saying 'come along' so we just went along... it seems to be the popular thing with students."

Secondly, a personal realisation of the need for blood, usually as a result of contact with illness, might also lead to the initiation of donation.

> "I started to give continuous when my son had his tonsils out and had 8 or 9 pints of blood solid and we have the blood transfusion people into the factory twice a year ..... "
>
> "Thats how I started to give, when I had my daughter - I read a letter - a woman writing in to thank people for her baby getting blood ..... "
>
> "When my son was born my wife had 2 pints of blood and they told me then that was 2 pints I owed."

Thirdly, a sense of social duty and a desire to serve the community can be a strong motivation to start giving blood.

> "Because I think it's wonderful to help people, I really do. I couldnae wait till my 18th birthday to go and give blood - I felt I was doing something for society ..... "

Finally, the initial donation might be a result of a spur of the moment decision, often prompted by a convenient opportunity to donate.

> "I started less than two years ago after many years of meaning to and never getting round to it ... the first time was when the bus came to the University where I worked and that overcame all inertia."
>
> "I was just bored one afternoon, nothing to do"
>
> "In 1968 or '69 I had a hangover one Sunday morning. I was away for a walk and saw the sign and walked in."

Factors encouraging continued donation: Again matching the previous research continued donation appeared to depend on two aspects, namely, the continued strength of the initial stimuli and a sense of intrinsic reward from donating.

In many cases the motivating factors which trigger people to decide to give blood once will be strong enough to ensure that they donate again, especially since they have overcome the major hurdle of the first donation. In particular, those who felt a strong sense of social duty were likely to continue. However, the strengths of these initial stimuli may fluctuate over time. For instance, people may be less likely to continue to donate if they are removed from the group donation situation or if attending a session requires more effort and planning.

> "I haven't given since I moved jobs. I used to give six monthly when it came to my (former) work."

Many donors, however, also felt an intrinsic sense of reward from giving blood and being associated with the BTS, conveying a feeling that it was a warm positive experience.

> "You get a wee bit of satisfaction after you've given a pint of blood."

Importantly, those who were receptive to such feelings were more likely to continue to donate, but for those who did not perceive and identify with a sense of reward the initial stimuli were more likely to fade, allowing inhibiting factors to gain precedence.

These informal rewards were mostly perceived by donors, non-donors often being unaware of them. A variety of aspects contributed to this positive feeling. Among these were:

- A feeling of having done something worthwhile.

> "I always feel it's helping someone less fortunate than myself."
>
> "It's a good feeling as well, something you do knowing you're helping somebody that needs blood."

- The enjoyment of participating in the session atmosphere.

> "Its twenty minutes of relaxation, isn't it?"

- An increased sense of well-being, both physical and psychological.

> "Believe it or not, I feel more energetic, I went in there and (then) I done my work - a doddle."

> "I feel that it helps you - helping your blood to create more blood - fresh blood."

- Contributing to the stock of blood for the potential benefit of themselves and their family as well as the general population.

> "You might need a transfusion yourself someday."
>
> "That's it, you never know what's ahead, anything could happen."

The benefit of a medical check-up through the routine testing of the blood, was also perceived by some to be a reward for giving blood.

> "My old man went once. He didn't have enough iron in his blood, so at least he found out that way and got a course of tablets from the doctor. Otherwise he wouldn't have known the difference - next time he was OK again."

For some, awareness of the routine blood testing for AIDS was an extra bonus, 'it sets your mind at rest,' although others would 'rather not know.' Hence tests appear as both encouraging and discouraging factors in this respect. In both instances it was apparent that the advent of AIDS has made the issue of blood tests more sensitive. This is discussed further below and in Section 1.2.2.

Discouraging Factors: Non-donors were deliberately under-represented in the current research, so discouraging factors were not mentioned as frequently as they were in the 1984 research. However apart from this, findings have remained much the same. Thus a similar range of factors emerged which interact with each other and also with the encouraging factors, in determining whether an individual will donate or not at a given point in time.

Interestingly AIDS was not mentioned spontaneously as an off-putting aspect of giving blood, except in that it increased the salience of the blood test and made the prospect of rejection potentially more embarrassing and some found this off-putting. The discouraging factors fell into five categories: fear, apathy, inconvenience, physical/health status and unpleasant experiences. These are now discussed separately.

Fear: A wide range of fears emerged relating to both the practical aspects of donation and to the images these evoked. Fear of needles predominated. This was confirmed by the quantitative findings where 12% of the sample mentioned fear of needles and injections as off-putting factors in relation to donating blood (Section 2.2).

> "I've thought about it but it's the needles that put me off - I don't think I could - I hate needles - I'm not a needles person."

Dirty needles received only minimal mention in this context (1%), and as described below (Section 1.1.3) respondents were dismissive of the possibility of catching AIDS by cross-infection via needles and other equipment. Thus the AIDS issue has not directly influenced fear of needles in relation to donation. However, Government publicity campaigns on AIDS and heroin abuse have drawn attention to dirty needles and contaminated blood as sources of HIV infection. A conceptual link between these images and the needles used in blood donation could have a negative effect, in particular adding weight where needle related fears already exist. This is also described further in Section 1.1.3.

Fear of needles involved fear of pain but also had more psychological implications of intrusion into the body.

> "My friends are terrified of needles - they'd love to give blood but they're frightened of needles - not just because of any diseases but just the feeling and the size of the needle when you see it."
>
> "I hate to think of a needle got stuck in my arm."

Others reacted against the clinical aspects of blood donation and the associations with other fears relating to hospitals, doctors and dentists.

> "I've got a terrible fear of it for some reason ... it's not the needles, maybe it's just everything about it - it's like doctors and dentists just because it's that kind of thing, clinical."

As well as fears relating to the practical aspects of donation procedures, there were also other related fears. For some the fear that an unknown illness might be detected through the routine testing was particularly strong. This 'not wanting to know' covered a broad range of illnesses (Section 1.2.2). However, as with the benefits of testing discussed above, when the detection of AIDS as part of the routine blood test was considered, reactions were more acute. Those who generally tended to react against finding out about illnesses prior to having symptoms, reacted more negatively in regard to AIDS. Furthermore, some respondents, in particular young people, were concerned that if they were turned away at a session, other people waiting would assume that the reason for rejection was AIDS-related (Section 1.2.1). This could potentially undermine the strength of group feeling as a motivating factor because donors would not wish friends or workmates to see them being rejected. Other fears included fear of the unknown, fears that 'something' might go wrong and worries about bruising, the sight of blood and possible embarrassment from doing something silly.

It should be remembered that all these fears are emotionally based and intrinsic to the individual and therefore hard to counteract by rational argument. It was also apparent that in some situations the fears described were rationalisations and that individuals were able to overcome them, providing the motivation was sufficiently strong. For instance, a respondent who professes a fear of needles could overcome that fear for a blood test which benefited him personally.

> "I've had samples taken at the hospital in my arm - and that's horrible - I dinnae think I could give a pint - only about that (a syringe full)."

Furthermore, other individuals with stronger motivation could overcome their fears to the extent of giving blood.

> "No I was frightened before I went - I don't like to go to anything like that - I was frightened. I thought about it a couple of times 'Aye fine - I'll do it another day' and then eventually when the bus came and I put my name down I thought 'God, I've got to go' and after the initial thing in the thumb it was no problem."

> "I'm a big coward, I hate everything about it - see when I'm lying down I actually feel sick - I just hate it - but I feel as if 'well I'm healthy'.... (therefore I can give blood)."

Apathy: Factors which can be loosely summarised as apathy were mentioned by both donors and non-donors. Often these were rationalisations for more emotive reasons but were sometimes real. Again the prevalence of this attitude was confirmed in the quantitative study (Section 2.2) where 10% and 5% respectively responded that they had 'never bothered' or 'never thought' about donating.

Non-donors might claim to have never thought about giving blood and had not noticed any local publicity about where and when to donate. They often did not know any donors and so had not experienced any group pressures to give blood.

> "I just haven't got round to it."

Donors might also experience a degree of apathy or laziness as their initial stimuli to donate declines or is overcome by inhibiting factors.

> "I used to give regular but I must have missed the last three at the community centre - laziness - you come in at night - it's too cold, the kids are playing up ..... "

Inconvenience: Inconvenience was seen as an important inhibiting factor. The easier it was to get to a session the more likely someone was to donate. Thus donating in the workplace during working hours was seen to be the greatest convenience and many donors regretted that workplace sessions were closing down. Attending donor centres and sessions in local community centres was considered more difficult, primarily because of the restrictions in times the sessions were open, but also because of the length of waiting times and distances to travel.

Health and the physical ability to donate: This was not mentioned at any length in the groups as it was taken for granted that 'you wouldn't go along to give blood unless you felt up to doing it.' Some respondents had been prevented from giving blood because of ill health but were able to resume once they had recovered. However, 20% of respondents in the quantitative survey mentioned health aspects as an off-putting factor in donation (Section 2.2). Some health problems were perceived as reasons for non-donation although these were not always clarified by medical opinion.

> "I'm a wee bit scared to give blood because I've always got cold hands and feet - I think if I gave blood that would give me a whole year before I made it up again."

On the other hand, the onset of an illness or a diagnosis by SNBTS of an abnormality such as anaemia could be reasons for discontinuing donating. Once people stopped donating for a while, it could be harder for them to return, either because they had got out of the habit or because they were not clear whether they were eligible to recontinue.

Interestingly, these health related reasons all concerned the well-being of the donor. The well-being of the recipient and the dangers to them of donating sub-standard blood rarely received any spontaneous mention.

Unpleasant experiences: Some respondents reported unpleasant experiences as potentially discouraging. These could be reported at first or second hand. This aspect was also mentioned spontaneously in the quantitative research, although infrequently (5%). Again the extent to which these experiences affected donors' attitudes depended on the relative strength of other motivations.

Most practical criticisms tended to focus on the thumbprick and bruising:

> "That gets me angry (the thumbprick) - maybe it's irrational - I get mad when I get that done - can't they take it from somewhere else."

> "When you go for the first time, provided you've not had any problems, you come out and think 'good, that was a relief, it wasn't really that bad,' but when you go the second time you think 'Oh, I've got go to through that thumbprick again."

> "I know quite a few people that give blood that have come away with huge bruises in their arms through difficulties in getting the needle in the vein ... I think that can put you off if you go once and you have a bad experience."

Some aspects of attending a session itself could also be unpleasant for some donors, according to their personal perceptions. While many donors find the session atmosphere pleasant, some reacted against a clinical atmosphere, while on the other hand some had misgivings about the less 'sterile' and more informal atmosphere at a community donation session. Sometimes staff were criticised for being 'starchy,' or 'off-hand' and sessions could be seen as too busy and rushed - a 'cattle market.'

In summary then, the motivating and demotivating factors which contribute to the decision whether or not to donate blood have changed little in the last few years, with the warm feeling of reward from giving blood still an important factor in continued donation. AIDS was not mentioned as relevant to blood donation at a spontaneous level. However, it was apparent that because of AIDS some aspects had become slightly more sensitive, for example testing of blood, concern about rejection and anxiety in relation to needles.

(ii) The Concept of 'Handing Over' Blood to SNBTS

A further relevant aspect of blood donation was that donors tended not to visualise an actual recipient for their blood, even if they had been originally stimulated to donate by the needs of an individual. Conceptually blood was 'handed over' to the SNBTS (even to individual session staff) trusting them to use it well.

> "You like to think it's going to someone, but as far as you're concerned it might be stuck in a blood bank and forgotten about for God knows how long."

> "It doesnae really bother you (what happens after). You think well, you've given your pint of blood and that's it."

> "You just think you're giving blood, there's a little bag with your blood - you don't think where it's going to."

In some ways this is an acknowledgement of the realities of the situation. Donors generally have to accept that it is impractical for them to know what happens to their blood in terms who receives it or what other purposes it is used for. However, this tendency might also make it easier for donors to avoid considering the possibility that the blood they donate might be contaminated and could therefore affect the recipient. This will be discussed in more detail below (Section 1.1.4).

(iii) Respondents' Suggestions for Improvements

When asked in general terms how SNBTS could improve donation levels, respondents made a number of spontaneous suggestions.

A need for more extensive publicity was frequently mentioned. Comments related to both national campaigns and the advertising of local sessions. Media activity will be discussed in detail below (Sections 1.2.3 and 3.3) but donors felt an overall need for increased 'prodding,' with more frequent and impactful reminders to continue to donate.

> "You used to get advertisements on the TV and magazines but you don't seem to get that nowadays. You used to get Noel Edmunds - cup of tea on the table. It seems to have quietened down in the last few years. They haven't publicised it anyway - you used to see posters all over the place, but even that's died down."

There was also the perennial plea to make sessions easier and more convenient to attend. Workplace sessions were perceived to be the most convenient but it was acknowledged that these were declining in numbers. However, some respondents suggested that SNBTS should hold community sessions in areas where smaller workplaces were concentrated and that management should be requested to give staff time off to attend. In addition, more session locations were requested and more flexible times for donation. Evenings were a particularly popular option.

> "You won't get as many people as you would like if you're going to make it difficult for people to get to you."
>
> "If they came to you and asked, you'd do it, but see if you've got to trail after them, it's a different story."

In conclusion, little had changed in attitudes towards blood donation in the past four years. The salient motivating and demotivating factors continued to be important. In particular, the warm rewarding feeling from giving blood and being a 'good citizen' remained strong motivating factors for continued donation. AIDS was not mentioned as a relevant issue although it might have exaggerated some existing fears. For example, reactions to testing blood for AIDS and concern about rejection were potentially more sensitive issues than before, and fear of needles could have been exacerbated by AIDS/drug abuse campaigns.

Respondents were still inclined to 'hand over' their blood to the SNBTS, without considering the potential recipient. This will affect the degree of conscientiousness with which they consider their own likelihood of passing on contaminated blood. There was still much goodwill towards BTS with concern shown about how to improve blood donation levels. Improved publicity and greater convenience for donors were mentioned as priorities, with no mention at all being made of the AIDS issue.

The findings showed that there is still much scope for boosting the positive aspects of blood donation in all aspects of interaction with the public including relationships with staff, session organisation and media material. The strength of the demotivating factors could be modified with appropriate action, in particular by reducing the occurrence and impact of unpleasant experiences and giving positive reassurance regarding generalised fears. Furthermore, where donors experienced positive emotional feedback from the experience of giving blood (for example being part of a pleasant atmosphere and acting with others to do good and to have their generous gift appreciated) this acted as a strong reward for continuing to donate. Thus it is very important to foster these positive feelings.

1.1.2 AIDS

Respondents were encouraged to discuss AIDS in some detail. It should be emphasised that thinking about AIDS and the implications of the syndrome at both a community and a personal level was unpleasant for many respondents. Furthermore, the emotions it evoked contrasted sharply with the warm positive feelings expressed about blood donation.

All respondents were aware of the AIDS issue, and most had a basic knowledge about the syndrome, although detailed understanding could be confused and patchy. Knowledge was attributed to the widespread media campaigns and frequent TV programmes about AIDS. Radio programmes and phone-ins were also mentioned together with other help lines. SNBTS publicity was not mentioned in this context.

> "AIDS is very well publicised - I don't think you can fault the publicity on AIDS anyway. I mean, everyone in the country must know something about AIDS. There is just no way unless you are totally detached from the world."

Indeed there was some reaction against a perceived over-exposure to the subject of AIDS which might lead individuals to metaphorically 'switch-off.'

> "I think the AIDS hysteria ... it's peaked and it's going down - I mean about a year ago you couldn't pick up the paper or watch TV - that's what you were getting AIDS, AIDS, AIDS."

AIDS was perceived to be a very serious disease, with no known cure. Initially it affected limited groups with specific lifestyles but was now seen to be spreading through the general community. The rate of spread was seen to be hard to predict but respondents were aware of a feeling of 'sitting on a timebomb'.

> "Now they're starting to publish figures, people are really getting scared. They're expecting so many more hundreds of thousands of people to be infected with it at the moment. There is this underlying grey percentage."

Again however, some respondents reacted against media treatment of the issue, feeling the risks were sensationalised.

> "I think people really have over exaggerated the situation and the media haven't helped, because when the big scare first came out it was programmes every night of the week .... Anyone who had been to a disco and gone back for a one night stand - that was you - you were caught."

It was known to be caused by infection with the HIV virus and that people can be carriers without showing symptoms of AIDS. Both carriers and sufferers were known to transmit the virus with transmission taking place via blood and semen. Transmission via saliva was thought to be very unlikely.

Respondents were aware that blood could be tested 'for AIDS' but knowledge was more limited about the effectiveness of current testing (see Section 1.2.2). For example, there was only limited awareness of the time lapse between catching the AIDS virus and being able to detect the antibodies in a blood test.

Within Scotland, Edinburgh was seen to have the highest incidence of AIDS, followed by Glasgow. Aberdeen was not perceived as having an AIDS problem currently.

> "I've never heard much in the paper about folk from Aberdeen having AIDS. It's never mentioned as much as Edinburgh, Dundee or even Glasgow."

> "I'd think twice about taking a girl home in Edinburgh."

However, it is important to note that location had no noticeable effect on respondents' attitudes towards blood donation and AIDS.

When respondents were asked who was at risk from catching the AIDS virus a loosely structured hierarchy emerged. Discussion about the spread of AIDS tended to concentrate on risk groups rather than risk behaviours. The greatest consensus was that homosexuals and drug addicts were high risk groups, homosexuals through their sexual habits and drug addicts through 'sharing dirty needles.' Opinion varied about how large these groups are in the community, with drug addicts thought to be more common in working class areas and homosexuality being more prevalent in more middle class 'arty farty' populations and in larger cities.

Prostitutes and haemophiliacs were also mentioned frequently. Haemophiliacs risked catching the AIDS virus as a result of treatment with blood products, although this risk was seen to have declined since 1985. Those who were sexually promiscuous, without being prostitutes, were also seen to be at risk.

Other groups mentioned less frequently were people who had visited certain countries and had sex there, in particular South Africa, the Sahara and Haiti, and babies of mothers who have AIDS.

> "It's a well known fact that there's three ways of catching it: prostitute, drug addict, homosexual."
>
> "It all stems into one thing, gangin' aboot wi' loose women, you're bent or you've been to South Africa or the Sahara."
>
> "It used to be haemophiliacs were the worst - not anymore. It's been tightened up a wee bit!"
>
> "It's to do with probability, the more (partners) you have, the more probable you're going to get it."

An indirect risk was perceived for partners of people with the lifestyles identified above. This could be at 'the first level,' ie. those in direct sexual contact with people leading 'at risk' lifestyles but it was also perceived that there was a risk for those who had indirect contact at a second, third or 'n'th level of transmission.

> "If you have a bisexual man he could pass it on to his wife or his girl friend if he's had relations with a man. She in turn, if she's promiscuous, could pass it on to dear knows how many people."

> "The best one is where they said whenever you sleep with this person, you're sleeping with all the people that person has ever slept with and all the people that they've slept with - and so on and so on." (TV programme)

> "You could marry somebody, I mean you don't know who they've been with in the years before. They could have been with anybody. Maybe it's only one person they've slept with before but that one person could be an AIDS carrier or have AIDS disease or whatever and that's you."

Respondents were uncertain as regards the probability of contracting the AIDS virus by this indirect route. Indeed they felt this was virtually impossible to calculate, as even 'the experts' did not know how many people in the population were currently infected and would not display symptoms for several years. However, it was felt that the risk was lower than for the high risk groups discussed above and that this risk would reduce as the 'distance' from these groups increased.

Finally, it should be noted that no matter how knowledgeable respondents were about AIDS and methods of transmission, the extent to which this knowledge affected sexual behaviour could vary from individual to individual and in individual situations. The following serves as an illustration of this knowledge/behaviour discontinuity; when one group of 18-24 year-olds was seriously discussing their changed attitudes towards meeting new people and taking precautions if they were having sexual intercourse with them, one member chipped in with a laughing "Of course, it all depends on how drunk you are at the time."

Ultimately then, respondents acknowledged that AIDS could be transmitted to 'normal' heterosexuals, and hence that everyone and anyone was at risk unless they were celibate. However, this acknowledgement usually only emerged after detailed discussion. The high risk groups tended to dominate perceptions.

> "I think everybody must at some stage in life must be at risk. Some girls tend to go out and sleep about, so you don't know. Just everyday working lassies that go out and sleep with somebody. They don't know where he comes from, what his background is. It can easily happen."

A further dimension of the risk hierarchy was an implicit apportioning of blame, with distinctions being drawn between 'innocent' and 'guilty' victims. Homosexuals, drug addicts and prostitutes were often put in the latter category. They were felt to 'know what they were doing' and, given current publicity, should be prepared to take - or even deserved - the consequences. Homosexuals were described in especially pejorative terms. By contrast other victims were seen to be 'innocent' or 'normal' members of society. These would include haemophiliacs, some secondary partners and babies of those in the major risk groups and those who came in contact with contaminated blood through their work such as doctors, nurses and policemen.

> "There are only certain ways you can catch it and if you are prepared, especially in this day and age with AIDS and Hepatitis B about, to take a risk where you could catch it, well then that's just your tough luck."

> "I think you could avoid that (sex before marriage) and then when you do get married, he could have went about a bit, about 6 years ago, and then you could get it despite having been careful."

> "I suppose you've got to include people, partners of these people. You could have a drug addict who has a perfectly reasonable partner. That's not to say the drug addict hasn't got AIDS and passed it on to the partner."

Thus, at an objective level respondents were aware that apart from the celibate 'everybody' is at risk of catching AIDS. They did not, however, readily relate this to their own lives. Therefore, the statement 'everybody <u>else</u>' is at risk of catching AIDS is a more accurate representation of their spontaneous feelings.

As noted earlier, respondents recognised AIDS as a very serious illness. Development of symptoms and even diagnosis as a carrier was felt to mean imminent and uncomfortable death. Prior to death and even before the onset of symptoms, diagnosis was seen to have a myriad of lifestyle implications. These include problems with employment, financial difficulties, such as obtaining a mortgage, and complications in one's family and social life.

As well as their fear of these dreadful practical consequences of AIDS, many respondents were deeply reluctant to connect themselves with a condition that they strongly associated with morally degenerate lifestyles.

> "Did you see the programme that was about AIDS - really sad. I think really it can't mean anything else but death. Just if you've got AIDS you're going to die - don't sleep around, use condoms."

> "It's the worst disease ever to get. You'll be treated like a leper if you get it. Cancer's just about as terminal and nobody treats them like lepers - but AIDS is another thing. If you heard some one had AIDS you wouldn't go near him."

> "I think the main reason for that (social ostracism) is because it was all thought to be gays - if you had AIDS it was thought you were gay."

It was also recognised that while 'everybody' might be at risk, either knowingly or 'innocently,' one would not be able to function normally if one continually thought about the risk.

> "I dare say people, the likes of heterosexuals could be at risk if they went with prostitutes or junkies. But if they went to prostitution to feed their habit and then they would go with heterosexuals who would then go with their wives so it could end up ... (pause). But there again <u>if you thought about that you'd put your heed in the oven</u> (laughter)."

Thus for a variety of reasons, respondents did not spontaneously acknowledge any personal risk from AIDS. They tended to distance themselves from the syndrome.

> "The way I seen it, I didn't have anything to worry about. I wasn't a homosexual or a drug user or going to go with prostitutes so I had no worries. I'm not going to catch it."

> "It's just a one night fling and that's it - bang - they don't think about after 'well I could have had AIDS now,' or if they did they would think 'it would never happen to me',"

Further prompting during the discussions showed considerable resistance to being forced to consider the possibility of personal risk. (This is further discussed in Section 1.2.1.) It was a very unpleasant concept and some respondents resented the process. However, probing did reveal underlying doubts for many. Generally, where there was an admission that they were at risk, it was considered to be from transmission at a secondary ('n'th) level and therefore at the lowest level on the perceived risk hierarchy. There was continued rejection of the concept that they would have direct contact with the 'high risk' groups who were seen as degenerate social minorities.

> "Well, there's risk and there's risks, isn't there? They're like <u>really</u> at risk, they've got to literally watch what they're doing (ie. homosexuals, drug addicts, haemophiliacs, prostitutes) - we don't - not yet - touch wood!"

The degree of willingness to admit personal risk varied by a number of factors. Age was most significant but gender and individual attitudes were also important.

The younger age group (18-24 years) were more used to considering the AIDS issue although it tended to be discussed in terms of uneasy jokes rather than serious comment. While they had basic knowledge about the transmission of the HIV virus, this did not always influence their behaviour. For example, they were aware that promiscuity increased the risk of AIDS but many acknowledged the probability of having sex with more than one partner. Although they knew about precautions there was a possibility of not using them, depending on the situation, for example, if they had been drinking, or ironically, it was the first time they had met someone. They also talked about the problems of knowing the sexual history of their partners but this tended not to act as a deterrent to intercourse. Finally, some teenagers even suggested that the minimum age for donation should be raised because many young people were 'at risk,' to some extent, because of their lifestyles.

> "It's going through everybody's mind. I bet everyone in here stopped at one point, even if it's only been a couple of minutes, and thought 'I wonder'."

> "It's not really talked about, just joked about. But myself, the moment you do think about it you think 'phew,' and I watch what I'm doing."

> "I mean you wouldn't turn round to a bird and say 'have you got AIDS before I get into bed with you?' That's what they're trying to put forward to you."

> "You can't exactly say before you get married 'excuse me but I want you to go and have an AIDS test.' It's not very romantic ... and he's not going to turn round and tell you he slept with a prostitute."

The 25-44 age group might also admit that they were 'at risk' from AIDS but slightly less readily. They were mostly married and hence viewed the risk either in terms of their past 'catching up with them' or (usually very reluctantly) infidelity.

> "You know, like you didn't think about AIDS 4-5 years ago - the time for prevention for this is past."
>
> "1977 is 10 years ago, that could be your average thirty year-old business man going back to his days of trips to the States of whatever."
>
> "For those of us who don't fall into these categories there's no reason why it should enter our minds that we might have AIDS."

The older groups (over 45 years old) felt themselves to be much more remote from the AIDS problem. They were reluctant to consider it at all, finding it most distasteful. The men in particular resented a perceived implication of moral degeneracy, especially homosexuality.

> "When you're given the card to read, its probably the only time in your normal existence that you're asked if you've got AIDS. I never like to talk about the subject and I don't really like to be reminded of it."
>
> "My aunts and uncles were up at the house and one of them said something about AIDS and my uncle said 'You'll never get AIDS, only poofs get AIDS,' and that was his attitude. The older generation tends to reject things."

In summary, there was widespread, if superficial knowledge, of the AIDS syndrome and the means of transmission of the HIV virus. There was awareness of risk behaviours, with perceptions dominated by the concept of a hierarchy of 'at risk' groups. Those at the higher levels of risk, homosexuals, drug addicts and prostitutes, were seen to be minority groups and morally degenerate. The lowest level of risk was seen to be for those who had had secondary sexual contact with partners of partners of those in higher risk groups. This was the level at which a larger proportion of the population would be potentially vulnerable.

However, thinking about AIDS and the implications of the syndrome was unpleasant for many respondents, both at a community level and, in particular, at a personal level. Respondents were therefore reluctant to consider any personal risk of having AIDS. The dreadful practical consequences were vividly perceived and, furthermore, many were reluctant to connect themselves with any implied association with unsavoury lifestyles. The latter image is in marked contrast with that of the responsible citizen who generously gives his blood to the community. Thus respondents distanced themselves from the syndrome, while acknowledging that 'others' could be affected.

1.1.3 BLOOD DONATION AND AIDS

At a spontaneous level, respondents were generally not concerned about AIDS in relation to blood donation. It was not seen to obviously discourage donation, with the range of inhibiting factors described above having greater salience - primarily fear, especially of needles, but also health problems, apathy and unpleasant experiences - AIDS being only mentioned by a few individuals. This was also observed in the quantitative research (Section 2.2) where only 5% mentioned AIDS as an off-putting aspect in relation to donating blood, in comparison with 12% mentioning fear of needles and 20% mentioning health problems.

> "I've heard a lot of excuses, but AIDS has never been one."

The only effect of the AIDS issue which was mentioned at a spontaneous level was that for some people it had increased the salience of the blood testing aspect of donation. As noted above this could be seen as both desirable and undesirable.

> "You're going to get a certain amount of people scared to give blood in case they find out they've got AIDS - 20-25 year-olds groups - played around - never known about AIDS until the past two years - too scared to find out."

> "I think that would stop a lot of people going though - say a man had been with a prostitute, say 5 or 6 years ago, and decided to give blood. You'd be frightened to go in case they said 'you've got AIDS or an AIDS carrier."

> "Because normally I get the incentive, ken - you get a free AIDS test - which it is! If you dinnae hae any word you ken it's you're OK."

However, many respondents stated that this issue had never occurred to them before.

When prompted to consider AIDS in relation to blood donation, the only issue to emerge with any regularity was the risk of donors being infected with HIV. The rest of this section therefore concentrates on this issue. The problem of blood supply contamination was much less salient until the discussion turned to transfusions rather than donations and the risk from contamination directly affected the respondent as a potential recipient. Certainly the idea of their donation of blood being a source of HIV contamination had never occurred to respondents and the suggestion that it might was both surprising and offensive. These issues are discussed in detail in the next Section (1.1.4) which concerns perceptions of AIDS and blood transfusions.

As already mentioned, without prompting, there were very few respondents who considered the possibility of contracting AIDS through donating blood at all. Even when prompted, it was argued that logically there is no risk. The main potential source of contaminated blood would be needles which had been previously used for a carrier of the HIV virus and then inadequately sterilised. Donors and most non-donors knew that new needles were used each time, together with disposable collection packs, making cross-infection impossible.

> "How they think they can catch AIDS by giving blood out that way, I don't know. To me it would take an awfully thick person that would think that. They're hardly going to use the same needle in you as they used on wee Mary next to you. They just don't do that."

> "There's no risk of getting it, it's all sterile needles and things... If you thought you were at risk you wouldnae give it."

Thus the large majority of both donors and non-donors, felt that fear of catching AIDS could not have any major negative effect on blood donation levels.

However, despite this consideration there was evidence of underlying doubts. These were expressed in a variety of indirect ways:

- 'others' opinions were quoted: for the most part, respondents denied sharing these views, however it is possible that they were in fact 'displacing' their own concerns.

> "It's probably at the bottom of a lot of minds, but I wouldnae ..... (think it)."

> "Some other people might get neurotic about it. I don't know anybody personally that's said 'no way am I going to give blood' but there are some people who might have that fear."

> "Maybe they keep saying 'No No' (ie. no risk) but maybe in the back of their mind they're a bit wary - in case - if you stay away from it (the donation session) you'll never catch anything - even if there's no way that you can."

> "I think the AIDS scare has put an awful lot of people off giving blood."

Often the AIDS-related fears attributed to 'others' focused on session proceedings, in particular on the possibility of the repeated use of needles, however remote, even though respondents were sure this did not happen.

> "I'm convinced that the Blood Transfusion use new needles every time but they (some people I've talked to) think they use the same needles and just sterilize them each time."

Other aspects which were highlighted as potential foci for concern included: the receiving tubes and packs (generally assumed to be fresh each time); the use of palm grips (believed to have been discontinued as people worried about them as a source of contamination); and just the presence of blood and the possibility that drops might accidentally escape.

It was generally felt that the AIDS issue might have more effect on non-donors rather than regular donors. Primarily this was seen to be because they might not know about the aspects mentioned above, in particular the discarding of needles after each donation.

> "I suppose if you don't know what's going to happen to you when you go along - you don't realise what kind of a risk you are taking. Whereas you know it's only one needle going in and they're going to dispose of it afterwards, but if you don't know that before you go - it's going to get a wash with soap and water or something."
>
> "It could scare someone who hasn't given blood ... because they haven't been told - they still don't know about the needles or anything."
>
> "I think they're maybe no' recruiting new ones because of AIDS but I don't think there's any blood donors stopping because they seen it cleanly done."
>
> "I could understand someone who's never given blood thinking there's blood going about and of course AIDS - you just need a touch of somebody else's blood on you."

While for some non-donors the AIDS connection might just tip the balance against donation it should also be remembered that for many, other inhibiting factors will have greater salience. This was also shown by the findings of the quantitative study (see Section 2.2).

There was no first hand evidence that the AIDS issue was discouraging existing donors. All the respondents felt that it would not discourage them personally and the majority could not quote anyone who had actually stopped donating, although again there was a feeling that 'some people' might be deterred. However, one group member cited a dramatic example of the impact of the AIDS issue on one regular donor.

> "A lady in my work she's given 30 odd pints. She'll not go back now that the AIDS things out because she's scared, just in case - there's a one-off chance she'll get a needle that somebody else has had by mistake, even though she kens beforehand that nobody gets the same needle twice."

Another thought it might have an effect in the future.

> "It could spread a lot quicker, which means I suppose getting more into the folk who are going to be a blood donor. You'd get more folk that do that already who wouldn't think about going once it started spreading."

- <u>an 'outside chance' of mistakes</u>: while some related the potential risk to reused needles or contact with blood some felt there was always a chance that 'something' would go wrong although there was no clear visualisation of what that 'something' might be.

> "Maybe a million to one but it's still there."

> "I suppose there's a very slim chance of getting it giving blood but it's always there, slim and all".

This relates to the more generalised inhibiting factors discussed above, again expressed as the fear of 'something' going wrong.

- <u>need for reassurance</u>: a few isolated donors reported having asked at the sessions for reassurance about catching AIDS, thus indicating some degree of underlying doubts.

> "Last time I went to give blood I asked 'Are these needles changed for everyone' but apart from that, that's the only thing. You can't really catch it from anything."

However, most donors relied on the evidence of their own eyes, as they saw the needles and receiving packs being opened each time.

Furthermore, most donors responded positively to reassurance in the statement 'You cannot get AIDS by giving blood' when shown the SNBTS leaflet 'AIDS and Blood Transfusion,' with the majority feeling that this reassurance was the most important part of the leaflet. (See also Section 1.2.3). Again this illustrates the existence of minimal doubts, but also illustrates their preoccupation with their own risk in relation to blood donation as opposed to the risk to recipient.

Thus there was evidence of underlying doubts within the community in relation to AIDS and blood donation and the risk of exposure to the HIV virus. It is hard to judge the extent of these feelings and their salience in altering the balance between donating and not donating. In such an assessment, it should be remembered that the donors who participated in the group discussion came from a wide range of social backgrounds, age groups and geographical locations, thus representing a good cross-section. None of them felt the AIDS issue had altered their attitudes to blood donation or their donating behaviour. Furthermore, there were only a very few isolated members who could report any change in behaviour by other donors, although a few more could report non-donors expressing adverse opinions. It should also be remembered that many other factors could discourage donation as well as AIDS.

Perhaps of more concern than these doubts, therefore, was the existence of an emotional or conceptual link between AIDS and blood donation. While on one hand it was considered to be irrational to feel that one could catch AIDS from donating blood, it was also seen to be understandable that people could make a connection between them. Blood donation involves needles and blood, and dirty needles and contaminated blood are the main sources of infection highlighted by Government publicity campaigns on AIDS and heroin abuse.

> "It's just a natural link. AIDS is a blood linked disease and you give blood at the Blood Transfusion Centre and so people think 'O well, there's blood there, and it's the base for catching AIDS."
>
> "The mention of blood - folk'll buy a leaflet - says you can catch it (AIDS) from blood and stuff like that - probably just that - blood involved - I might catch AIDS."
>
> "I think they just hear you can get AIDS from a needle and they think 'Oh these needles at the Blood Transfusion, I'm not going back' but it's mad."
>
> "People are going to see needles in that advert which is good (SNBTS) then they're going to see needles in the AIDS advert - parallel - the two syringes."

It is also clear from this and other research that the imagery projected by the Government anti-AIDS and anti-drug injecting campaigns is very disturbing, both in isolation and particularly for those who already react adversely to the concepts of needles and blood even without such publicity.

It is probable that the conceptual link between the two issues, if made with any strength, could adversely affect donation levels. Government campaigns highlight the negative imagery of AIDS, exacerbating the conflict between this and the warmth and good feelings generated by blood donation which was noted at the beginning of Section 1.1.1. Furthermore, they could exaggerate existing worries about needles and blood which donors were initially able to overcome. It is also apparent that the anti-AIDS material with its unpleasant connotations has greater impact than current SNBTS publicity.

Further AIDS-related aspects may also have salience in modifying attitudes to blood donation, namely the exacerbation of potential embarrassment from rejection if it is assumed the reason is related to AIDS, and fears of the routine testing revealing that one has AIDS. These are discussed in Section 1.1.1 and Section 1.2.2.

In summary, therefore, the research has revealed little evidence of any overt fear of catching AIDS through donating blood. The issue did not emerge without prompting. It was felt to be logically impossible and, although doubts arose, these were remote from current donors.

Perhaps more significant, however, is the existence of a conceptual link between AIDS and blood donation, forged by the imagery of needles and blood, and tempered by recent publicity on drug abuse and AIDS. Any effect this has on donation levels will be indirect, shifting the balance of the encouraging and discouraging factors in favour of the latter, in particular undermining the warm emotional reward that donors get from giving blood. Further AIDS-related negative influences include fear of test results and increased potential embarrassment from rejection. Again these effects are probably marginal in themselves but could be potentially cumulative.

Thus, respondents' main preoccupation in relation to blood donation and AIDS was whether or not giving blood meant exposure to the risk of catching the HIV virus. The issue of contamination of the blood supply was not important for them until they visualised themselves as possible recipients of a transfusion. The possibility that they personally might be a source of contamination did not occur to them without prompting and, as discussed in the next section, the implication could be both offensive and disconcerting. Again, the overall impact of AIDS on blood donation is that the images it evokes contrast sharply with those of blood donation, in this case with the image of the respectable citizen doing the 'right thing' for the community.

1.1.4 BLOOD TRANSFUSION AND AIDS

The AIDS issue and in particular the contamination of the blood supply by the HIV virus became more salient for respondents when the discussion turned to blood transfusions.

> "The only way it's changed (since AIDS) was to receive blood. That's the only way I connect it. Before you never thought about receiving blood - healthy again from getting blood - but instead you've contracted a disease because you got blood."

> "I think the fear's not so much in giving blood but in receiving it - because there have been one or two accidents in hospitals where people have received contaminated blood."

> "There must be a slight risk but a pretty small percentage I would think - because after it's happened once they're really going to tighten up, especially now it's hit the headlines."

> "You wouldn't like to think you went in for an operation, came out and a couple of years later had something else."

The majority felt that there was a risk of contracting AIDS from receiving a blood transfusion although it was thought to be minimal. This link between AIDS and transfusion was much more definite and concrete than the link between AIDS and donating. Similar findings emerged from the quantitative research (Section 2.3). 45% of respondents felt that it was very or quite likely that you could catch the AIDS virus from receiving a blood transfusion (12% and 33% respectively) with only 17% saying it was not at all likely. In contrast only 19% had felt it was very or quite likely one could catch AIDS from donating blood.

However, the dangers from transfusions were felt to be decreasing. Respondents argued that in the past blood had not been adequately tested for AIDS but that since about 1985 there had been a marked improvement in the situation, with the introduction of efficient testing and heat treatment.

The current procedures were seen to be very effective, if not 100% foolproof. Knowledge of the 'window' - the gap between blood being contaminated and the HIV antibody showing up in tests - was patchy. Paradoxically, however, despite their great faith in the testing procedures, most respondents retained a conviction that blood transfusions continue to carry a risk of HIV infection.

> "The chance of catching AIDS through a blood transfusion is negligible now, I think, especially because years ago blood didn't get tested."
>
> "I would say anyone that's had a blood transfusion before 1985 should go and be tested for HIV because they have reason to be worried."

Interestingly, despite the risk, respondents said that they would still accept a transfusion because the direct personal benefits from receiving blood would outweigh the negligible risks - "it's better than dying." This contrasts with donating blood, where, if a risk was perceived at all, overcoming the fear would mean taking a personal risk with negligible direct personal benefits.

> "I think if it was life or death you'd have to go for a transfusion."
>
> "If you're going to die for want of blood and even contaminated blood would get you stitched up and see you for another five or six years ... so you're still winning."
>
> "It's just a chance, if you're dying - you've been in a car accident, you're given blood - you don't say anything, just have to take what you get given."

Furthermore, there was some feeling that even if the blood was contaminated and one caught the HIV virus, one might still not develop the full symptoms of AIDS.

> "You don't get a blood transfusion unless you need it and the situation is if you don't take it you're going to die anyway, and if you catch AIDS the chances are you might not die. There are a lot of people walking about that are HIV positive but aren't going to die."

It was also suggested that while one might not refuse blood in a life or death situation, blood might not need to be given as freely as before.

> "Not a serious case like that (major operation) - maybe if they're getting just a couple of pints of blood they could have a long slow recuperation (instead of blood) like they did in the old days."

Awareness about the transfusion/AIDS issue was closely linked by respondents to media coverage in this area. It was recognised that much reporting was sensationalising isolated 'horror' stories but nevertheless these were very vivid. Haemophiliacs contracting AIDS were most frequently mentioned.

> "Still a case a few months back - someone caught AIDS even although the news sort of went round - haemophiliac."

> "The stories you read in the paper which I think is really horrific - very small children - the haemophiliacs through getting blood with AIDS - it's really sad."

> "Look at all those haemophiliacs that have got AIDS and people aren't wanting them in school with their children and nobody wants to be branded as an AIDS carrier."

A few thought this publicity reflected badly on the BTS but the majority were more philosophical, lumping it with other risks of medical and surgical intervention.

> "It will always happen - someone could go into hospital for an operation and something completely unrelated to the operation could happen. It shouldn't stop other people coming in."

> "They say 1 in say 100,000 will slip through and it's unfortunate for the person who gets that 1 in 100,000 pints ... nowadays it's so negligible it's foolish (to worry about catching AIDS from transfusions) and it's really just ignorance - people are ignorant of the facts and really they're afraid."

Respondents recognised that the source of HIV contamination of blood for transfusions was from donors giving infected blood, that is by 'bad blood' 'getting through.' Perhaps inevitably in view of the very negative perceptions of AIDS discussed in Section 1.1.2, these infected donors were always assumed to be 'other' people.

Typically, imported US blood was mentioned most readily in this context, especially in relation to the blood factors given to haemophiliacs. It was commonly thought that all donations in America were paid for which was in itself an emotive issue for many donors. It was felt that this had attracted unsatisfactory and unhealthy donors, including drug addicts and that some people would donate whether or not they had AIDS, as long as they received their money. However, this was seen to be a problem of the past and Britain was no longer thought to be importing blood.

> "I think they overcame that - that was American blood - but the original idea stayed in the mind, that there was contaminated blood coming across from America. The information should be projected that this has all been solved - no contaminated blood can be given."

> "When it first came out it was from America and I feel they were doing it because they were selling their blood. It could be these ones, even if they knew they had it, they could be selling their blood ..."

Infected domestic donations were also mentioned. Initially they were seen to come from donors who were completely unaware of the fact that they might be carriers. Again this was felt to have been more prominent in the past, when AIDS had received less publicity and risk behaviour was less widely known about.

> "They wouldn't have known (that they were at risk of being carriers). I mean this was before AIDS came out."

However, while initially describing past accidental contamination in relatively tolerant terms, it subsequently became clear that perceptions were less sympathetic. As already mentioned homosexuals and drug addicts predominate in people's perceptions of AIDS carriers, both in the past and in the present. Therefore, contamination of the blood supply was seen to derive from these categories, whose lifestyles were perceived as degenerate. Such lifestyles were remote from 'ordinary' people and often distrusted and disliked to varying degrees. Thus even if contamination had been unintentional it was viewed in pejorative terms as a further example of the irresponsible behaviour of 'others' and very remote from 'ordinary' people.

Subsequent discussions revealed a recognition that indeed some people might donate blood knowing that they had been at risk of catching the HIV virus or even after they had been diagnosed as carrying it. Such people were seen to be irrationally trying to 'get back' at society in some way, psychotics and prostitutes being mentioned. Such behaviour was given excessive publicity by media as 'horror stories' and was actually felt to be very rare.

Thus blame for contamination of the blood supply was readily assigned to 'others.' The idea that they might donate HIV contaminated blood had never occurred to most respondents, and often relatively deep probing or overt prompting was necessary before it was considered.

For most the suggestion that their blood might be a source of contamination was deeply resented as well as arousing dormant fears. As noted in Section 1.1.2, HIV infection was seen to carry with it not only appalling physical and social consequences but also offensive connotations about lifestyle and personal morality. Thus the image of the HIV carrier contrasts sharply with most peoples' self image. More specifically, and of greater concern to the SNBTS, it is particularly dissonant with their image as blood donors.

As already noted, fundamental rewards for giving blood include the strong feelings of generously doing the 'right thing' for the community and receiving its grateful thanks. The imputation of HIV infection by SNBTS negates such warm rewarding feelings, reducing the strength of the motivating factors. Furthermore, donors prefer to disregard it, and thus avoid considering whether their blood could be a contamination source.

In summary, a risk of contracting AIDS from blood transfusions was perceived and with a more concrete link than in relation to blood donation. It was, however, perceived as a minimal risk and much reduced since 1985 with the introduction of routing testing.

Sources of contamination were always assumed to be 'others,' without acknowledgement that an infected donor could be like themselves. Earlier incidents of recipient infection were attributed to imported blood, collected from paid donors, in particular drug addicts, although this danger was seen to be past. Homosexuals and drug addicts predominate in perceptions of HIV carriers and were therefore seen as the main source of contamination. These were seen as minority groups, with different lifestyles and often disliked and distrusted. Prompting to consider a personal risk implied an association with these 'at risk' lifestyles which were viewed pejoratively. This could arouse negative reactions of resentment and otherwise dormant fears, emotions which contrast sharply with the warm positive feelings which normally act as rewards for donors. However, in normal circumstances, without overt prompting respondents were unlikely to consider the possibility that they personally could contaminate the blood supply, indicating a potential for the donation of HIV blood by those in less prominent risk groups.

1.2 PERCEPTIONS OF SNBTS RESPONSE TO AIDS

The SNBTS strategies are analysed under three main headings:

- Pre-donation procedures (1.2.1)
- Post-donation procedures (1.2.2)
- SNBTS publicity (1.2.3)

1.2.1 PRE-DONATION PROCEDURES

Current SNBTS practice involves a two stage defence against the donation of HIV infected blood:

(i) Pre-session: when they are invited to the next session, current donors are sent information about the conditions which would make donations unacceptable. These conditions include a range of AIDS risk categories. This information provides the opportunity to self-eliminate without attending a session and without being required to give an explanation.

(ii) At the session, prior to donating: all potential donors are asked to read a similar checklist detailing conditions which preclude donating, again including AIDS. They are asked to sign a form to confirm that they have read it. This process may also be supplemented by varying levels of personal questioning by staff. Again, the opportunity for self-elimination is provided, or alternatively, having read the check-list the potential donor might question staff about some aspect of his own suitability and be rejected as a result.

At both stages SNBTS relies heavily on the donor's sense of responsibility in considering the exclusion categories in relation to himself. It is the potential donor's initiative in deciding not to give blood, rather than any staff activity, that is the main defence against the donation of contaminated blood. Therefore his reactions to the information provided by SNBTS and the way he uses it are of prime importance.

Both pre-session and pre-donation material have many similarities, with both including some form of checklist which has a section on AIDS. Consequently reactions to both sets of material were often similar. However, they comprise separate approaches and so this section will discuss the two screening stages separately; first covering the pre-session checklist and second the pre-donation checklist.

(i) Pre-session checklist

Material is sent to existing donors prior to their next session. This includes explanations about relevant aspects of donating blood, and lists the conditions for which donation is unacceptable, including AIDS. In the Glasgow based area this is an integral part of the computerised call-up letter and in the Edinburgh and Aberdeen based areas, this information is on a separate sheet sent together with their invitation.

In theory this strategy enables unsuitable potential donors to self-eliminate before attending a session. There is no requirement to reveal the reason for not donating, and so embarrassment should be negligible. Apart from the minimal possibility of peer criticism for not giving blood again there is no risk of external censure. To be effective, however, this strategy does require the donor to confront himself with the possibility of his personal risk of AIDS, and this is clearly problematic (as described in Section 1.1.4 above).

There was only very limited awareness of any pre-session material concerning AIDS. When asked if they had seen any such material only a minority mentioned receiving 'something' with their session appointments. Furthermore, for those remembering it, recall was vague and uncertain - '<u>only</u> the stuff with your appointment.'

> "You usually get a wee ticket in about AIDS (with the call-up reminder) but it's the same thing all the time. Just a square thing - white paper thing."
>
> "You get it when it comes through the post - it usually has something to do with AIDS."

Even when shown the material its AIDS content was not widely recognised, although respondents showed high awareness of receiving call-up reminders and responded favourably to such invitations.

The idea of sending out AIDS information in this way was considered acceptable although the response was generally luke warm rather than enthusiastic. There was some acknowledgement of SNBTS intention, in that it was seen that it might make it more likely for people to assess their own eligibility and would avoid embarrassment at a session.

> "They're trying no' to isolate the AIDS cases so I suppose it's to try and nae embarrass them as well. Warning them (AIDS cases) not to bother coming if they're going to get embarrassed. I suppose it could turn into a nasty situation - the boy could turn round and say 'Are you accusing me of having AIDS'."

One lapsed donor even suggested sending such information to homes as a screening strategy, thus indicating that he had not previously noticed such material, although it is possible that he had not been sent one since his last lapsed donation.

> "You get all this mail through that the next (SNBTS) Unit will be in this area ... they should put something in with that, telling you all the facts, for all it would cost."

Two drawbacks were occasionally mentioned. Firstly, the AIDS material could suffer the fate of other unsolicited information - 'junk mail' - and be thrown away without being read.

> "If a leaflet comes through my door I'd just crunch it up, put it in the bin."

> "You don't look at it - normally put it in the bucket."

Secondly, there was felt to be a danger that sending AIDS-related material to named individuals at their personal address, could be interpreted as a direct implication that they were an AIDS contact. The current material was not felt to be doing this but it is clearly a potential problem that requires monitoring.

More important than these isolated objections, however, is the apparent inefficacy of the material to encourage self-elimination. Interestingly it was seen to have the potential to do this. Self-elimination would indeed be easier at home rather than at a session, where there was more time to think, and less likelihood of embarrassment.

> "If you get a letter with 'dos and don'ts' you've more chance of changing your mind sitting in your own home than you have sitting in a queue waiting to give a pint of blood."

However for several reasons this potential is unlikely to be fulfilled. First, as noted in Section 1.1.1, many factors are weighed in the decision to give blood, and physical suitability is only one of them. Second, the weighing process is based on common sense rather than by reference to literature. It was something one 'just knows about.'

> "You usually ken beforehand - don't bother going if take tablets, etc."

Thus, donors' perceptions of their physical suitability depend on how they feel and on current illnesses such as colds or the 'flu, rather than on their medical history or past contacts. For example if they felt unwell or tired on the session day they would not go.

Thirdly, consideration of their physical suitability was in terms of whether they felt able to give blood, not whether their blood would cause contamination. The latter issue did not seem to occur to them in general terms, and as already noted it certainly did not occur to them in relation to AIDS.

Reactions to the content of the pre-session material were similar to those for the session pre-donation check-list. This is discussed in more detail below and in the publicity section (1.2.3). To reduce repetition, the relevant points are highlighted here:

- overall, the material was seen as familiar to donors and thus only received a cursory glance

> "I dinnae look at it. I've read it once."

- specifically, respondents tended to distance themselves from the AIDS material, seeing it as irrelevant to them and were thus even less likely to read that specific section in detail.

- as with other SNBTS AIDS-related material the balance was seen to be wrong, with an emphasis on negative factors rather than highlighting the need for individuals to give blood or giving reassurance that there was no risk to donors from AIDS.

> "Its all pretty negative. If they're sending it out to folk there's nothing saying 'come and give blood.' Its all 'don't do this, don't do that' or 'if you haven't done this or you haven't done that."

In summary, respondents reacted positively to the invitation aspect of the mail-out, but had little reaction to the screening material, notably distancing themselves from the AIDS sections. The low impact meant that it did not give offence but for most respondents it was not an effective prompt to consider whether they personally might contaminate the blood supply. The decision whether or not to attend a particular session was influenced by a variety of factors, with SNBTS AIDS-related literature having negligible salience. Furthermore, consideration of physical suitability to donate was in terms of whether they felt able to give blood, not whether their blood would cause contamination.

(ii) Pre-donation checklist

All donors are asked to read a checklist prior to giving blood. It lists a variety of conditions SNBTS need to know about, with a substantial part containing relevant information about AIDS, including specific exclusion categories. Donors are required to sign a form to say they have read this information. This is the second line of defence against the donation of HIV virus contaminated blood and again in theory it enables unsuitable donors to self-eliminate. It also aims to encourage requests for clarification by donors with any doubts, which might in turn result in rejection.

This section discusses response to the pre-donation checklist, with particular reference to the issue of AIDS. It starts by examining awareness and acceptability of the checklist, in particular its primary role of facilitating the self-elimination or rejection of unsuitable donors. It then assesses the feasibility and achievement of this role. Detailed response to the layout and design of the checklist is covered in Section 1.2.3 concerning BTS publicity.

Awareness and acceptability. Awareness of the pre-donation checklist was higher than for the pre-session list. Many could recall it spontaneously, that is before a copy of the checklist was shown. When it was revealed all donors recognised it and most were able to remember specific references both to general health and to AIDS. They were also aware that donors had to sign a form saying they had read the checklist although this was not prominent in their recall of procedures.

Furthermore, the purpose of the checklist - to assess the suitability of donors - was also familiar. More specifically the BTS was seen to have two motives: firstly, to ensure that giving blood would not be detrimental to the donor's health (for the donor's benefit), and secondly, preventing contamination of the blood supply (for the benefit of SNBTS and ultimately the recipient). The checklist was seen to help achieve these aims by either encouraging self-elimination or by enabling BTS staff to reject unsuitable donors.

> "It might not be healthy for you to give blood if you have certain diseases ... obviously if someone goes and they take iron from a chronic anaemic ... they can't take blood off somebody who has a haemoglobin of 9 - it'll come down to 6."

> "They're trying to eliminate people in high risk areas, drug addicts, homosexuals, prostitutes."

> "In case you're carrying any disease and you pass it on to someone else - obviously they don't want you to be giving your blood away if it's bad and poison someone else with it."

In objective terms it was felt that both motives were equally important, and that the SNBTS cared about the donors' welfare as well as the purity of the blood.

> "I think they are just as concerned that taking blood off you is going to make you unhealthy as they are taking blood off you if you're going to make other people unhealthy."

However, from the donors' perspective their own welfare took precedence in deciding eligibility and as already discussed this was considered using common sense prior to the session. Consequently the pre-donation questioning seemed acceptable if rather tedious - 'a necessary evil.'

Further probing into the purpose of the checklist, focusing on the AIDS section, led to suggestions that it was designed to save the BTS time and bother in testing and eliminating contaminated blood.

> "Avoid wasting time - if they think they have AIDS - in any of these categories - leave now."

> "Save time and money."

> "I think they need to rely on the donor's honesty at first to save time. There's lots of different tests it all goes through once it's been collected."

> "That means handling infected blood, that's what they're trying to avoid."

> "Maybe so they won't have all the bother."

The checklist was also thought to provide a safety net, since although the blood is tested routinely nothing could be 100% effective all the time.

> "You can't guarantee that any process can be absolutely 100% - there's always a chance of some mistake or human error or failure of equipment to allow an affected sample to be taken at all. It reduces the risks."

However, knowledge of the major reason for listing the AIDS risk categories on the checklist, namely that HIV antibodies cannot be detected for some time after the initial contamination with the virus, was limited and patchy. At a spontaneous level, this was mentioned in only a minority of groups, and then not always with detailed knowledge; for example, 'its something to do with the antibodies' and imprecise knowledge of the length of the time-lag. Knowledge of the effectiveness of testing is discussed below in more detail in Section 1.2.2.

> "There can be a time-lag between someone being infected and antibodies developing in the blood stream."

> "I think it's all tested anyway - the only way they couldn't test it - they say there's an incubation period where it doesnae show up - say a man went with a prostitute and two days later he went to give blood. It wouldnae show up until a month later say .... That's where they've really got to rely on donors' honesty."

When prompted, more donors were aware of this factor but again not in detail, and many were surprised when they read the relevant paragraph in the leaflet 'AIDS and blood transfusion.' Even those aware of the time-lag factor did not readily associate this problem with the contamination issue.

Lack of awareness of the 'time-lag' factor was also illustrated by the suggestion to avoid donating contaminated blood by having a regular blood test. This suggestion was made fairly frequently.

> "It may be easier to get all the blood tested. Make it that you have to go to your doctor and get your blood tested every year and then if you're found to be positive then you're banned from giving blood and that's it."

> "Have a testing room as part of the donor centre, where they can say 'Anything you're unsure about - been to foreign countries recently - pop in and have a wee test before you give blood.' That way ... you can go up to the donor centre - say 'Well, the coach is coming next week, can I get my test'."

Interestingly the absence of knowledge about the specific problem for SNBTS, namely the time-lag factor, did not reduce the perceived acceptability of the checklist, nor understanding of its primary purpose of screening donations by stimulating and facilitating self-elimination and rejection by BTS staff. However, this recognition was expressed in objective terms, and as discussed above, donors were unlikely to see screening as relating to themselves personally even though it was generally acceptable for 'others.'

> "I dare say there are some who have got it and don't know that they've got it and that's how when you go you're getting screened for AIDS."

> "Only by asking questions at the beginning (can you discourage 'at risk' donors). 'Read that chart - do you fall into any of these categories, tick them off if you do' - so someone who's a homosexual ticks it off. The decision then has to be made by the people at the Blood Transfusion Unit - 'do we accept or don't we' - but it comes back to the point that you have to ask questions at the beginning."

Feasibility. At a rational level respondents were aware that it would be sensible not to give blood if they were not healthy enough themselves or if any contaminants in their blood would affect the recipient. However, for the majority this was clearly a more emotive subject than it might first appear.

As in our previous research, before the prominence of AIDS, there were some underlying feelings of unhappiness at being turned away for whatever reason once they had made the effort to attend the session. Even if the reasons were logically understood, it was still an uncomfortable feeling to be considered in some way not good enough to participate in the warm atmosphere of a session and to be thought to have blood that was defective. This was exacerbated by the fact that the rejection would be observed by many others in the room, often family, neighbours or workmates, who would typically watch closely because they had nothing else to occupy them while they waited for their turn. One donor described it as similar to being turned down once one had worked up the courage to ask someone to dance.

Respondents' embarrassment at the thought of being turned away again highlighted their preoccupation with self rather than with the quality of blood for the recipient.

Thus for many, once they attend a session they are unwilling to reconsider whether they are suitable to give blood and as discussed above, might not read the screening checklist in any detail for this reason.

> "Once you're there you're going to give blood anyway. Once you're there you wouldnae go up, read this and think 'I'm not giving blood.' I wouldnae think so."

Since the AIDS issue has gained prominence there has been an escalation of the potential for embarrassment from having to leave a session without giving blood. The concern, real or imagined, is that if one is asked to leave a session everyone present will assume it is because one has AIDS. Even if this assumption is only made in joke form it could be very distressing to the individual involved. Again this is exacerbated by being readily observed, often by people one knew.

> "I'd be embarrassed ... because you'd think everyone would be looking at you, wondering what kind of disease you've got - moving away from you."

The older age groups were less likely to be affected by this, showing a tendency to be 'sensible' about being turned away in general.

> "They explain why they turn you away. They give you an explanation - 'It's because you have a cold and we will accept blood from you after your cold is finished'."

The older age groups were also less likely to be conscious of the possibility of being thought to have AIDS and did not think it was an assumption they would make if they saw anyone else being turned away. They were aware of the many reasons for which potential donors might leave including a wide range of 'acceptable' illnesses one might have together with feelings of squeamishness or fear, much like having second thoughts and leaving a dentist's waiting room.

> "I wouldn't particularly say someone who got up and walked out had got AIDS. It could be anything - just plain fright and so 'Och no, we'll no bother'."

By contrast, the under 25s were more prone to the perception that other people waiting and watching would assume that AIDS was the reason for being turned away or walking out, probably reflecting their sexual lifestyles and their greater awareness of the risks of their being in contact with AIDS. Thus, the majority of the following comments about potential embarrassment relate to younger people, although it should be noted that by no means all young people were sensitive to this issue. As noted earlier AIDS and blood donation were not readily connected.

> "People are always going to think the worst, especially nowadays, with everybody being hysterical over AIDS and hepatitis B."

For many the embarrassment was anticipated rather than actually experienced.

> "Right enough, if you've got something on that list and got turned away it would be embarrassing right enough."
>
> "If you say 'no' to a couple of questions you're walking out with a brown envelope in your hand."

However, there were first-hand examples of feeling embarrassed and reports of others being teased for having been rejected.

> "I went just after an operation ... and I had a word with the doctor and she came out and said 'It's too soon, come back next time,' and I was that embarrassed. I just got up and walked out ... you feel that size ... St.Vincent Street's pretty busy and they can't always hear what you've just been told. They wouldn't know that (ie. rejected because of operation) and you're walking back out again, and they're watching you."
>
> "There was a girl at work. She was on tablets for an ulcer (and was rejected). They said, 'Aye, aye, you've been with a prostitute and everybody went ... ken ... she was right into the room (before rejection)."

For some, however, it was not so serious.

> "They don't usually make such a big deal out of it - (not) 'She can't give blood - police escort - big matron'."

As noted in our previous research the organisation of sessions contributed to the degree of embarrassment. For example, attention was drawn to rejected donors by their having to follow a different route from the normal progression from waiting area to screening area to donation area. Frequently this meant leaving by the 'In' door rather than the 'Out' door.

> "There's a set route you follow and if you deviate from that route then everybody's got the accusing finger right at you saying 'What's he been doing'."
>
> "That's the worse thing, it's right in the middle of the car park so everybody can see you walking out if you get rejected ... you go in one door and if you're giving blood you've got to go right through the whole bus so you come out the back door. But folk that get turned away just go straight out the door they came in - (laughs) 'something wrong with him, something wrong with her, I'd rather not meet her up the town'."

The often crowded conditions exacerbated the problem, leading to a lack of privacy.

> "If she says 'Have you got AIDS,' and you say 'Oh yes' - that's it - the bus is cleared - it's quite public."
>
> "On the mobile buses it's quite public - there's folk on each side of you sitting giving blood, so if there was anything wrong with you there's no way they could tell you confidentially - and if they drag you to one side somebody's going to say, 'Well there must be something wrong with him'."

Lack of privacy also made it difficult to ask questions without attracting attention.

> "It would be quite noticeable if you were just to sort of say 'Sister, can I have a word with you,' I'd say that would be noticeable."

In many session settings, for example the mobile bus or a community hall, the problem of privacy is hard to overcome. However, contrary to suggestions prior to the research, donor centres did not seem to be substantially better for avoiding embarrassment. Although privacy might be easier to provide it would still mean leaving the recognised routes. The alternative of setting a room aside for asking questions in private (as described at Laurieston Place, Edinburgh) was seen to have drawbacks.

> "The impression you get is 'Alright if I go into this room there's going to be a big light flashes up on the ceiling that says 'The next person that walks out of this door has got AIDS'."
>
> "If she (the nurse) was able to answer your questions straight away then there wouldn't be an embarrassment. Because you've asked the question, you've got the answer, and you've not had to sneak off to a back room with a doctor standing four feet behind you with a pair of rubber gloves on or whatever. You've got to cut down the embarrassment factor."

One solution to the routing and privacy problem appeared to be for donors to be taken individually for screening into a room with a closed door and then to leave that room by different doors depending on whether they were accepted or rejected. This would greatly reduce the number of waiting onlookers that would realise blood had not been given.

> "Certainly closing all the areas off and sending you through one at a time through the corridor might be an idea."

An alternative strategy that donors themselves might employ was suggested by a number of respondents. This was the possibility of giving staff an alternative 'acceptable' reason for not giving blood other than being in one of the seven AIDS risk categories.

> "If you went and read that (1-7 AIDS categories) and you thought 'Oh Aye' (I'm in this) then you would say 'Oh by the way, I've been in contact with measles' (laughter), I mean that's what they would do. There's no way they would pop up and say 'Oh, wait a minute, I've got AIDS'."

If this strategy was adopted it would fulfil the purpose of the checklist since ultimately the donation would not be given.

Thus, anticipation of embarrassment from possibly having to leave a session without giving blood had some salience in the attitude of some respondents towards attending a session. This might interact with other potential areas of embarrassment such as fainting or 'making a fool of ones self,' as well as other fears about donation, thus increasing the negative balance against donation, making some donors less likely to return.

Even in isolation, anticipation of embarrassment about being found unsuitable to give blood at a session, enhanced by the AIDS issue, could be strong enough to reduce donation levels. On the one hand, both new or current donors might decide not to attend a session at all and thus avoid any potential embarrassment. On the other hand, people might be less willing to attend with friends or workmates, in case they are seen being turned away and the 'worst' is suspected. This would greatly diminish the influence of group pressure and support to attend a session, weakening what is for many one of the strongest factors encouraging them to donate.

> "People that haven't given blood before, if they're in doubt at all about what the sifting process is, who they take and don't take, then I'd think 'Well I'm not going with any of my mates, that's for sure, in case I get turned away,' and they'd probably get put off going at all because of the embarrassment that they'd face if somebody says 'Sorry, but you're too high risk' and, you think 'God I'm going to die'."

> "Nothing more embarrassing than when
> you're going in with your pals and you
> get kicked - turned away."

Thus the ultimate purpose of the checklist was understood to be the encouragement of inappropriate donors to self-eliminate. However, as we have seen this strategy is very problematic. Detailed response to the checklist suggests that it would not succeed in this direction.

Achievement. There was a clear tendency for donors to merely skim over all the categories in the checklist, just giving them a cursory glance, seeing it as an automatic part of the donating process. Similar reactions were observed in the previous research (1). A number of factors contributed to this:

- Decision to donate already made: potential donors felt that they had already considered whether they were eligible to give blood as part of the decision to attend the session. They would not have come if they had had any doubts. The form of this decision making may well be suspect. It would, for example, involve a number of interacting factors as well as physical eligibility, and even in considering physical eligibility the donor's own welfare is likely to take precedence over any considerations of the recipient. Nonetheless, it militated against the use of the checklist as part of making the decision whether or not to donate.

  > "You usually ken beforehand - don't
  > bother going if you're taking tablets,
  > etc."

- Dislike of rejection: as discussed above donors find the idea of rejection, for whatever reason, unpleasant and embarrassing. Perhaps not surprisingly therefore, there is a reluctance to participate in it with any enthusiasm. They simply don't want to contemplate it.

- Session organisation: in some situations attempts to streamline the session organisation discouraged detailed reading with donors being moved on from stage to stage quite quickly. This was generally not a complaint as donors preferred not to be kept waiting at different stages.

> "They ask you questions like, if you have different diseases, prick your finger to get a sample of your blood, and then they put you on a table and dig a thing into your arm and that's you."

> "It just depends, if it's really busy, it really is like a factory. You come in, go up to the desk 'Hello, my name is ... I want to give blood.' 'Fill in this.' You go away, sit down, you hand it in. 'Sit across here.' You all go in. 'Have you been anywhere nasty in the last 5 years? Have you done anything nasty in the last 5 years - stick your thumb out'."

> "When you sit down you speak to the woman and you're supposed to look at the bits and she's working away at your ear at the time."

> "The nurse is onto the second question before you've answered the first, it's really quite quick."

- Too much information: the checklist was felt to include a lot of information making it difficult to absorb quickly.

> "I think it's a lot to take in at a glance when you come."

> "Every time you go there's more stuff on the card."

The bulk of material was especially overwhelming for first-time donors who would be dazed and preoccupied by their anxiety about actually giving blood.

> "You've just psyched yourself up to give blood and the next moment you're hit with all these questions."

> "I think especially because first time they're just glimpsing it - they're not actually reading it."

> "When I went for my first time to give blood they gave me this form to fill in - she says 'Can you fill that in' and I looked at it - big line of questions. What's all this? What diseases have you had? Had that? Had that? Millions of it ... I thought is it this hard to give blood, this big line of questions."

> "I can see someone going in and hit with all this ... 'All I'm trying to do is be a good citizen and I'm getting 20 questions - so I'll not be back'."

- Familiarity breeds contempt: conversely, however, regular donors may skim over the material simply because it was so familiar to them. Some donors admitted this, without any feeling of having been irresponsible.

> "I dinnae bother to read it. It's just the same. I come in and it's the same thing, as soon as you see the first three lines you say 'Oh it's the same as the last time'."

> "Aye that's the first time I've read through in detail (when shown the list at the discussion group). I've skimmed through it though."

Further indications that they had not read the checklist in detail were shown by the expressions of surprise at the content when reading it at the group discussion. Frequently, for example, people said they had not seen HGV or PSV drivers listed before and loss of weight was also noted with surprise. As one very regular donor said.

> "There didn't seem to be so many the last time."

Reactions to the AIDS section of the checklist reflected all the above points, with an exaggeration of some of the effects. For example, AIDS information was even less likely to prompt a reconsideration of the decision to donate and rejection was more difficult to contemplate if it was felt that everyone at the session would assume one was leaving because of an AIDS-related illness. Additional factors also came into play. Responses tended to change as the discussions progressed and respondents were asked to consider the checklist in greater depth than they normally did at a donor session.

Initially, respondents tended to distance themselves from the AIDS material. This was apparent in all age groups but was more noticeable for over 25 year-olds. Because they felt AIDS was not a factor in their lifestyle they felt it was nothing to do with them and there was therefore no need for them to read it.

> "That bit, you don't read it at all, that doesn't concern you, you just don't read it at all."
>
> "But the average person, none of that would affect them at all - you ken what you've been doing, you ken wha you've been with - I reckon the majority of that is unimportant to the average person."
>
> "I think we just have a natural reluctance to look at it and read it.... First of all there's so much to look at and secondly my mind tends to close up when anyone says 'Have you had sex with a man in 1977.' It doesn't mean anything to you."

In part this reflected a common reaction to 'switch off' when people come in contact with any material related to AIDS. A feeling of media overkill about the topic was fairly general.

> " ... at the end of the day you're saying 'O God, not that again, I'm fed up with looking at this'."

In the normal circumstances of the donor session, therefore, respondents seemed to have simply ignored the AIDS section of the checklist

Interestingly the cursory treatment given to the AIDS questions and to the check list as a whole did not appear to be affected by the requirement to sign a form confirming that these had been read. This was simply a routine part of the donation process.

> "You sign your name when you're getting yon needle in your ear."
>
> "Just sign at the bottom - just nod and go in."

When the moderator of one group pointed out that most members appeared not to have read the list, despite signing to that effect, the response was:

> "Och, you know - I think it's pretty safe to say ... items 1-7 there, you know you don't qualify there, you know you haven't got AIDS."

Most donors did not appear to consider any legal implications from signing such a document, and were willing to do so as part of the routine whether or not they had read the AIDS section in detail.

There was occasional discussion about the possibility of prosecution but this was for giving contaminated blood rather than for making a false declaration. Some respondents wondered whether legal action could be taken as a deterrent but did not know what the charges could be. This was expressed in remote terms with no evidence of personal concern that they might have made a false declaration.

> "I don't think there's anything they can do, it's totally up to them (ie. the individual) isn't it."

> "I think prosecution's a good idea because if they've been diagnosed with the AIDS virus, obviously they know they've got it, so you've got to prosecute these people if they try to give blood."

There were also a few isolated reports of prosecution of a donor in England who had given blood on more than one occasion, knowing he had AIDS.

> "Can they prosecute them. I saw somewhere if you did give it and you kent you had it and you were found out. I think I saw it in the press."

Although the AIDS section of the checklist is largely ignored in the donor session, the research gave us the opportunity to press respondents into considering it in greater detail. Initial reaction to this was uncertain. For example, some respondents were inclined to deny any risk from AIDS to themselves, although further probing produced the admission that they were at least technically at risk.

Others raised the problem of genuinely not knowing if one was at risk when that risk was as a result of AIDS contact at the secondary or 'nth' degree of sexual contact.

> "If you don't know yourself how can you tell them. Your boy friend or your husband might not know. It could be someone that he slept with that slept with someone else."

> "There's some of these groups that you wouldn't have known - I mean you could have been with someone, see how it says even on a single occasion - now you could have just been somewhere and met someone and thought he was an alright guy - I mean you don't know whether they're in this group."

In addition, there was some underlying suggestion that the possible donation of contaminated blood would be less serious in some way if one had answered in good faith that one was not in the risk group - 'an innocent party.'

> "Say the likes of us went and had been with another partner like that - now you wouldnae know if there was a risk but if they're screening the blood there shouldnae be any danger - you could be an innocent party."

There was also a tendency to reinterpret the categories, incorporating perceptions of a hierarchy of risk in relation to AIDS (see Section 1.1.2). Thus, while respondents would acknowledge the need to exclude the high risk groups, it was seen as less important for the low risk categories - namely 'nth' level heterosexual contacts.

> "If you're not sure .... you see some of the things you know definitely. If you've been sharing needles with somebody else you are in a very high risk group, but if you say, had a South African girl friend in the last ten years, then you think 'Oh what the hell, I'll give blood'."

Continued discussion about the risk categories often elicited one of two rationalisations. On the one hand it was put forward that the blood would be tested anyway and so it was not important to think about the risk categories. Some even thought that the thumbprick test performed this function, although most understood its real purpose.

> "Well if they (ie. AIDS carriers) do (ie. give blood without knowing they were AIDS contaminated) the blood's tested, so even if they do go up, the BTS should still say 'That's virus infected blood'."

On the other hand, it was rationalised that if SNBTS strictly enforced the categories, especially item 7, then only a minority would be eligible to donate and SNBTS would have an insufficient supply. Following the latter line of thought they then felt able to make a judgement on behalf of SNBTS that it was more important to maintain an adequate blood supply than to totally exclude donors with a low risk of contaminating the supply. Both rationalisations are clearly not consistent with SNBTS policy.

Further probing, asking respondents to look at the AIDS material in more detail and relating it to people like themselves began to generate negative reactions because it was seen to imply that they were at risk from AIDS. As has already been discussed such implications arouse a mixture of anger, resentment and personal vulnerability.

Thus some respondents were offended by the questions on the checklist. Clearly this is a very sensitive issue. People are generally critical of the lifestyles of AIDS victims and if donors interpreted the questions as implying that they themselves were carriers they would resent such a judgement (Section 1.1.4). Furthermore, they could be sensitive to a feeling of interrogation, of cross-examination about one's intimate lifestyle.

> "When you're given the card to read it's probably the only time in your normal existence that you're asked if you have got AIDS."

Being confronted by the possibility of being AIDS carriers by reading the AIDS checklist could also induce feelings of personal vulnerability. Being forced to consider the issue was an unpleasant experience, especially for those whose lifestyles did indeed put them on the fringes of the lower levels of the risk hierarchy, ie. being vulnerable through having had sexual contact with a partner whose previous sexual history is unknown.

> "They're not annoying, they just put people off. They cast big doubts on your past. I think - 'Well I'm not sure about that girl's past or whatever'."
>
> "You've been with more than one girl hopefully since 1977, so that does put the frighteners on you a wee bit."

These negative reactions of anger and vulnerability were perceived as potentially greater for first-time donors, already dazed from other procedures and preoccupied by the imminent prospect of giving blood. However this projection of negative reactions onto first-time donors might be a reflection of the strength of feelings held by current donors.

> "I think it would put a lot of people off though - first timers, they come along and see this ... and especially folk at 18 and 19 years do as well."
>
> "If it's like that for people who give blood regularly then it must be a deterrent for non-donors, mustn't it - obviously something thats offensive."
>
> " ... then the nurse is at you and asking you all the same questions again. It's quite a wee bit intimidating - a wee bit heavy going, you think 'All I was in here for was to give a pint of blood, I havnae got all of this bloody stuff - what the hell are they picking on me for?"

It is important to remember that, as already noted, raising negative emotions by deeper probing into the donor's risk of being an AIDS carrier conflicts strongly with the warm, positive feelings about blood donation normally held by donors. Two main strategies for resolving the resulting dissonance emerged. One was to not read the checklist at all, as happens now, but for more definite reasons. The second was not to give blood again in order to avoid having to think about the possibility of AIDS.

> "I think if people started to think as deeply as that they'd get paranoid and just wouldn't give at all."

In summary, therefore, respondents were aware of the pre-donation checklist, and its purpose of encouraging and facilitating the self-elimination or rejection of unsuitable donors whether because of AIDS or for other reasons. They also accepted this purpose as necessary and even desirable.

However it also seems to be a very difficult purpose to fulfil. There are many barriers to self-elimination and inviting rejection generally and these are more marked for AIDS. Consequently, at present the checklist, and especially the AIDS sub-section, are given only cursory attention. The need to sign an acknowledgement form makes little difference to this.

Furthermore, if in the interests of preventing HIV contamination of the blood supply, this disinterest is overcome the results can be counter-productive. In the groups interviews, for example, respondents were pressed to consider the AIDS question in detail and at a more personal level and this caused resentment. People found the implication of AIDS risk intrusive, offensive and threatening. It is also particularly dissonant with the emotional rewards of giving blood. This puts the SNBTS in a difficult predicament. On the one hand low key enquiries about the HIV status of potential donors are likely to be ignored, on the other hand more overt approaches are likely to offend and even drive away donors.

1.2.2 POST-DONATION PROCEDURES

Once the donation has been made, the primary SNBTS strategy for preventing HIV contamination of the blood supply is laboratory testing. This testing procedure was not very important to donors, probably reflecting two factors. First, donors are inclined to hand their blood over to the SNBTS and think no more about it. They are not greatly interested in what happens to it thereafter (Section 1.1.1). Second, they tend not to contemplate the possibility that their blood is substandard or diseased (Section 1.1.4).

Respondents' disinterest in the testing procedure is reflected in a lack of knowledge and understanding about it.

The majority of respondents were aware that a wide range of tests including one for the HIV virus is applied to donated blood before it is considered suitable for transfusion.

> "The blood must surely go away to some lab to test for all these different -, well, whatever diseases you get from blood. They must test for everything that you get."

When asked which diseases were tested for, most people tended to say 'everything,' although a few were able to give more detailed responses.

> "To tell if there's jaundice, measles, AIDS virus - there's a variety of diseases I've never ever heard of that they check the blood for - and maybe use the blood then for research - they don't always pour it down the sink - work away with it, whatever they do with it."

Continued discussion, and in particular prompting with the checklist and the SNBTS leaflet 'AIDS and Blood Transfusion,' revealed further gaps in knowledge (Section 1.2.3). The post-donation testing for AIDS was clearly new information for some people. Others were unclear about what tests were carried out and a minority claimed that they did not know for certain that any tests were carried out and had only assumed that they were.

> "You've got to have a test now for HIV?"
>
> "I don't think anybody knows what happens once that bloods come out of you, where it goes. It must go through a complicated process, but you don't know what happens to that blood once it leaves you. I don't think anyone knows what happens to it before it goes into that other person."
>
> "You're never really told what tests are carried out and what they test for. It's just a sort of vicious rumour that's going about that blood is tested for AIDS ... It'd be silly if it isn't but they've never actually turned round and said ... Even if the nurse was to sit there and say 'Right, well once you've given your blood it'll be tested for this, that and the next thing'."

Thus respondents often asked for further information about the testing, in particular what the tests were for. However, it should be noted that in social advertising research respondents often ask for more information about a topic, but, unless it relates to their own personal needs, they are generally unlikely to utilise such information when it is provided, at least in a leaflet format. For example, in both the current and previous survey, respondents often asked for further information about uses of blood even though leaflets were available and on display.

There was further confusion in relation to the timing and nature of the test. The majority seemed clear that it was some sort of laboratory test and some were able to describe the collecting of samples at the donation point.

> "Usually put some of blood in a separate small tube that goes down to the lab - double labelled."

However as noted in the previous section, some erroneously thought that the test on the drop of blood obtained prior to donation, for example by thumb-prick or ear prick, was sufficient to test for all diseases, including AIDS, and not just for anaemia.

> "They take blood before you actually give it to test if you've got AIDS or not."

Some respondents advocated pre-session testing, feeling it would solve the problem of the donation of contaminated blood, for example, by calling in at a donor centre or attending their GP. Such suggestions show lack of awareness of any technical limitations, in particular the time-lag in the ability to detect the HIV virus mentioned below.

> "They send you a letter and say 'It's been six months since you last gave blood.' Send you maybe a letter in five and a half months saying 'It's been five and a half months since you last gave blood, pop in, have your AIDS test and you can give blood in a couple of weeks or however long the test takes'."

> "Instead of answering a questionnaire it's your own GP who knows what's going on."
>
> "You could go and have your test in the morning, if you were working in town, then go back and give blood in the afternoon, provided everything was alright."

There was also uncertainty about the effectiveness of testing.

Initially respondents tended to claim that the post-donation testing was completely effective. Indeed, this perception was often used as rationalisation for not considering the AIDS section on the checklist. For some, however, this seemed to be a matter of hope rather than fact, apparently reflecting concern about themselves as future recipients rather than considering current recipients.

> "I should certainly hope they're almost foolproof."
>
> "Especially if you're a blood donor, you can never be sure that one day you're not going to be in need of blood and you want to feel safe, not only giving it but receiving."

Further probing showed that some felt there had been inadequacies in screening in the past. There was, for example, fairly common awareness that people had contracted the AIDS virus from blood products and transfusions, notably haemophiliacs and children, and so clearly it was not foolproof. Effectiveness was now felt to have improved however. There was a general assumption that techniques had been gradually improving over time, and the year 1985 received frequent mention as a milestone (the year when testing of all donations was introduced) although often without clear understanding of why that year was significant.

> "Aye, it's originally slipped through. I don't know if it's still slipping through, but you don't expect it to slip through now. They must obviously - the test they've got - they've got pretty good machinery. I don't see any danger."

Subsequently some respondents expressed the opinion that the testing might still not be fully effective. They argued that it was impossible to guarantee any procedure because there will always be some form of error, either mechanical or human.

> "You can't guarantee that any process can be absolutely 100% - there's always a chance of some mistake or human error or failure of equipment to allow an affected sample to get through. If it's cut out at source by not being taken at all it reduces the risk."

Finally, awareness that it was not totally successful was deduced from the fact that the pre-donation questions would not be asked if they could test effectively.

> "It can't be 100% otherwise they wouldn't say 'Oh, don't come and give blood if you've done such and such and been such and such places' - so the testing methods can't be 100%."

The main reason that there is a potential for the blood supply to be contaminated in spite of laboratory testing is that an individual might donate at an early stage of infection before they have formed antibodies to the virus. The test detects antibodies rather than the virus and if insufficient antibodies have formed, the test might give a negative result.

There was some awareness of this at a spontaneous level, although it was by no means common (see Section 1.2.1). Even for those who were aware of the issue it was not always clearly linked conceptually to the contamination of the blood supply.

> "I don't think the screening process detects the virus itself - am I right. There can be a time-lag between someone being infected and antibodies developing in the blood stream."
>
> "A few weeks or something at the beginning when someone has contracted the disease and it doesn't show up - until a further stage."
>
> "It does get tested. It gets tested but they ..., say you just caught it yesterday, I think there's an incubation. It lies for a month and it doesn't show up so if you caught it within that week and you gave blood the next day, that month it doesn't show up. That's what they were saying - it's the only way that it could be contaminated now, because everyone is tested."

Estimates of the length of the time-lag ranged from a few weeks or a month, as above, to three months and even five years, the latter reflecting confusion with the length of time for the development of symptoms of the AIDS syndrome.

> "They'd probably have to start doing it every three months. There was something on the telly the other night and the guy there said something about a blood test for everyone and he said it would be impossible because they'd have to do it every three months and it would cost so many million pounds, because of the incubation period they couldn't find it in your blood for the first three and after that if you giving at six monthly periods."
>
> "But takes 5 years to develop - how can they tell there and then."

However, more significantly, when prompted, in particular with the 'AIDS and Blood Transfusion' leaflet, information about the time-lag was clearly new for a substantial proportion of respondents and others needed to clarify their previously vague perceptions.

The testing of blood was therefore a low key and rather vague procedure for most respondents. Nonetheless, a number of attitudes to it emerged. These can be divided into advantages and disadvantages.

Taking the advantages first, at a very general level, knowledge of testing boosted the positive images of BTS as a caring organisation that was acting responsibly to do the maximum possible to avoid contamination of the blood supply, notably by the HIV virus. This was seen to be for the benefit of recipients in general, but a priority in respondents minds was for themselves and their families as potential recipients.

A further benefit perceived by many donors was that testing provided them with a 'clean bill of health.' As already described (Section 1.1.1), some donors perceived this to be a motivating factor, acting as a reassuring health check. (Others reacted negatively to the prospect, preferring not to find out about illness - see below.) Where testing was a motivating force it was generally at a secondary level, acting in combination with others, rather than being the sole reason for deciding to donate. Most people did not appear to have had specific worries or perceptions that they actually were ill or that the tests would show any abnormalities.

Nonetheless, the fact that SNBTS had found their blood to be healthy, thus 'certifying' it to be 'up to standard' and acceptable, was reassuring. Furthermore, it could act as a subtle accolade for the donor, giving a sense of superiority - in particular after repeated donations - as well as increasing warmth towards BTS as the source and reinforcement of that feeling of superiority.

Attitudes towards testing tended to become more extreme in relation to the emotive issue of AIDS.

For many it was felt to be a bonus to be able to feel that they were not infected because they had not heard anything from SNBTS after giving blood. This was expressed in terms of it being 'in the back of everyone's mind' that they might have AIDS, and that it was a relief not to have received notification.

> "I don't think it would be off-putting - I think it would be in their favour in a way - it must be at the back of everybody's mind - they think OK well whatever they've done in the past few years - they could have caught the virus and they don't know about it and you won't know about it until something like this happens and you're giving blood or the doctor and they're doing some test on it ..."
>
> "If you've had a test for your blood and then you've given blood, then just the fact you're carrying a blood donor's card must mean you're alright."

Furthermore, the experience of having repeatedly given blood and not being found to have the HIV virus seemed to give an extra reassurance to some that they were clear of AIDS, almost to the point that they felt they could not be touched by the syndrome. Again, passing the test could act as an accolade, making them different from the general public and, by implication, superior. Following this logic, some felt it was less important to consider the AIDS section on the checklist if one had been repeatedly found to be clear.

> "If you keep on getting clean bills of health then it reassures you."
>
> "Well we've all given blood more than one time and we're healthy so we must be pretty sure that items 1-7 we don't need to bother with much."

By implication it would appear that such respondents must have had some reason for having this worry 'at the back of their minds.' Thus it is possible that they were at some level of risk of being carriers of the HIV virus and so strictly speaking should not have given blood according to SNBTS criteria.

> "I think it's a bonus in a way because at least it clears your mind - Oh I haven't got it, that's fine, I'm clear .. Because everybody must ..."

However there was no guilt expressed or censure from other group members, perhaps reflecting the concept of risk hierarchy and that some levels of risk are perceived to be markedly less important than others. Indeed for some, donating blood, and hence allowing testing, was given virtuous overtones, since if one found out that one was AIDS positive one would be able to avoid affecting others. This view was without consideration of the potential risk to the recipient of the blood.

> "Surely they'd want to find out to save spreading it to other folk."
>
> "I've been out with girls - know that I mean ... my own satisfaction - then I would know to stay away from kids etc - ignorance could spread it on."
>
> "I think personally - that's being selfish (to being frightened of testing). If you didn't know you could pass it on to someone else, but by the same token to know that you're actually going to die but you feel quite healthy at the moment - and then at some point in the future you are actually going to go through the process of dying."

Occasionally giving blood was seen as a means of being tested for AIDS for those who had specific reason for concern. However, this was expressed in hypothetical terms, with no evidence that respondents actually behaved in this way or knew anyone who would do so.

> "If I thought I had a chance of AIDS I'd go and give blood to find out if I thought I had it."
>
> "Say you were worried you might have AIDS then one way of checking is going to give a pint of blood."

> "Some folk might think 'I think I've got this disease, I'll go along and give blood. They're bound to find it'."

> "Do you think people would use that so that they could be screened for AIDS without anybody knowing."

> "I think that's likely, a lot of donors that go, go back because they think 'Well, that's another clean bill of health'."

There was awareness of alternative means of being tested if one had personal worries about AIDS rather than using the BTS, primarily through the GP or a 'VD' clinic. However, going for a test in isolation, whatever the location, could be problematic. It would be embarrassing, both in terms of perhaps being seen by others, and having to explain to friends or family where you were going. More emotive would be the fact that in going, one has declared a belief of risk, and the possibility that one might be found to be HIV positive, with all the horrific consequences.

> "You won't go through the hassle of going to get a test because of embarrassment that it causes you going to get one of these tests, because you've got to sneak round all your family, saying 'Oh, I'm just away to the doctors for a severe case of athlete's foot or whatever.' The last thing you want to do is to turn round and tell anybody that you're going to get an AIDS test."

> "They should make it an everyday thing, rather than walking in with black paper bag over your head 'I don't want anybody to see me because I'm going to have my blood tested for AIDS'."

Attending the GP could be embarrassing, both in asking for the test and in potentially receiving a positive result from someone you knew and knew your family. This in spite of the fact that the GP would find out ultimately. It should be noted that, following the reverse reasoning, some respondents preferred the idea of being tested by their GP.

> "It's when they actually say 'go away and see your doctor.' There you go, it's embarrassment again. A lot of people don't want to talk about certain things to the doctor."
>
> "But then again some people might go along because they don't want to go to your doctor - they might want a more impersonal - someone who doesn't know them, rather than their doctor telling them they've got AIDS."
>
> "But a totally anonymous way is to do it this way, at donor sessions."

Attending a VD clinic also had potential for embarrassment, in particular if one was seen going there, but had the further drawback of the image of an unsavoury atmosphere and unpleasant procedures.

> "Some people know that they test for it and they think 'Well, I'm not going to a VD clinic, I'll go to the Blood Transfusion and they'll test me'."
>
> "That's one good thing about it - one of my mates went to the clinic (after going with a women), it was just at the beginning of the campaign - he was a bit naive and they put a tube right down - worst thing he ever had."

Thus there was some feeling that being tested through donation was preferable to the alternatives, although these were hypothetical rather than real considerations.

Some respondents felt that SNBTS should set out to provide a testing service. This was seen to have the benefits of anonymity and an apparent expertise in dealing with blood. Furthermore it was felt that it would provide a better image for the SNBTS as caring for people at risk of AIDS rather than vigorously trying to turn them away. However, the image of possible AIDS victims trouping through a donor centre would probably not be beneficial.

Finally, some respondents cited the existence of testing as a reason for ignoring the checklist. Generally this was a rationalisation as a response to deeper probing about risk group membership - "It's tested anyway" - rather than a conviction they normally felt.

In contrast, there were those who perceived testing to be a disadvantage in relation to giving blood. As described in Section 1.1.1, these reactions could be at both a general level and in relation to AIDS, the latter usually at a greater extreme.

This general negative reaction to the concept of testing had been described in the previous research primarily by non-donors. They would be reluctant to give blood in case 'something' was found to be wrong, without any grounds for feeling this was the case, in terms of symptoms or past contacts. This was often linked to a number of fears in relation to other forms of health screening.

The majority of respondents in this research were donors and had generally overcome these fears and were less likely to be influenced negatively by the testing issue. Thus while there was an appreciation that the prospect of being tested and being found to have AIDS could be daunting, this was not expressed at a personal level in the donor groups. Thus the majority of comments were conjectural, anticipating the reaction of 'others' although they might give some indication of respondents' own subconscious feelings. However, the issue had greater salience in the non-donor and an ex-donor groups.

> "That's quite frightening - you give blood and then you might find you're HIV - is that not enough to put you off?"
>
> "Goes back to what we were discussing - I thought that could be a big reason for not going along - I thought that before - in case you were diagnosed."

For most people this attitude might not be felt at a conscious level or with great strength. However, it might be an additional demotivating factor which alters the balance between giving and not giving blood in a negative direction.

> "I think now you're going to get a certain amount of people scared to give blood in case they find out they've got AIDS."
>
> "I think that the main thing is that people are just scared of finding out what they don't know."

In particular young people were perceived to be relatively more likely to be reluctant to be tested, since their lifestyles were seen to put them at greater risk.

> "That's why a lot of youngsters dinnae want to come along, because they're feart. They're feart they might find out that they've got AIDS."
>
> "I never thought of that. Some people yea - really don't want to know, 20-25 age group, played around, never known about AIDS until the past 1-2 years - scared to go because they're really too scared to find out."

When it was pointed out that AIDS victims were going to find out eventually, the response was that some people would still like to postpone finding out for as long as possible. This was by no means universal and as mentioned above many would prefer to know so that they could act appropriately.

> \- "Because with AIDS you're going to die anyway so they'd rather face it then - instead of being told - it could be another 2 years before they start getting symptoms. But if they're leading a normal happy life and they're going to find out because they've given blood, that's them finding out before they have to."

The other major drawback to the test giving a positive result was problems of confidentiality and the resulting problems experienced in everyday life if one was known to have AIDS.

> "The thing is I might like to know I've got AIDS but I wouldn't like other people to know - you're virtually like a leper when you've got AIDS."

The range of feeling about testing is illustrated by reactions to the concept of notification of a negative result. Initially, the majority were confident that the SNBTS would contact them if any blood defect had been detected, including the AIDS virus. If nothing was heard one was 'clear,' although few people were sure about the whole range of illnesses tested for.

> "Well, if there's nothing wrong with your blood, you don't hear anything at all."
>
> "You just get a letter 6 months later."
>
> "If there's anything wrong with it - if somebody gave a pint of blood and they see they've got an AIDS virus, they must in turn tell the people involved."

Contact was generally thought to be by letter, although there was some uncertainty about whether the letter would suggest contacting the SNBTS or their doctor. A few thought that the donor would not be notified and could continue to donate without realising they had the virus. Some thought that contaminated blood could be screened out but not traced back to the donor.

However, the strength of reaction of those who had given blood only very shortly before they received their introductory letter from the SNBTS about the research was often extreme. Thus underlying fears about testing and the results were apparent even on the part of regular donors who would not normally be subject to such worries. Apart from clearly coming from the SNBTS, many had an AIDS message franked on the stamp by the GPO.

> "I got the fright of my life when that letter arrived because I'd only given it about a week before - not that I'm thinking I had AIDS or anything."
>
> "You usually get the circular that comes round. It's square shaped, but to actually receive a letter in an envelope!"
>
> "I'd not long given blood when that letter came to come here and I went 'Oooh!' (laughter) They're sending me a letter and no-one else in the family had got one."
>
> "We had all gone at the same time to given blood and then mine came back - what have I done? - back to the diary - it makes you think."
>
> "Ken, it was a bit of a shock when I got a letter through the door (ie. the respondent notification letter) two weeks after giving blood (laughs from everybody)."
>
> "Just saw the letter with 'please give blood' and I thought 'Oh, no, there must be something wrong'."

Although there was laughter in the groups when this was mentioned, members sympathised with the reaction which was felt to be perfectly natural. Such fears were not confined to AIDS but related to finding out about almost any ailment. However, the effect of AIDS might, for some, have heightened existing underlying fears of finding out about illness and disease.

> - "If you gave blood and about a week later - you usually hear nothing - you see a letter from the Blood Transfusion, you think 'Oh, God, what's happened?'"
>
> "It's just a natural reaction because you only ever hear if there's something up with you ..."
>
> "... not AIDS but anything else."

In summary, for most respondents post-donation testing was a low key issue and this is reflected in the vagueness in their knowledge. It was felt that donated blood was tested for 'everything' and that testing was nearly foolproof and much improved in recent years. However, knowledge of the difficulty in detecting the HIV antibodies immediately after infection was limited in extent and confused. Even among those aware of the time-lag problem, it was not always connected with the problem of contamination of the blood supply.

Reactions to the concept of testing varied. The majority of donors viewed it favourably. It showed BTS to be doing the maximum possible to ensure recipient safety. Many also reacted positively to being checked for a variety of diseases feeling reassured even if they had had no specific worries. This 'all clear' was seen almost as an accolade, especially after repeated donations, confirming the superiority of the donor. For some the possibility of AIDS was 'at the back of their mind' and the test was seen to be particularly reassuring in this respect. There was isolated mention that giving blood had potential as a means of being tested for the HIV virus. However, this was expressed in hypothetical terms, with no evidence that respondents would actually behave in this way.

In contrast, some respondents, in particular non-donors, reacted negatively to the idea of finding out about an unknown illness, more so with AIDS, and this could be a deterrent to donating blood. However, the alarm expressed by those receiving a letter from SNBTS regarding the research soon after their donation suggests that most people have underlying fears about testing and hearing the results.

1.2.3 SNBTS PUBLICITY

This section examines response to:-

(i) SNBTS general publicity

(ii) SNBTS AIDS-related publicity

(i) SNBTS General Publicity*

Response to the SNBTS general publicity was only examined at a spontaneous level. Respondents were not shown any prompt material but were asked what publicity they had seen and to make general comments about it. Thus, what follows is not a structured analysis of all SNBTS material but sets the context for the main focus of the section, namely AIDS-related SNBTS publicity.

The general feeling, from both donors and non-donors, was that there is a lack of general publicity from the SNBTS and a need for greater visability.

> "Definitely try and advertise it mair."
>
> "People know about giving blood, they just aren't reminded enough of the importance of doing it."

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* It should be noted that all except two of the sixteen groups were conducted prior to the SNBTS TV campaign, launched in March 1988.

Furthermore, if anything, SNBTS media presence was felt to be dwindling. Not much had been seen recently.

> "You used to get advertisements on the TV and magazines but you don't seem to get that nowadays - used to get Noel Edmunds, cup of tea on the table. It seems to have quietened down in the last few years, they haven't publicised it anyway - You used to see posters all over the place, but even thats died down - They send out to their regular customers."
>
> "They had a spell for the TV for a while, publicly advertising on TV: 'Come in and give blood.' You don't see that now."

What had been seen lacked impact and could be ignored.

> "Well, you forget about it. You just go on with your normal everyday life and unless a thing hits you between the eyes you just don't give it a thought."

Comments about specific campaigns covered material in a variety of media, including television, stickers, leaflets, posters, press and radio. These will be discussed in turn.

Television: Respondents most frequently recalled television advertising that featured Noel Edmunds, Sue Barker and the Spinners. These tended to be grouped together conceptually. A Rowan Atkinson commercial, and the latest TV commercial, 'Come Back,' was mentioned less often. No distinction was made between advertising emanating from the Scottish or English NBTS, although it should be remembered that for the 'Come Back' commercial only a minority of respondents had had an opportunity to see the caption.

The Noel Edmunds, Sue Barker and The Spinners advertising was felt to be old-fashioned and lacking in impact.

The personalities were seen to belong to the past, and were sometimes difficult to recognise let alone relate to. The clothes worn, especially by Noel Edmunds, exaggerate the old-fashioned characteristics. Perhaps more importantly, these advertisements have the potential to arouse antagonistic feelings and, apart from Sue Barker, mention of them was often accompanied by groans. Similar comments were made about these commercials in the 1984 report.

> "Aye, there's that one with the <u>really</u> old boys in from Liverpool - can't even remember their names - 1960s stuff."
>
> "The advertising campaign they had before - it sticks in my memory. It was Noel Edmunds and that turned me right off because I cannae stand him - he was just lying there ... 'Oh, switch it off!'"

Because they were 'dated,' the commercials lacked the style of current TV advertising and hence had less credibility. They also added to BTS's image as a 'Cinderella' service, with limited funds.

> "They could do with some new ones."
>
> "Moneywise - they've obviously had to cut back in expenses the same as everybody else."

They were also criticised for under-emphasising the need for blood. Many thought it would be more effective to stress this need rather than other aspects such as 'it's painless' or 'it doesn't take long.'

On the other hand, these more low key issues could be communicated indirectly by showing the session procedures in order to give general reassurance to potential donors. This would also make it possible to show that new needles were used each time, if playing down the risk of AIDS from donation was considered a publicity objective. (As we have discussed already the donors in this study did <u>not</u> see this as an important issue.)

> "If they advertised properly the necessity of giving blood - the amount of blood they collect in and the amount of blood being used. Instead there's this daft advert on television, the caption 'Giving a pint of blood does not make you tired,' a collection of bowler hatted guys doing keep-fit after giving a pint of blood. That does not come across, that does not project the necessity for giving blood."

> "Most of them ... you see fit and healthy people playing tennis and then they rush in and go 'Stick it in me.' Then they come out with their cups of tea thinking 'Well, that was brilliant. That was a wonderful, exciting experience.'"

Finally, reactions to the new SNBTS TV campaign, 'Come Back,' were generally positive. It had been noticed by some memebers of the groups held after the launch date, with fair recall of the content, the catchy tune and lyrics receiving most comment. The message was quite clear.

Stickers: The 'Please Give Blood' stickers had been seen widely.

Leaflets: At this spontaneous level (that is without being prompted with copies of material), few respondents could recall seeing BTS leaflets - whether about general topics or AIDS - at donor sessions. Even those who did recall seeing them had not actually read them. A few remembered receiving 'something through the post' with their call-up letters but it had little impact. Indeed, awareness and the tendency to use leaflets had changed little since our earlier research (1).

Poster, Press and Radio Advertising: Respondents were aware that these media had been used to publicise specific blood donating venues. However, the general feeling was that current advertising of this type was insufficient and should be boosted to achieve a higher profile.

> "In one whole hospital I've only seen one poster - it's white with a heart on it and a blue line - it's just 'Oh, there's a poster.' It's nothing."
>
> "It's just a small ad even for the blood donors, just in the back pages. The kind of pages naebody would look at - just a small ad."
>
> "The last week I read in the paper about this survey you are doing and it had been in Airdrie and it's now going into Coatbridge, and they were saying how low they were getting - that's the first I've seen in any paper. I think they should advertise it a lot more."
>
> "Sometimes you hear it maybe on the radio, there's a blood donor session at such and such."

As well as being insufficiently prominent, information about specific venues and dates was often not publicised early enough.

> "There's never a poster up saying it'll be there next week or maybe in a few days time - it's just there on the day so I suppose if you're passing it's fine and you'll see it and you can go in. But if you're passing and it's going to be somewhere central next week, I would go down."

These remarks tied in with the overall feeling that donating blood should be made more accessible, although this in turn could be, for some, a rationalisation for not 'getting round' to giving blood. These issues are described in more detail in Section 1.1.1.

Respondents' Suggestions

The discussions stimulated a variety of suggestions about publicity. Respondents were concerned about the fall-off in donation and keen to help. However, it should be noted that comments were made without insight into SNBTS specific objectives and targeting and without knowledge of the effectiveness of different types of advertising.

Suggestions included:

- Adopting a negative approach. It was felt by some that inducing guilt and emphasising the dramatic aspects of the need for blood transfusion, such as horrific road accidents, would be a useful approach. Such a strategy is commonly thought by the public to be effective in changing behaviour but in reality proves ineffective. Such extremes tend to be rejected by those whose behaviour one is trying to change. For example, just as smokers can rationalise that not all smokers die of cancer, non-donors can argue that there is always some blood available in an emergency and no-one dies from lack of blood. Thus this approach should be viewed with caution.

> "If you want this campaign to be effective, you've got to get at people's conscience. You've got to make them feel guilty about not giving blood because that's the way they should feel as far as I'm concerned."

> "They keep on acting on it being simple to give blood ... it doesn't take very long, doesn't hurt you and what have you. I think they should strike more at people's conscience, because that's how you'll get them to go along. If you say 'If you don't give blood just think - somebody could die from it' or whatever."

> "If they did something more like the drink drive campaign - you know, a crash and ambulance and people lying about. That would get to you more than just a heart with a blue line through it."

It was also apparent that even those respondents who advocated this approach generally saw it as a means of encouraging others to give blood. The respondents themselves wanted a different, more positive approach. In particular, for current donors, there seems to be the potential for a campaign that promotes the psychological rewards of giving blood - the feelings of doing a good deed, performing one's duty and being 'worthy,' discussed in Section 1.1.1.

- Statistical evidence of the need for blood. Some felt specific details of the quantity of blood needed would have more impact. However, such an approach is again rather negative and merely providing information is not sufficient in itself to modify behaviour.

> "I believe to a certain extent it's the fault of the blood transfusion unit or the medical profession. It's a thing that's not hammered home on television or newspapers - putting forward these statistics - how much is required - what the illnesses are - the injuries."

- Personalising the campaign. One way of being more positive is to link donations with actual recipients and their families concentrating on how they have benefited from donated blood. For example, it should show people who have recovered thanks to blood donations, rather than people who might have suffered through lack of donations. Analogies were made with organ donor campaigns, including Ben on 'That's Life.'

Furthermore, although this aspect was not mentioned by respondents, such an approach would have the advantage of tending to focus attention on recipients, thus increasing awareness of the individual's responsibility to avoid donating contaminated blood and not to just 'hand it over' to the SNBTS. The tendency to 'hand over' a donation was highlighted in Section 1.1.1 and the personalisation strategy is further discussed in Section 3.3.

> "They could put it in their adverts. Instead of going round telling everyone, they could just make a few examples. They could say 'Mrs Bloggs went along, gave her pint of blood. Little did she know on Saturday night Joe Bloggs was driving his car - winds it right round a lamp post and needed the two pints that she'd donated in the last two years,' or whatever."
>
> "If they emphasised more what was going to happen - you could save somebody's life. You just think there's a pint of this blood in this bag - where does it go? You never ever bother to think where it goes, it doesn't occur to you."
>
> "If maybe you got a letter once in a while saying '... the blood that you donated on such and such a day was used to save somebody's life ...' I know it would be a lot of administration but even if it was just a gimmick, disnae have to be true."
>
> "Likes of kidneys and that on TV - this boy would have died without this machine and then they get a kidney and they're better - sliding down the chute - this is what he can do now with a new kidney."
>
> "Like kidney donor cards - no-one carried cards until Ben on 'That's Life.'"

- Appeal to younger people. Comments were made in general terms that publicity should be made more attractive to young people. This partly reflects the negative reactions to the dated TV campaigns discussed above, but also might acknowledge the common belief that donors tend to be young and that starting the habit of donating early tends to make continued donating more likely. However, the AIDS issue confuses this pattern, with young people's lifestyles being more likely to put them 'at risk.'

> "You're trying to aim it at slightly younger people - get like the Skol advert, some sort of good music, pop music - we'll sit and watch it."
>
> "Many of us (in the group) started as youths and I'm wondering if that should be the section of the population that should be recruited. For youngsters bravado helps - competitions we used to have to see which college could give most blood."

- Visualisation of attending a session. This approach was discussed above in the context of the 'personality' TV advertisements. It was felt that such an approach could be useful to help non-donors overcome the 'fear of the unknown.' In the context of AIDS, it might enable it to be made clear that new needles were used each time. For some it was the wrong emphasis and did not focus on the need for blood, the benefits to recipients and the value of donors.

Thus, donors suggestions for publicity approaches ranged from negative scare tactics to more positive approaches, in particular, encouraging awareness of the recipient of a donation and visualisation of donor sessions. The latter positive approaches are likely to have greater success, both in terms of maintaining donor levels and avoiding contamination.

Visualisation of both the recipients and the sessions allows emphasis of the warm feelings many donors experience in relation to blood donation. The former can show duly grateful individuals who have benefited from the generosity of donors; and the latter can illustrate the pleasant atmosphere of a session, with friendly staff and the experience of camaraderie with fellow donors, all acting together to 'do good.'

It has always been important to emphasise these positive themes. Such warm feelings act as strong rewards for many donors and are one of the major factors encouraging continued donation. For those who react positively to such sentiments, their strength can overcome many of the inhibiting factors which might be experienced. Currently it has become more important to boost the strength of the motivating forces, because the influence of the AIDS issue has tended to increase the strength of some demotivating factors, in particular the wide range of AIDS-related fears experienced.

In detail, donation might be encouraged by using the approach of visualising the sessions in order to allay fears about contracting the HIV virus by giving blood. The use of fresh needles for each donor could be highlighted, although caution would be needed in order to avoid raising further needle-related anxieties.

Furthermore, in relation to reducing contamination, visualisation of individual recipients might stimulate greater concern for the potential recipient of one's own blood, reducing the tendency to 'hand over' the donation and encouraging deeper consideration of the risk that one might personally be donating infected blood.

In summary, SNBTS general publicity was seen to be limited and even dwindling in extent, and was lacking in impact. The Noel Edmunds/Spinners series of television commercials were prominent in respondents' perceptions. These were seen to be dated and there was a tendency for the personalities and the approaches used to be irritating. There was low recall of SNBTS leaflets and minimal usage was reported. The overall comments relating to general publicity tended to echo those made in the 1984 research, indicating little perceived improvement in strategy in the past four years.

Among the publicity approaches discussed, the conveying of positive themes rather than negative aspects has a greater potential for success.

Visualisation of donor sessions and actual recipients gives scope for conveying the warm feelings that act as rewards for many donors, thus helping to counteract any increase in the salience of demotivating factors which might be induced by the AIDS issue. Furthermore, visualisation of individual recipients might stimulate a more detailed appraisal of the risk that one might personally contribute contaminated blood to the blood supply.

It should be noted, however, that for the recipients themselves the issue of AIDS was not seen to be important even in the context of publicity, and at a spontaneous level there was no perceived need for it to be mentioned either in terms of risk from donation or contamination of the blood supply.

(ii) SNBTS AIDS-Related Publicity

In response to the advent of the AIDS issue, SNBTS have developed a range of publicity which is intended to make potential donors aware of the problem of AIDS in relation to blood donation, to encourage and enable them to check whether they are in the 'at risk' groups and, ultimately, to discourage donation among those at risk. As discussed in the introduction, however, a small number of sero-positive donors have been identified who subsequently turned out to be members of risk groups as defined by the SNBTS material. This indicates that the current strategies are not completely effective and the suggestion which formed the basis for this research was that the message might not be getting through sufficiently well - people may be unaware or misunderstand the relevant publicity. This section, therefore, focuses on reactions to the material itself.

When first asked whether they had seen any SNBTS publicity about AIDS, most respondents could not recall any. However, it was clear from the discussions that all donors had seen the pre-donation checklists and the majority would have received an information sheet with their invitation letter, both of which address the AIDS issue. Thus it was apparent that this material was not overtly linked with AIDS and consequently was not readily cited as an example of AIDS-related publicity. This reflects the general lack of salience given to the AIDS/blood donation issue by donors and the extent of the process of 'skimming' and 'distancing' described in Section 1.2.1. Spontaneous awareness of other AIDS-related material, in particular the SNBTS leaflet and the post-donation slip, was negligible.

As a result, detailed response to the material could only be obtained by showing examples to respondents. A range of items were used, the most important of these being the pre-donation checklists and pre-session notes, the SNBTS leaflet 'AIDS and Blood Transfusion - a guide to donors,' the post-donation slip and the poster. (Copies of these are contained in Appendix 2.)

Common overall reactions to all the material emerged. These will be discussed first, followed by individual response to the risk categories that appear in the pre-donation and pre-session material, the leaflet, the post-donation slip and the poster.

Overall reactions: Respondents did not spontaneously query the purpose of the material in the discussions, tending to see it as merely part of the general range of communications to donors from SNBTS. Furthermore, since it was immediately clear that the material was related to AIDS in some way, it was not seen to be anything to do with them personally. They preferred to feel that AIDS was not an issue that affected them and so initially the items were discussed in remote objective terms.

When prompted to read and discuss the material, perceptions of the objectives were in line with SNBTS intentions of giving information about the types of people who were 'at risk' from AIDS and urging potential donors not to donate if they came within these groups. There was little confusion about the purpose and these aims were accepted in general terms.

Thus at a rational level, the material appeared to contain all that was needed to prevent contaminated donations, in that it gave the necessary information and asked for appropriate action. However, the research has revealed a wide range of negative attitudes in relation to AIDS and AIDS-related aspects of donation, all of which tend to act as conceptual barriers, militating against effective use of the material.

As described in relation to the pre-donation procedures (Section 1.2.1), when respondents were prompted to consider the material in detail, an initial inclination was to distance themselves from it, perceiving it to be aimed at 'others.' They were most reluctant to consider any personal risk from AIDS and thus be exposed to all the subsequent horrific consequences and indeed many rejected the possibility out of hand.

Further probing aroused a variety of negative emotions, primarily resentment and fear. In particular, the concept of AIDS was extremely dissonant with their perceptions of blood donation and themselves as blood donors doing the 'right thing.' To avoid these dissonant feelings there was again a tendency to skim over or ignore the material.

Four other factors contributed to this tendency to disregard the AIDS publicity; first, the decision whether or not to donate is often subject to a variety of influences, among which the systematic use of SNBTS literature has minimal salience; second, having decided to donate, donors are reluctant to reconsider; third, the prospect of self-elimination or rejection is unattractive, in particular because of the potential for embarrassment; finally, perceived familiarity with the information together with the assumption that it is personally irrelevant also lead to a tendency to skim over the material without considering it in detail.

Overall then, respondents did not want <u>any</u> AIDS-related donation publicity that targeted them and when confronted by the SNBTS material were very reluctant to identify with it. This suggests that effective communication of the message and the consequent elimination of potentially contaminated donors is going to be problematic in whatever format.

In the group discussions we were able to overcome people's inclination to ignore the material. Detailed response revealed five criticisms. First, none of the publicity makes it clear why certain groups of the population should not donate blood - namely, that it is difficult to detect the virus in the early stages of infection. As noted above this was new information to many people (Section 1.2.2). The pre-session and pre-donation notes and the poster list the high risk groups simply stating that these people should not give blood. Even in the leaflet 'AIDS and Blood Transfusion,' which does mention the difficulty of early detection, this is not clearly linked to the statements about people who should not give blood, the latter being further on in the text and on another page (see below). Consequently when asked why the SNBTS used the pre-donation checklist, respondents were more likely to argue that it was to save money, time and bother in testing and eliminating contaminated blood, rather than that the laboratory test could not be guaranteed (Section 1.2.1).

This explanation as to why 'at risk' groups should not donate is important because it helps legitimise the screening process, and encourage people to consider the possibility that they personally might contaminate the blood supply. As one respondent said in relation to the SNBTS leaflet, "I suppose if you read that first (the time-lag information) you'd pay more attention to what's going on." Furthermore, without this explanation, the bald statement 'AIDS - people who must not give blood' followed by the seven risk categories, appears cold and dictatorial and does not encourage co-operation.

The 1986 NBTS/DHSS leaflet 'AIDS - what you must know before you give blood' addresses the issue clearly and directly, stating that '... the test may not pick up early cases of infection. That is why people who may have been exposed to the virus ... must not go to donor sessions ....' It is important to remember, however, that this information should be presented within a positive context in order to minimise the raising of doubts about receiving transfusions.

The second criticism was that the material is discouraging rather than encouraging. It emphasises the idea of <u>not</u> giving blood rather than promoting donation. It concentrates on defining undesirable donors without bolstering the image of 'desirable' donors. At the very least this represents a lost opportunity for the SNBTS.

> "I don't like it - 'if you're healthy come and give blood. If you're not healthy, dinnae bother'."

> "It's pretty difficult to discourage wrong folk and then get the right folk. You can't really do that in the one advert. Having the positive and negative sides of blood on the one thing. It cancels each other out even though it's not meant to. When you see 'come along but not if' then it gives all the various terms, or whatever, it's bound to put folk off a bit. Wouldn't think it would put off folk that have already given. Just folk that would be thinking about going or maybe hadn't even thought about going and seen the advert and just given it a swerve."
>
> "Use publicity to encourage folk to go along not to discourage."
>
> "Then they've got 'please remember we need you' at the very bottom (laughs). Lucky if you're gonae read that far."

Furthermore, this emphasis questions the acceptability of donors' blood and their suitability as donors. In particular it conflicts with the image of donors being solid citizens doing the right thing for society. There was a tendency to feel slightly confused and resentful at this interference with their motivation to donate. This reaction applies to the screening material as a whole but is exaggerated in relation to the more sensitive AIDS issue, in particular as many people's perceptions are that the groups most at risk of AIDS are social minorities leading unsavoury lifestyles with which they do not expect to be associated.

The third criticism was that the material is very negative and hence is unattractive to consider. It leads people to think about the consequences of HIV infection, which is clearly threatening. It contains personal and intrusive questions which the majority would not normally consider. It also firmly links AIDS and blood donation; either confirming and reinforcing existing emotional links or introducing the connection to those unaware of it.

> "Gives you the idea 'Can I catch AIDS being a blood donor.' You've got the big heading AIDS, so naturally you associate it with a blood donor."
>
> "It's just bringing AIDS into the whole subject of blood donating more, which - they should keep out of it."

Although there are some positive elements in the material, for example, reassurance that one cannot get AIDS from donating blood, SNBTS concern for the safety of donors and guidance about what to do if one is worried about AIDS, these are outweighed by the great bulk of the negative messages.

> "I suppose you don't really think about them together unless they did promote it (the AIDS issue), which I don't suppose would do them much good if they did. It wouldn't do the blood donor service much good, if they started promoting it like that."
>
> "I don't think you'll be able to change people's attitude about being scared at finding out what they've got, by advertising, because there's no real way around it. They can't turn round and say 'Right, we're not going to test anyone so you won't have to find out the bad news until something falls off or whatever'."

The fourth criticism was that from the donor's perspective, the material emphasises the wrong aspect of AIDS. As discussed in Section 1.1.3, if donors had any concern about AIDS it was whether giving blood put them at risk of contracting the virus. It was only when considering transfusions that the issue of contamination of the blood supply had salience for them. This reflected donors' preoccupation with themselves rather than the recipient of potentially contaminated blood. Thus while they would prefer not to consider the AIDS issue at all, if they had to do so it was felt that the greatest emphasis should be on the lack of risk for donors. In most of the material such reassurance, if given, was confined to a single sentence and given little prominence

> "I think the headlines are wrong - I would have in big black letters - in red - DONORS CANNOT CATCH AIDS FROM GIVING BLOOD. Then underneath you simply say 'do not give blood if you are the following ...' and list all these things. I would have in red the positive side. They've put the negative approach first and the positive last. I would turn that round."

Hence the material was criticised for putting too much emphasis on contamination which was not perceived to be relevant to them.

> "All this is is a leaflet telling you what AIDS is and how you can get it. It's nothing to do with blood donation. It doesn't tell you anything about blood donation. All that's telling you about is AIDS."

Finally, the layout of the material, in particular the pre-session and pre-donation checklists, was felt to isolate the AIDS message from all the other information. For example, it is often separated from the rest of the text, perhaps on a different page or put to the end and given a disproportionate amount of print, relative to mention of other topics or diseases.

For a minority of respondents this was considered to be a rather illiberal approach. The under 25 year-olds were more sensitised to the topic, being more aware of the issues and generally more likely to be involved in behaviour that could put them at risk. The feeling was that AIDS is now part of everyday life, and that it should not be sensationalised. The current treatment was felt to reflect and encourage societal judgement by separating out the 'normal' illnesses versus AIDS (by implication 'abnormal').

> "Then on the back page, as you turn over, as you're about to think you're safe, you get hit with the quick 7 one-liners. 'Must not give blood' stamped underneath it, whereas on the other page you look at it and it's got all sorts of things - treated for high blood pressure, jaundice or hepatitis, or been abroad in a malaria country or anything like that. That's perfectly acceptable, but anything to do with the AIDS business is treated as being one of the guilty few that's been up to something that they shouldn't have."

> "See there. They've put that on a big separate page. They've got 'Health Checks for Donors,' then right on the back page in a sort of dirty, sly way, they've got that separate."

Apart from being offensive to some, it was clearly an approach which would reduce the effect of the message for the great majority who saw themselves as remote from the issue anyway. The layout matched their perceptions that those at risk were isolated and different from 'ordinary' people. Furthermore, the physical separation made it easier to ignore the AIDS information.

Risk Categories 1-7: A list of seven high risk categories appears on a variety of SNBTS material, notably the pre-session and pre-donation checklists (see Appendix 2). Detailed reactions to the information are discussed here, and overall reactions to the checklists and the way they are used are described above (Section 1.2.1).

Initially this was seen by respondents as familiar information. As already mentioned, familiarity and a tendency to distance oneself from anything related to AIDS, meant this section was usually skimmed over. (Section 1.2.1)

Encouragement to read and discuss the section in the group discussions showed that respondents were aware of the major risk categories (Section 1.1.2). Thus, categories 1-3 and 6 were seen to be self-explanatory and appropriate, namely, anyone who has the AIDS virus, is a homosexual, drug user or is/has been a prostitute, should not give blood.

> "You can't really argue with it."

However, some queried the reasoning behind highlighting prostitutes rather than sexually promiscuous people in general, and tended to automatically reinterpret the section to include anyone sleeping with a large number of partners.

> "It says, any man or woman whose been a prostitute at any time since 1977. You don't have to be a prostitute to sleep with 60 boys or 60 women or whatever, so why are they saying a prostitute. OK, they're probably a high risk but anybody can sleep about."

Despite their apparent familiarity with the list, continued probing revealed a degree of uncertainty about specific details in it.

Some questioned why the year 1977 was a cut-off point. (Categories 2, 4, 5, 6.) This was earlier than many people's perceptions of the outbreak of AIDS and appeared to be almost pulled out of the air.

> "It seems to be the magic year."

Others were unsure of the significance of Africa, south of the Sahara. (Category 4.) There was awareness that AIDS was thought to have originated in Africa, but there was some scepticism about the importance of this category. In addition, some misinterpreted it and thought it applied to everyone who had been in these areas at all rather than those who had had sexual intercourse there. Others queried why other areas where AIDS was thought to be widespread were not included, for example, Haiti and New York.

There was also uncertainty as to why those receiving blood products regularly are excluded. (Category 5.) This ruling conflicted with the experience of some respondents who came into this category or knew of someone who did, but was still being allowed to donate blood.

> "That would be me then (had an operation) and I still give blood."

Some did not know what was meant by blood products and felt there should be a further explanation, for example, whether it related to having a transfusion or being given drugs?

> "They could explain what blood products were without taking up too much space."

Others reacted critically to the implication that blood products were not always safe and could contaminate the recipient's blood.

> "I suppose the one about blood products is a bit of a worry because that's putting themselves down. I suppose it depends if they're producing the blood products or if it's meaning chemicals or whatever."
>
> "I like number 5 - anyone who has been treated with blood products - shows they've no' got any faith in their stuff."

However, the most widespread uncertainty was caused by the list's apparent disregard of any hierarchy of risk from AIDS. As noted in Section 1.1.2 respondents believed there were different degrees of risk. In the context of the SNBTS list, for example, most respondents were convinced that categories 1-3 and 6 were at much higher risk than categories 4, 5 and, especially, 7. Consequently they couldn't understand why categories 1-7 were all 'lumped together.'

Category 7 was particularly problematic as it raised the issue of transmission via partner, partner's partner, and so on. As discussed in Section 1.1.2, if AIDS could be passed on down through a long chain of partners, then category 7 was one which could potentially exclude anyone who had ever had sex in the last decade, hence eliminating a large proportion of the population.

> "It says here sexual partners of people in these groups, this includes regular relationships - you could look at that and say well I haven't been with a man who has had sex with another man or been with a drug abuser or a haemophiliac or someone whose ever lived in Africa but it could be somebody whose been with someone - a drug abuser - it doesn't really put ... I think there's some people who would look at that and say 'Right - I'm alright, I've ticked them all off and I'm fine.' They don't put down - you <u>could</u> have been with someone."

Thus, it was felt that more clarification of category 7 was required - at what degree of doubt should one not donate? There is a need to acknowledge the problems of knowing the sexual history of one's partner or one's partner's partners, in particular as far back at 1977.

> "If you are a heterosexual and gone out with a couple of girls in the last year or two which for just about most guys it will be - will the BTS want our blood ... Under 25's basically shouldn't be giving blood."

> "I think the worry is that it goes back a long way - it's conceivable that someone had forgotten they had had sex with someone in Africa in 1977 - 10-11 years ago."

> "I think a lot of the time people wouldn't actually know who they were having sex with - if you believe in casual sex then you don't really know who you're sleeping with - for all you know they could be a drug addict and you're only meeting them for a one night stand."

> "I think there's a lot of people, they go out or they go on holiday and they meet someone they don't know anything about them and they sleep with them - I mean how do you know?"

As discussed above (Section 1.2.1) there was a tendency for respondents to dismiss Category 7 as a 'catch-all' used by SNBTS to give the appearance that they are taking all the proper precautions. Consequently it was possible to feel that it need not be considered on a personal level. A further rationalisation was that if adhered to it would exclude so many potential donors that SNBTS would be dramatically under supplied. It was felt that this was not desirable and so where Section 7 suggested only a remote possibility it was felt that it could be ignored.

Finally, before leaving the risk categories it should be remembered that in normal circumstances at the donor sessions these categories are largely ignored. In the interviews we were able to push respondents into detailed and personal discussion of them. As noted in Section 1.2.1 this often caused feelings of fear and resentment.

<u>'AIDS and Blood Transfusion - A Guide for Blood Donors'</u>: Respondents were not aware of this SNBTS leaflet at a spontaneous level and when shown copies recognition was negligible. Thus response is at a prompted level, stimulated by this first sight of the material. A copy is shown in Appendix 2.

First impressions conveyed by the leaflet were off-putting. The use of large elongated capital letters and the dimensions of the leaflet made it similar to Government AIDS publicity. This suggested it would say nothing new.

The prominence of the word 'AIDS' would exacerbate any embarrassment at being seen to pick up and look at a leaflet on this topic.

> "You'd be feart to pick that up, in case people think 'I wonder what she's looking at that for?' (laughs)."
>
> "I think people would be too embarrassed - like they're in a doctors or something - see something on the other side of the room - to go across and pick it up - headlines AIDS."

The deep red front cover was felt by some to be 'rory' or 'gory' and potentially upsetting to people who dislike the sight of blood.

> "Anyone coming in to give blood for the first time - it's blood-red. You're trying to take their mind off it really. You see this blood-red thing - sets your mind off into overtime (ie. red - off-putting)."

Finally, the fact that it was a leaflet reduced its impact reflecting general feelings about this medium.

> "Another leaflet."
>
> "For AIDS? There is a leaflet - where you go for a cup of tea there's a lot of leaflets and you just pick up what you want. I remember seeing them but I don't know what they look like - more interested in getting my tea!"
>
> "... cheap and nasty, that's what you think about them. You walk in, see that, you smile, cheap and nasty. They're telling me the same rubbish all the time, because every leaflet you pick up tells you the same. They're all different sizes and colours and everywhere you look - AIDS - health check."

More detailed consideration of the title revealed two further weaknesses.

First, giving such prominence to AIDS in a blood donating situation was seen to be strongly inadvisable as this would create negative impressions and associations.

> "It's the heading again. It's got AIDS in big letters. Then it says 'A guide for blood donors' - that's linking the two."

Second, the phrase 'and blood transfusion' is redundant as it is not a subject of immediate relevance to donors (see Section 1.1.4). They do not tend to see themselves as giving blood for transfusion, rather they hand over their blood to the SNBTS. Consequently, this did not attract their interest as much as the phrase 'a guide for blood donors'.

Reflecting their preoccupations, respondents tended to rename the leaflet 'a guide for blood donors.' However, this subsequently led to criticism that the title did not reflect the content which was primarily about AIDS and therefore often perceived to be irrelevant to most donors.

> "It's like an information leaflet on AIDS, rather than something for blood donors. 'What is AIDS?' 'How is it spread?'"

Thus the content, in general terms, was felt to include too much background information about AIDS, for example, how AIDS could be caught and passed on. In this sense it was not so much a 'Guide to blood donors' as a guide for 'everyone else.' Furthermore, the material on donation is very negative, and discouraging. The need for and appreciation of donors is given too little emphasis.

> "I think if it's a guide for blood donors it should be everything that happens to your blood and how many lives a year it saves and all that sort of stuff, rather than just about AIDS."

> "Basically that's not a guide for blood donors. That's a guide for people who they think have got AIDS, because when you read through it, the only bit there is that actually affects donors is 'Are all donations tested for the AIDS virus?' Everything else is to do with people who've got AIDS."

> "That leaflet's got nothing to do with blood donors. So there's no point in giving it to them."

The most important AIDS-related information for donors was seen to be that 'You can't get AIDS from donating blood.' The response to this and other sections of the leaflet will now be discussed in detail.

> "I think everybody, although they give blood, there's maybe doubts in the back of their mind that they're not letting come up and I think that should allay those doubts. People should go in and feel safe to give blood."

'What is AIDS?/How is it spread?' Some respondents were against these sections, in particular, being in a 'guide for donors.' It was felt to convey accusatory overtones, implying that such information was more relevant to them than anyone else. In addition, the information was not new - 'we've heard it all before,' 'everybody knows that,' were typical comments. Hence, there was a tendency to 'switch off.' Finally, the presence of so much generalised information detracted from the main messages SNBTS should convey, namely, the reasons why certain groups should not donate and reassurance that there was no risk to donors.

'You cannot get AIDS by giving blood.' This statement was liked as it provides the desired reassurance. If material on AIDS and blood donation is to be produced, this and similar aspects should be its primary emphasis rather than facts about AIDS. It should have a more prominent position and provide a more detailed explanation of why AIDS cannot be caught from giving blood. In the current leaflet this information is confined to a single statement and the reader is left to deduce the reasons from the previous paragraph about the ways in which cross-infection <u>can</u> occur. It does not make clear why cross infection <u>cannot</u> occur as a result of donating blood. In particular, mention should be made of fresh sterile needles and equipment being used for each donor, which was the evidence respondents found most reassuring when they agreed there was no risk of infection (Section 1.1.3).

The 1986 NBTS/DHSS leaflet 'AIDS - what you must know before you give blood,' addresses this issue more obviously. The relevant text is outlined giving emphasis and the explanations are unequivocal and backed up by mention of sterile materials which are only used once. (See Appendix 2.)

> "It (the SNBTS leaflet) doesn't reassure you in any way. It's got four sides in it and you've got one sentence saying you cannot get AIDS by giving blood and the rest of its all about what happens if you do get it or if you have got it when you give blood, etc, etc. It doesn't reassure folk that are going, that they can't get it. As I say, one line. That's about it. I'm sure folk that are thinking about giving blood, if the AIDS aspect does come into it, they're wanting a bit more reassurance, as opposed to what could happen or if they have got it."

> "That's too small - 'you cannot get AIDS by giving blood' - it's in the wrong place."

'Are all donations tested for the AIDS virus?' Although the majority were aware of testing, information about the potential three month time-lag in diagnosing the virus was new to many respondents (Section 1.2.2). After reading this section a few respondents recognised the significance of this information realising that it highlighted the importance of the pre-donation checklist and the need to consider their personal risk of AIDS.

> "At least in that section there it's explaining why they're giving you the list of who must not, so I suppose if you read that first you'd pay more attention to what's going on. (Explains) It says 'although all blood donations are tested for antibodies the test may not pick up early cases of infection,' so I suppose it gives you more reason to read your green sheet."

However, many respondents did not make such a conceptual link. The vital information about the problem of being unable to detect the HIV antibodies at the early stages of contamination was not clearly linked in the text to why certain groups should not donate blood. Indeed, mention of people who must not donate was on the reverse side of the page. Thus, without detailed reading and interpretation, it was not clear why SNBTS could not rely on post-donation tests, and respondents were still asking for information about why it was so important that the 'at risk' groups should not donate given that there was routine testing. In the same way, the text did not clarify why people should not use SNBTS for a blood test if they suspected they had AIDS.

The equivalent paragraph in the 1986 NBTS/DHSS leaflet, 'AIDS - what you must know before you give blood,' covers this more clearly and directly. The following extract illustrates the point '... the test may not pick up early cases of infection. That is why people who may have been exposed to the virus ... must not go to donor sessions, even if they later receive another call-up card. The BTS will not ask people why they do not go.'

'It is vitally important that people who want to know if they have been infected by HIV must NOT DONATE BLOOD to the Transfusion Service.' This single statement with the visual emphasis of larger darker print, contributed markedly to the perceived negative overtones. Stated like this, it tends to raise fears and is unsympathetic. As mentioned above, the leaflet should explain more obviously and clearly why certain people should not donate.

Furthermore, there should be more detailed and sympathetic explanations of what to do if someone wants to know if they have AIDS, and to advise them how they can resolve the doubt.

Post-donation slip: This is given to donors in some areas once they had given blood. It is intended to encourage donors to notify the SNBTS after their donation if they suspect they should not have given blood.

The idea was acceptable and was seen to have some potential value as a thank you note. There was some acknowledgement that it might work as intended.

> "But what about the people who don't know about all this - and then go along and see all this about Africa, say 'I don't want to walk out of here I'll need to just give it' - and then they'll give it - and they'll get this wee thing and they'll say 'we'll give it a wee phone-in'."

However, as a screening measure it was generally not seen to have much effect. The majority of those who were prepared to admit to being at risk would not come to the session. Failing that, they would not have given blood. Alternatively, those who were unwilling to admit a risk prior to donation either to themselves or SNBTS would also be unwilling to formally admit the risk afterwards.

Poster: This suffered from the same weaknesses as the written material, ie. it over-emphasised the negative aspect of AIDS and under-emphasised positive aspects such as encouragement to come along, the need for blood, gratitude for donations, and reassurance that it is safe to give blood.

> "Instead of small print I would have that in red DONORS CANNOT CATCH AIDS BY GIVING BLOOD. Hits you immediately when you go in the door or wherever you give your pint. It's there in front of you that reassurance. That's it - it hammers the point."

In summary, the SNBTS AIDS-related publicity is intended to convey awareness of the contamination problem and prompt consideration of the possibility of personal risk to the point of not donating if one is in one of the risk categories. However, as highlighted in previous sections of the report, there is a wide range of perceptual barriers to personal consideration of risk, and thus effective communication can be problematic whatever the format.

There was low awareness of SNBTS AIDS-related publicity per se. Although respondents were all aware of the pre-donation checklists, these were not strongly linked with the AIDS issue.

There were some weaknesses which were common to all the material, both the pre-session and pre-donation checklists, and the SNBTS leaflet. The overall impression had negative connotations. It was seen to discourage rather than encourage donating, and to be accusatory, casting doubts on the suitability of one's blood. Furthermore, it was seen to encourage distancing from the AIDS issue by separating the material from the 'normal' illnesses. It also failed to emphasise and explain two important points, firstly, the precise nature of the contamination problem, namely the problem of detecting the HIV virus soon after infection and, secondly, the lack of risk for donors for giving blood.

Six of the seven risk categories were generally understood although there was some confusion in that the list did not take into account perceptions of the risk hierarchy, 'lumping' all levels of risk together. However, there was scope for misinterpretation of the seventh category, referring to sexual partners of any of the former risk groups. Although the discussions revealed that many of the respondents had had sexual contact with a number of partners with unknown histories, there was a tendency to dismiss the last category on the one hand as a 'safety net' included by SNBTS as a formality and, on the other hand, as excluding far too many people and therefore not to be taken seriously. Thus there should be acknowledgement of the problems of knowing the sexual history of one's partner(s) and clearer guidance about the degree of doubt at which one should or should not donate.

Thus, the research shows that there is scope for a more positive approach in the material, with modifications of the overall tone and, in particular, emphasis of the most relevant points. In this way the unpalatable information should be conveyed within the most positive context possible.

2.0 QUANTITATIVE RESEARCH

As discussed in the introductory section, the quantitative research was designed to focus on the possibility of there being unfounded worries among the general public that donating blood exposes people to the risk of contracting the HIV virus. It was intended to establish whether or not such fears existed and how extensive they were, and also to compare their salience in relation to other potentially off-putting factors in the area of blood donation. This information would contribute to the assessment of the extent to which AIDS-related fears might be responsible for reduced levels of blood donation. Useful information about the pattern of blood donation in Scotland was also obtained.

The quantitative data were collected using an 'Omnibus' survey. As described in the introduction, 947 respondents were interviewed, forming a sample designed to represent the population of Scotland in terms of age, sex and social class. The sample is shown in detail in Table 3 in the introduction and the questionnaire and computer print-out of findings are given in Appendix 3.

The main findings are divided into three areas:

- The occurrence of donors in the Scottish population (Section 2.1)
- Off-putting aspects of donating blood (Section 2.2)
- Perceived risk of HIV infection from donating and receiving blood in Scotland (Section 2.3)

2.1 THE OCCURRENCE OF DONORS IN THE SCOTTISH POPULATION

Respondents were asked whether or not they had ever donated blood. Those who had were asked when their last donation had been. Responses were then grouped within the following parameters, corresponding to the definitions of donor

TABLE 2.1: PATTERN OF BLOOD DONATION

		Age						Sex		Social Class			
	Total	15-24	25-34	35-44	45-54	55-64	65 +	Male	Female	AB	C1	C2	DE
Base:	976	171	252	177	130	113	133	467	509	103	206	305	362
	%	%	%	%	%	%	%	%	%	%	%	%	%
Current donors (within 2 years)	10	13	16	14	11	2	2	12	8	9	14	13	6
Lapsed donors (2-4 years)	5	5	10	6	6	2	-	5	5	7	4	6	4
Ex-donors (over 4 years)	16	-	15	20	21	17	28	21	12	20	13	14	18
Never donated	67	78	59	59	61	76	66	59	73	57	66	67	70

status used in the qualitative research:

- less than two years ago (current donor)
- two to four years ago (lapsed donor)
- more than four years ago (ex-donor).

Table 2.1 shows that one third of the population have given blood at some time. They comprise 10% current donors, 5% lapsed donors and 16% ex-donors.

These findings are similar to a UK wide survey carried out in 1987 as part of an evaluation of the Government's AIDS advertising (2). In this case, 31% of respondents had given blood before and 9% - 11% were current donors.

Analysis by socio-economic subgroups reveals that although donors come from all sections of society they are most likely to be young, male, and from an ABC1C2 social class background. Thus, the highest incidence of current donors is in the 25-34 years age group and only 2% of 55-64 year-olds continue to donate. Predictably ex-donors are increasingly represented in the older age groups. Similarly, 12% of males are current donors compared with 8% of females and 41% of males have donated at some time, in comparison with 27% of women. Finally, in terms of social class, current donors tend to come from C1 and C2 groups (14% and 13% respectively of these groups being current donors). Those in the AB social classes, however, are more likely to have given blood at some time (43% of this group having given blood at least once). DE groups are least likely to have donated at all (only 30% having donated at some point).

2.2 OFF-PUTTING ASPECTS OF DONATING BLOOD

Respondents were asked whether or not there was anything that put them off the idea of giving blood. This question was asked prior to any mention of the topic of AIDS. The replies were therefore entirely at a spontaneous level with no other prompts being given. More than one aspect could be mentioned.

It should be noted that the question refers to 'off-putting' aspects rather than asking what would actually stop respondents from giving blood. The

TABLE 2.2: OFF-PUTTING ASPECTS ABOUT THE IDEA OF GIVING BLOOD

- TOTAL GROUP AND DONOR STATUS

		Donor Status			
	Total	Current Donor	Lapsed Donor	Ex-Donor	Non-Donor
Base:	976	108	56	157	639
	%	%	%	%	%
Specified off-putting aspects	47	15	37	47	53
Nothing off-putting	32	58	50	30	28
Never bothered/no time/not got round to it	10	1	5	8	12
Never thought of it	5	-	1	1	7
Specified off-putting aspects:					
Any health reasons	20	2	19	20	24
(Poor health/medical reasons except blood disorders)	(9)	(2)	(12)	(10)	(10)
(Anaemic/HBP/other blood disorders)	(7)	(-)	(5)	(5)	(8)
Fear of needles/injections	12	3	6	3	16
Specific mention of dirty needles	1	1	-	2	1
Too old/too young	7	3	2	13	6
Bad experience (personal/hearsay/expected)	5	6	9	7	4
Possibility of catching AIDS	5	1	4	5	6

qualitative part of this research (in particular Section 1.1.1) and previous ARU research (1) showed that donors, as well as non-donors, might find aspects of giving blood off-putting but would still continue to donate if sufficiently motivated.

Table 2.2 shows that almost half of the population (47%) find something off-putting about the idea of giving blood. In contrast 32% have no concerns. A further minority have 'never bothered'/'got no time'/'not got round to it' or 'never thought of it' (10% and 5% respectively).

In a comparison of donor status, current and lapsed donors are most likely to find nothing off-putting about donation (58% and 50% respectively compared with around 30% of ex-donors and non-donors). Conversely and predictably, non-donors are most likely to mention off-putting factors (53%) with former donors also being relatively negative (47% ex-donors, 37% lapsed). By contrast, only 15% of current donors cite off-putting aspects.

At this spontaneous level, the possibility of catching AIDS does not emerge as a major off-putting aspect of donating blood. It is mentioned by only 5% of people. Other factors including donor's health (20%) and fears of needles and injections (12%) are clearly more prominent. These aspects, together with the apathy noted above, had been found to be important demotivating factors in our previous research, and clearly have continuing salience. In the comparable UK study of those who had ever donated but not in the last year, only 1% - 3% cited AIDS as a factor for not donating recently.

Further analysis shows that, while lapsed, ex- and non-donors were increasingly more likely to mention off-putting factors in general, this tendency does not emerge to any significant extent for specific mention of AIDS (4% - 6% for these groups v. 1% current donors). Thus, AIDS does not seem to be an important factor in discouraging either initial or repeated donations.

The main reasons for discontinuing donation appear to be health related, as this off-putting factor is the most prominent one among lapsed and ex-donors (around 20%). Health factors also seem to influence the decision whether or not to start donating, as they are important for non-donors (24%) but fear of

TABLE 2.3: OFF-PUTTING ASPECTS ABOUT THE IDEA OF GIVING BLOOD
– DEMOGRAPHIC SUBGROUP ANALYSIS

		Age						Sex		Social Class			
	Total	15–24	25–34	35–44	45–54	55–64	65 +	Male	Female	AB	C1	C2	DE
Base:	976 %	171 %	252 %	177 %	130 %	113 %	133 %	467 %	509 %	103 %	206 %	305 %	362 %
Specified off-putting aspects	47	46	43	48	44	49	53	38	55	54	45	42	49
No/nothing off-putting	32	34	37	34	31	27	30	38	27	18	35	37	33
Never bothered/no time/ not got round to it	10	9	11	11	13	8	7	11	8	12	13	10	7
<u>Specified off-putting aspects</u>													
Any health reasons	20	10	17	21	31	27	21	11	28	26	19	17	22
(Poor health/medical reasons except blood disorders)	(9)	(5)	(8)	(7)	(11)	(16)	(12)	(6)	(12)	(9)	(8)	(8)	(11)
(Anaemia/HBP/other blood disorders)	(7)	(4)	(4)	(7)	(12)	(9)	(6)	(3)	(10)	(9)	(5)	(5)	(7)
Fear of needles/injections	12	20	18	18	2	6	1	10	13	10	12	13	12
Specific mention of dirty needles	1	1	1	1	1	–	1	1	1	2	1	*	1
Too old/too young	7	6	–	–	1	7	28	8	6	8	6	5	10
Bad experience (personal/ hearsay/expected)	5	5	5	6	5	7	2	5	5	7	4	5	5
Possibility of catching AIDS	5	10	4	6	5	3	2	6	5	4	7	4	6

needles and injections is also significant here (16%), as is apathy (12% 'never bothered,' 7% 'never thought of it').

Finally, in discussing donor status, it is worth noting that although current donors made negligible mention of each of the factors identified, the aspect which was mentioned relatively most frequently related to 'bad experiences' (6%). This serves as an extra reminder to SNBTS that such experiences should be avoided where possible.

Table 2.3 shows further analysis by sex, age and social class. Women are more likely to cite off-putting aspects than men (55% v. 38%) and less likely to say the idea is not off-putting (27% v. 33%). This matches the finding that women are less likely to be donors than men. The major reason for the difference appears to be health, mentioned by 28% of women compared with 11% of men. Mention of fears of needles is only marginally higher for women (13% v. 10%) and other specified factors, including AIDS, show little difference between the sexes.

In terms of age, younger people are marginally more likely to feel that there are no off-putting factors than their older counterparts. There is less variation across the age groups for the specific off-putting factors (43% - 49%).

AIDS-related fears are most prominent for the 15-24 year-old group and least important for the over 55 year-olds (10% v. 3%). The salience in the 15-24 year-old group could indicate a lack of factual knowledge about cross-infection of the virus amongst the younger members of that age group but might also reflect a heightened awareness of the AIDS issue for young people. This tendency is unfortunate since current donors tend to be in the younger age groups.

Of the other aspects, health factors tend to be more important for the older age groups (eg. 10% 15-24 year-olds v. 31% 45-54 year-olds) and fear of needles for the younger age groups (eg. 20% 15-24 year-olds v. 2% 45-54 year-olds).

TABLE 2.4: LIKELIHOOD OF THE PEOPLE IN SCOTLAND CATCHING THE AIDS VIRUS

- TOTAL GROUP AND DONOR STATUS

	Total	Donor Status Current Donor	Lapsed Donor	Ex-Donor	Non-Donor
Base:	976	108	56	157	639
	%	%	%	%	%
<u>From giving blood:</u>					
Very likely (+4)	4	5	-	*	5
Quite likely (+3)	15	2	8	10	19
Not very likely (+2)	27	28	29	27	26
Not at all likely (+1)	48	63	62	56	43
MEAN SCORE	1.74	1.48	1.46	1.52	1.85
<u>From receiving a blood transfusion:</u>					
Very likely (+4)	12	9	4	9	14
Quite likely (+3)	33	12	31	31	37
Not very likely (+2)	37	47	41	37	30
Not at all likely (+1)	17	30	23	19	13
MEAN SCORE	2.42	2.00	2.16	2.31	2.54

The social class distribution shows that AB socio-economic groups are the most negative in their reactions with only 18% saying there were no off-putting factors and 54% specifying something off-putting. The C2 and C1 groups are the most positive, reflecting the pattern of more current donors coming from these groups. Again this pattern seems to be largely explained by variations in perceptions of health related aspects, with 26% of the AB group mentioning this in comparison with 19% and 17% of the C1C2 group. There appears to be little consistent variation between social class groups in reporting of other factors, including AIDS.

2.3 PERCEIVED RISK OF HIV INFECTION FROM GIVING AND RECEIVING BLOOD IN SCOTLAND

Respondents were asked what, if any, was the risk of people in Scotland catching the AIDS virus, firstly, from giving blood, and secondly, from receiving a blood transfusion.

They were offered a four-point scale, with responses ranging from 'very likely' (score 4) to 'not at all likely' (score 1) for each of these possibilities. This made it possible to analyse response in terms of mean scores. The data are presented in Table 2.4.

From the top half of the table, it is evident that the majority of people think that catching the AIDS virus from giving blood is unlikely; 48% believe it to be 'not at all likely' and 27% 'not very likely' and the mean score is 1.74. However, around 20% of people have some doubts (15% quite likely, 4% very likely). Underlying doubts are also apparent from the qualitative research and are discussed in Section 1.1.3.

The AIDS campaign evaluation found that a larger minority (two fifths) saw this as a potential risk, although there had been some decline in this belief during the period of the survey.

Analysis of donor status shows that the mean score for lapsed and ex-donors does not differ significantly from that of current donors (MS 1.46 and 1.52 v. 1.48), indicating that there is no direct link between perceived risk from

TABLE 2.5: LIKELIHOOD OF THE PEOPLE OF SCOTLAND CATCHING THE AIDS VIRUS

– DEMOGRAPHIC SUBGROUP ANALYSIS

		Age						Sex		Social Class			
	Total	15-24	25-34	35-44	45-54	55-64	65 +	Male	Female	AB	C1	C2	DE
Base:	976	17	252	177	130	113	133	467	509	103	206	305	362
	%	%	%	%	%	%	%	%	%	%	%	%	%
(a) <u>From giving blood</u>													
Very likely (+4)	4	6	3	1	5	6	2	3	5	–	3	5	5
Quite likely (+3)	15	17	12	16	14	17	17	14	17	14	8	15	21
Not very likely (+2)	27	28	31	23	29	23	25	27	26	30	34	23	24
Not at all likely (+1)	48	45	51	56	46	42	46	51	45	55	49	51	41
MEAN SCORE	1.74	1.83	1.65	1.61	1.76	1.85	1.72	1.67	1.79	1.58	1.62	1.71	1.90
(b) <u>From receiving blood</u>													
Very likely (+4)	12	12	10	13	12	11	12	10	13	7	11	10	15
Quite likely (+3)	33	36	29	27	27	37	39	31	35	27	22	32	43
Not very likely (+2)	37	35	42	35	39	25	23	37	30	42	47	33	21
Not at all likely (+1)	17	13	15	22	19	15	17	18	15	22	13	19	14
MEAN SCORE	2.42	2.49	2.35	2.32	2.33	2.50	2.52	2.33	2.50	2.18	2.33	2.36	2.63

AIDS and any tendency to discontinue donating. However, non-donors are more likely than those who have given blood at all to think that there is a possibility of catching AIDS from donating blood (eg. MS 1.85 v. 1.48).

Table 2.5 shows further analysis by age, sex and social class. The differences are not statistically significant at the .05 level of confidence, but the following trends are apparent; the youngest and the older age groups are most likely to believe that the AIDS virus can be caught by giving blood, as are females and the DE social groups.

The bottom of Table 2.4 shows that transfusions are seen to carry a bigger AIDS risk than donations. Thus, the mean score is 2.42 with 12% and 33% thinking it 'very' and 'quite' likely respectively and only 17% thinking it 'not at all' likely. A similar question in the AIDS campaign evaluation revealed that 'only one third adults believe that you can't catch AIDS from blood transfusions nowadays.'

Non-donors are more likely to think that infection from transfusions was possible than people who have given blood at some time, especially current donors. For example, the mean score for current donors is 2.00 and for non-donors 2.54. This difference is significant at the .05 level.

Table 2.5, showing further analysis by age, sex and social class, also reveals some significant differences at the .05 level. Females are more likely to believe that the AIDS virus can be caught in this way than males (MS 2.50 v. 2.33 respectively), and DE groups were more likely to feel this than AB social groups (MS 2.63 v. 2.13).

2.4 SUMMARY

In summary, concerns about catching AIDS from donating blood were minimal at both the spontaneous and prompted level. However, a recognisable minority had some doubts about the matter, feeling that there was a remote possibility that this could happen. This was borne out in the qualitative research where at a rational level the possibility of infection was rejected, but at an emotional level some indicators of uncertainty were expressed.

There were no indications that the possibility of catching AIDS from giving blood is a reason to discontinue donating and at both a spontaneous and prompted level current, lapsed and ex-donors responded similarly in their attitudes to this specific worry. For non-donors the AIDS factor also had low salience as an off-putting aspect of donating at the spontaneous level, with other considerations being more important. However, at the prompted level, non-donors tended to give a relatively more negative response to the possibility of risk. Although at a low level, this indicates that this worry has relatively greater salience for those who have never donated, and therefore could play a marginal role in discouraging initial donation.

Sub-group analysis showed that often those tending to react more negatively than their demographic counterparts in one aspect, tended to react negatively in all aspects. For example, female, DE socio-economic groups and 15-24 year-olds were more likely than their demographic counterparts to think it possible to catch AIDS from both giving and receiving blood, were more likely to mention off-putting aspects and were less likely to give blood. In contrast and perhaps not surprisingly, current donors tended to respond more positively in all aspects, especially in comparison with non-donors. For example, they were least likely to feel you could catch the AIDS virus from both giving and receiving blood.

However, it should be noted that the qualitative research revealed a wide range of other AIDS-related factors which had potentially equal or greater influence on the inclination or disinclination to donate blood. These primarily relate to the negative connotations of fears and resentment stimulated by SNBTS AIDS-related screening procedures, in particular, the pre-donation checklists where respondents are asked to consider their own personal risk of HIV contact and the routine testing of donated blood for AIDS. Furthermore, knowledge of blood as the major medium for transferring the virus, and the emphasis on dirty needles as sources of infection in the Government anti-injection campaign tends to encourage a conceptual link between AIDS and blood donation, in particular for those already sensitive to blood and needles.

Thus, although the overt fear of catching the HIV virus from giving blood appears to be unimportant, the AIDS issue as a whole, with all its complex connotations, may be influencing donation behaviour.

3.0 SUMMARY AND IMPLICATIONS FOR SNBTS STRATEGY

Both qualitative and quantitative research was carried out in order to gain insight into the influence of the AIDS issue on blood donation, with particular reference to the two major problems identified by SNBTS. The qualitative research (Section 1.0) focused primarily on the issue of the potential contamination of blood supplies by donors infected with the HIV virus. The main focus for the quantitative research (Section 2.0) was the possibility that the unfounded fear of catching the HIV virus from giving blood might discourage donation. This summary focuses on these two problem areas utilising relevant information drawn from both parts of the study. This is followed by more detailed consideration of the implications for SNBTS strategy.

3.1 POTENTIAL DONATION BY CONTAMINATED INDIVIDUALS

This section explores the potential for people to give blood despite falling into SNBTS defined risk categories. Attitudes to blood donation and to AIDS were explored separately initially and then together in the context of screening procedures and media material.

Attitudes to blood donation are very similar to those observed in the previous pre-AIDS study (1). A balance of motivating and demotivating factors still determines whether or not an individual will give blood and, for the majority of those who give blood, donating continues to give a warm, rewarding feeling of doing the 'right thing.' Most of the factors identified as influencing the decision to donate were important before AIDS became prominent, but the advent of AIDS has increased the impact of some of them. For example, the testing of blood is more sensitive because of AIDS, both for those who would 'rather not know' about any hidden illness and for those who feel that the health check is a bonus. The potential for embarrassment and discomfiture resulting from rejection at a session is also greater because AIDS might be assumed to be the reason for being turned away, especially among younger people.

Donors also remain willing to 'hand over' their blood to the SNBTS, without considering a potential recipient, thus transferring the responsibility for its safe use.

Donors have a basic knowledge about AIDS. For example, they understand that blood and semen are the major routes of transfer for the virus and, in their terminology, that certain groups are particularly at risk.

They also perceive a hierarchy of risk, with homosexuals, drug abusers and prostitutes being in most danger, other groups such as haemophiliacs and visitors to Southern Africa being at slightly less risk, and those having sexual contacts with the major risk groups, perhaps only as a partner of a partner to the 'nth' degree being at least risk. The latter group is seen to form the largest section in the population and there is some feeling that those at such extended levels of secondary risk are not really in the 'at risk' groups at all and hence by implication do not need to exclude themselves from donation.

Thinking about AIDS and the implications of the syndrome is very emotive and many people are unwilling to consider it at a personal level. Not only is the certainty of a lingering death extremely unpleasant but AIDS would also dramatically affect work and home life and cause social ostracism. Furthermore, many people, especially as they get older, are reluctant to connect themselves even indirectly with lifestyles which they consider to be unsavoury and unacceptable. Thus, people distance themselves from the AIDS issue while acknowledging that 'others' could be affected.

Donors do not readily perceive any links between AIDS and blood donation at a spontaneous level. When prompted to discuss the issue, their only concern is whether giving blood exposes the donor to the risk of catching the HIV virus. This is felt to be logically impossible, although minimal doubts do exist. The potential effect of this on donation levels is described further in the following section.

The possibility of HIV contamination of the blood supply is not an important issue for donors until they visualise themselves as possible recipients of a transfusion. The risk of receiving HIV infected blood is seen to be slight but greater and more definite than the risk of infection as a result of donating blood.

Donors' preoccupation with their own welfare, emotional as well as physical, rather than being concerned with the potential recipient, underlines many of their attitudes towards the contamination issue. The possibility that they, personally, might be a source of contamination does not occur to donors. In the same way as the AIDS issue is not relevant to them, but to minority groups with unsavoury lifestyles, so too, the possibility that they could be a source of contamination is not considered. Any contamination comes from 'others,' not people like themselves. Thus, in normal circumstances at donor sessions, without overt prompting, there is potential for the donation of HIV blood by those in less prominent risk groups.

The prevention of the donation of contaminated blood currently relies on donors' co-operation because the HIV virus cannot be detected in the blood in the early stages of infection. Thus the objectives of SNBTS strategy have been, firstly, to raise awareness of the problem by providing information, notably about the risk groups, secondly, to encourage donors to read the information and relate it to their personal circumstances, and thirdly, to discourage donation of blood by those in the 'at risk' groups. For a variety of reasons, relating to the perceptions highlighted above, the achievement of whole-hearted co-operation from donors and thus avoidance of donation by 'at risk' individuals is extremely problematic.

Current SNBTS practice involves a two-stage defence against the donation of HIV contaminated blood. First, information is sent to donors with their call-up letter; second, all potential donors are asked to read a checklist at the session prior to giving blood. In addition, AIDS-related media material is on display at the session. Reactions to these strategies are summarised first, followed by reaction to the material itself.

The AIDS material sent to donors' homes at best receives only cursory attention and is often not remembered at all, although the invitation letter that accompanies it is recalled. At worst, the AIDS material is treated as unsolicited mail and just thrown away.

Although donors are potentially more receptive to considering self-elimination prior to a session than they are at a session, where it arouses embarrassment and inconvenience, the barriers just discussed still apply. Furthermore, if self-elimination is considered, it is in terms of whether they feel able to give blood, not whether their blood might cause contamination. In these circumstances any SNBTS AIDS-related literature is unlikely to have much effect, and the current circular has negligible impact.

Awareness of the pre-donation checklist is high. Its purpose is seen to be the encouragement of self-elimination of unsuitable donors for a variety of reasons, including AIDS. This is seen to be necessary and desirable but at the same time to be relevant to 'other' unsuitable donors rather than themselves. Thus, despite the checklist, donors still do not seriously consider whether their blood would contaminate the supply in any way, let alone with the HIV virus.

Furthermore, self-elimination for any reason is unlikely because donors come to a session having already decided to give blood. Not giving blood especially as a result of being rejected can cause a resentment that contrasts with the usually warm feelings of giving blood. It can also be an embarrassing experience and there is a feeling, more common among younger donors, that everyone would assume that the reason for rejection or self-elimination is AIDS-related, making the embarrassment more acute.

For these reasons the checklist, and especially the AIDS sub-section, is again given only cursory attention. The need to sign an acknowledgement form makes little difference to this.

It should be noted that any attempt to overcome donors' disinterest in the issue of HIV contamination could be counter-productive. In the group interviews, for example, respondents were pressed to read the AIDS material and to consider their personal risk at a much greater depth then normally occurs. This aroused a variety of negative emotions. The implication of AIDS risk was, for many, intrusive, offensive and threatening and particularly dissonant with the emotional rewards of giving blood. This presents a dilemma for SNBTS. On the one hand, low key enquiries about the HIV status of potential donors tend to be ignored, as at present, and on the other hand, more overt approaches are likely to offend and even drive donors away, rather than have the desired effect of safer donation. Thus, while a screening strategy must be practised, it is important that it be carried out within a context that is as positive as possible.

Post-donation testing of blood is a low key issue for most donors and knowledge is vague. It is assumed to be nearly foolproof and indeed is sometimes cited as a rationalisation for not personally considering the AIDS-related information and exclusion categories. Knowledge of the difficulties in detecting the HIV antibodies immediately after infection is limited in extent and confused. Furthermore, although this problem is the main reason why the SNBTS has to rely on pre-donation screening, even those who were aware of the time-lag problem did not always connect it with the contamination issue.

The effectiveness of the SNBTS AIDS-related publicity material depends to a large extent on the reactions to the screening procedures just described. The tendency to distance oneself from any material relating to AIDS to the extent of ignoring it and the reluctance to reconsider a decision to donate, in particular the perceived difficulties of self-elimination, mean that effective communication is problematic whatever the material.

However, despite these fundamental communication problems, it is still important to examine the performance of the current material in achieving the two objectives of raising awareness of the AIDS/blood donation problem and encouraging donors to consider their personal risk from the syndrome.

Firstly, in raising awareness of the problem, the publicity does convey a connection between AIDS and blood donation. Because it is not read in detail, however, the material merely enhances personal concerns about the general issue of AIDS and blood donation without highlighting the specific problem of contamination of the blood supply. Thus negative images are conveyed, without achieving the main objective.

Furthermore, the text does not communicate the precise nature of the problem of contamination, missing an opportunity to strengthen its message. Separate mentions are made of people who should not donate blood and of the existence of post-donation testing. However, the fact that the tests cannot be guaranteed to detect early HIV virus infection is not included in the checklists and is only mentioned indirectly in the SNBTS leaflet 'AIDS and blood transfusion.' This information is not widely known and heightening awareness of this specific aspect of the problem might encourage more serious assessment of personal risk, counteracting the rationalisation that the blood is tested anyway. However, this should be expressed in a positive context, to avoid increasing concern about the safety of blood transfusions.

The second objective, the encouragement of consideration of personal risk, is fraught with problems. As already mentioned, such a prospect is extremely threatening and not one people wish to consider. Thus, people tend to distance themselves from the AIDS issue and would rather not look at the material at all.

However, the research showed various criticisms in relation to tone and content of the material which are worth considering and modifying in order to maximise its potential. First, the material puts too much emphasis on general information about AIDS which obscures what should be the two main messages, namely, the problems of detecting the HIV virus and the lack of risk from giving blood, the latter being of greatest importance to donors themselves.

Second, the overall tone is extremely negative, emphasising what one should not do and casting doubts on donors' suitability. This is at the expense of encouraging donation and emphasising the need for blood. Thus, there is scope for presenting the unpalatable aspects of the contamination issue in a much more positive context.

Finally, the tendency to lump all risk groups together in categories 1-7 (see Appendix 2) is also disliked, as it does not take into account perceptions of the hierarchy of risk from AIDS. Categories 1 - 3 and 6 are seen to be at much higher risk than categories 4, 5 and especially 7. Interpretation of category 7 is problematic and there is a need to acknowledge the problems of knowing the extended sexual history of one's partner(s) and to give guidance at what level of doubt one should or should not donate.

In conclusion, there is little evidence of deliberate defiance of SNBTS requests not to donate, but rather the messages are not getting through with sufficient impact. Current strategies are unlikely to make a substantial contribution towards discouraging donations by those in contact with the HIV virus. To a large extent this reflects people's unwillingness to consider such a risk at a personal level and donors' main preoccupation with their own welfare rather than that of the recipient. Without further prompting, people are unlikely to use the material in the intended way. If the publicity material is not read, screening cannot be effective. As shown in the research, however, more vigorous prompting arouses negative reactions such as fear and resentment, which might increase the tendency to distance oneself from the material and also deter donation. More acceptable methods of identifying contaminated blood could be explored, but the requirement for donors to consider their personal AIDS risk status cannot be avoided.

However, modification of the material would improve its potential. There is a need to include explanations about why contaminated blood should not be donated in spite of routine testing, and why there is no risk from giving blood. In addition, the tone of the material should be much more positive, stressing such aspects as the need for donations and the value of donors, as well as the contamination issue.

3.2 POTENTIAL EFFECT OF AIDS ON BLOOD DONATION LEVELS

The observed fall in donation levels since 1983-84 coincided with the increasing impact of the AIDS issue. The AIDS issue has become more prominent both in media directed at the general public and, within the context of donation, with the development of AIDS-related screening procedures, namely, the introduction of AIDS categories on the checklist and the testing of all blood with the donor's consent. Thus, it seemed probable that the AIDS issue had affected donation levels in some way and the pre-research hypothesis was that fear of catching AIDS from donating blood would have been the main influence.

Both the quantitative and qualitative research indicate that such fears exist but only at a minimal level. From the quantitative study, it is apparent that AIDS is only salient to a small minority of the population being mentioned spontaneously by just 5% of the sample as an off-putting aspect of giving blood. Other factors have greater salience such as the potential donor's state of health, fear of needles and apathy. Furthermore, although lapsed, ex- and non-donors respectively are progressively more likely to mention these other off-putting factors, this trend is not significant for AIDS.

When directly asked how likely they think it is that people can catch AIDS from donating blood the majority think it unlikely (48% 'not at all likely,' 27% 'not very likely'). Furthermore, lapsed and ex-donors do not differ significantly from current donors in their attitudes indicating this factor is not a reason to discontinue giving blood. However, response among non-donors is slightly more negative, suggesting that this aspect of the AIDS issue might tend to discourage new donors, although still at a low level.

Similarly, from the qualitative study when considering the balance of motivating and demotivating factors, AIDS is rarely mentioned as a reason not to donate. Again other negative aspects have greater salience, with fear of needles and apathy being prominent. At a prompted level, donors also reject the possibility of catching AIDS through donating blood, giving the rational answer that fresh sterile needles and equipment are used each time.

However, the fear of catching AIDS from giving blood is not completely dismissed, with 20% of the quantitative sample responding that it is 'quite' (15%) or 'very likely' (4%). (Non-donors tend to be most negative, the equivalent figures being 19% and 5%.) Indicators of some uncertainty also became apparent as the group discussions progressed. For example, some donors acknowledge a need to reassure 'others,' perhaps displacing their own anxieties. A few know of people who have stopped going to give blood 'just in case,' while there are also isolated reports of non-donors who are put off by the risk. However, it should be noted that none of the respondents, who were drawn from a wide cross section of the population, felt that concern about exposure to the HIV virus had altered their attitudes to blood donation or altered their donating behaviour.

Thus it is apparent that overt fear of catching AIDS is having little influence on the decision to donate. Probably more significant than any such overt fear is the emotional link many people make between AIDS and blood. This link is epitomised by the images of dirty needles transferring contaminated blood featured in recent anti-AIDS advertising, and, however illogical, can become connected with the images of needles and blood in relation to blood donation.

However, perhaps more important than either of these issues is people's clear reluctance and distaste for considering the issue of AIDS at all at a personal level. Pressure to do so in the group interviews aroused a variety of negative emotions, primarily fear and resentment. People fear having the virus with all its implications, they fear finding out they have the virus and they even fear other people <u>thinking</u> they have the virus. They resent being questioned on this issue with the accompanying implication that they lead an 'at risk,' and hence 'unsavoury,' lifestyle.

These emotions are the complete antithesis of the warm feelings which normally accompany donation and which act as a reward, encouraging further donation. Especially strong is the underlying feeling that those making the effort to give their own valuable blood to the community are doing the 'right thing' and should be applauded rather than treated with suspicion.

Despite this giving blood is one of very few situations where healthy people are asked to consider their risk from AIDS, both with the pre-donation checklist and the post-donation testing of one's blood. The potential for alienating donors is clear and this may have contributed to the fall-off in donation levels.

Furthermore, the screening process and related publicity concentrate on intercepting unacceptable donors, and do little to welcome and encourage acceptable ones. It is perhaps not surprising, therefore, that donors tend to ignore such interventions, as far as is possible. Whilst this may minimise the risk of alienation, it also has two important drawbacks. First, as discussed above, it means that the SNBTS anti-contamination strategy is not working effectively. Second, it means a lost opportunity for the SNBTS to communicate with its donors in a positive way that would encourage donation.

Thus the fall-off in donations may have as much to do with the absence of positive encouragement to donate as with any damaging influence of AIDS and a large scale positive publicity campaign could help redress the balance. Certainly when donors are asked to suggest a solution to the problem of decreasing donation levels they call for positive campaigns, that highlight the need for blood and the value of donors rather than material that quells people's fears about AIDS. They also claim that there has been a reduction in such publicity in recent years.

3.3 MEDIA IMPLICATIONS

The media implications of these findings for campaigns aimed at the general public and those aimed at donors are discussed separately.

(i) Material aimed at the general public

The decline in donation levels, in particular the fall in new donors, suggests an urgent need for an increased SNBTS publicity presence, primarily with the objective of recruiting new donors but also maintaining the commitment of those who have already donated. Although the AIDS issue appears to have some adverse effect on donation levels, for many this will be only marginal, and a large scale publicity drive emphasising the positive aspects of blood donation could do much to counteract this influence.

As the research shows, however, the presence of AIDS makes mention of blood even more sensitive than before, and therefore great care must be taken in the messages projected. Thus, material aimed at the general public, designed to increase the number of individuals deciding to attend a donor session, should not include mention of any aspect of AIDS. At best, the inclusion of AIDS messages would be ineffective. Generalised material is unlikely to convey successfully either of the two main AIDS messages, namely the need for those in the AIDS risk groups not to give blood, and the lack of risk for donors from giving blood. The latter message would be difficult to convey convincingly and might raise fears which are currently minimal. The former is unlikely to be successful as a screening strategy as it could only be delivered in a very general way without sufficient probing to encourage personal consideration of risk. At worst, such AIDS messages could be counter-productive, drawing attention to the connection between AIDS and blood donation with all the ensuing negative connotations.

Instead, SNBTS should concentrate on general encouragement to donate, deferring the AIDS issue until potential donors are identified. It is important to adopt a positive approach, in particular conveying the warm sense of reward many donors feel. Such approaches can include emphasis on the need for blood and hence the need and importance of donors, and the expression of positive gratitude towards donors, never taking them for granted. In this way individual recipients can be highlighted, illustrating these needs by, for example, allowing recipients and their families to personally thank donors.

It is important to promote the need for blood in a positive way, however, showing people who have recovered thanks to a blood donation rather than people who are ill or dying because there is not enough blood for them. The latter 'scare' approach, while apparently powerful, is more likely to promote negative responses and defensiveness on the part of non-donors.

Use of recipients in the publicity might also have the additional benefit of raising donors' awareness of the fact that individual people receive their blood, counteracting the general tendency to simply 'hand it over' and abdicate responsibility for its safe use to the SNBTS. This might encourage donors to consider the possibility of contamination, even including HIV, in their blood and hence whether or not they should donate.

The research suggests that a successful campaign would involve the complete revitalisation of recruitment publicity. Current material is perceived to have changed little over the past years, becoming dated and unattractive. There is also a need for the media presence to be increased, both at a national level, with television and posters boosting the idea of donating and also at a local level, with more effective publicising of individual sessions.

Targeting decisions should also be made. Currently the majority of donors are young and it would seem this group has the greatest potential for further recruitment of new donors and reinforcing those who have already given blood. In this way one might argue that media material should be directed towards younger people. However, this age group is also at greater risk of contracting AIDS, since many are not in stable sexual relationships. Thus, SNBTS might wish to avoid encouraging young people, given the problems of discouraging donations from those potentially at risk.

The effect of positive publicity can be enhanced if the actual experience of donation is pleasant. This would encourage return donations and also avoid non-donors being discouraged by horror stories. First and foremost, the quality of staff interaction is crucial, making the donor feel important as an individual, making sure they feel their donation is appreciated and that any problems will be dealt with tactfully and sympathetically. The donation can be followed up by formal thanks, tokens and invitations to return.

In summary, increasing the impact of general publicity is a matter of urgency. The material in all forms should be more pervasive and needs to be updated in presentation - especially the television commercials. The publicity should be used to convey positive images about blood donation and the high esteem of donors and, when targeting the general public, AIDS should not be mentioned. Two complementary approaches are suggested. First, everyday aspects of a donor session could be used to convey the warm rewarding feeling experienced from donating blood, and indirectly imply donor safety. Second, situations where recipients have benefited from donations could be used to convey their gratitude and that of their families and hence the value of blood donors. Although those with a deep-rooted distaste for giving blood are unlikely to be persuaded to donate, a more impactful campaign will help prompt donations from those who are willing to co-operate together with those who have minimal inhibitions. Furthermore, a large scale publicity drive emphasising the positive aspects of blood donation will help counteract the negative conceptual connections between AIDS and blood donation, and in particular the negative effects generated by the essential screening procedures.

(ii) Material aimed at potential donors

The AIDS issue can best be raised once a donor is identified but prior to donation. This can probably be done most effectively at the session rather than with a pre-session mailout of information but both approaches are worth maintaining. Currently, every donor is given the relevant information which describes the 'at risk' groups and asks that people self-eliminate if they fall within the categories. Respondents are asked to read this and sign that they have done so.

The research has shown that, for many reasons, the current strategy is largely unsuccessful, primarily because potential donors do not see the material as relevant to them personally and therefore do not consider it in any depth. As well as being ineffective in discouraging potentially contaminated donations, it has the further disadvantage of arousing negative reactions. The implication that donors have any connection with AIDS is resented and is particularly dissonant with the donor's self-image as a 'good citizen.' At the same time, confrontation with the AIDS issue, and being asked to consider it at a personal level, is disconcerting and arouses a variety of fears. Furthermore, the current AIDS-related material is unduly negative in tone and tends not to emphasise the AIDS message which is of interest to most donors, namely, that giving blood does not expose them to any risk from the syndrome.

However, in spite of the problems, it is essential that some attempt is made to encourage donors to act responsibly and hence avoid donation of contaminated blood, although clearly this must be done with caution.

An essential modification of pre-session material is to adopt a much more positive approach, promoting and enhancing positive feelings about donation. The emphasis on AIDS in current material creates a depressing and unpleasant effect. Instead of rewarding donors for giving blood, it tends to promote negative images, questioning their suitability as donors and, by implication, casting doubts on them as individuals. Although the AIDS-related information must be given and the questions asked, and applied to his or her own circumstances by the donor, this can be placed within a more positive context. In particular, there should be more emphasis on the need for blood and gratitude to donors, and the AIDS message should be integrated with information about other illnesses and made more concise.

However, while this process will make the material more acceptable and therefore less likely to be rejected out of hand, such modifications are unlikely to be enough in themselves to prompt donors to relate to the material on a personal level.

The obvious response might seem to be more vigorous confrontation of donors with the problem, in particular using staff to more actively interrogate prospective donors. However, this could serve to raise a wide range of negative emotions, primarily fears and resentment, without achieving the desired effect, and even making donors more likely to reject the possibility of their personal contamination. As the research showed, forcing people to consider the chance that their donation may be HIV infected, with all its threatening personal and moral implications, is going to cause offence.

Thus, coping with the dilemma is problematic. On one hand, without additional prompting, donors do not use the AIDS-related material. On the other hand, additional prompting arouses negative emotions and is non-productive, perhaps even deterring people from continued donation.

Three strategies are given here, but they are put forward as suggestions rather than definitive solutions and are not mutually exclusive.

Continue current policies: In effect, every donor is currently provided with the information about the AIDS 'risk' groups and it is stressed that they should not donate if they are in these categories. However, there is no personal interrogation or confrontation and the level at which the donor analyses his personal risk is left to his own discretion.

Continuing as before has some advantages. SNBTS are seen to be taking action to reduce the risk of contaminating blood supplies and the information provided may prompt some 'at risk' donors to self-eliminate. Furthermore, since 'average' donors tend to distance themselves from the AIDS material, it may not cause significant offence. More controversially the relatively low profile and the fact that donors ignore the material, may enhance the quantity of donations since the logical extension of the 'risk' groups (especially Category 7) is that the vast majority should not donate blood.

However, without further pressure, for example, personal interviews and more aggressive material, 'average' donors currently distance themselves from the AIDS information and avoid considering whether they themselves fall into the risk categories. In short, it is not an effective screening process.

There is also the continued danger of alienating donors, even though the material is so low key. Furthermore, current policies also lose the opportunity to be more positive and constructive. Their only purpose is seen to be the <u>discouragement</u> of donations.

As discussed above, some of the problems with the current material could be removed by redesigning it, especially be making it more positive. Such modifications will make the material more acceptable, but they are unlikely to have much effect on the average donor's willingness to relate personally to the AIDS risk categories. To do this other strategies need to be considered.

'<u>Easing the process</u>': One possibility is to tackle the issue in a less threatening and pejorative way, for example, by making it easier and less embarrassing for donors to declare potential risk.

A number of approaches could be considered here.

First, the issue of donor safety could be separated from that of contaminated blood. Donor safety requires elimination of potential donors <u>before</u> giving blood. It is also non-threatening and can be tackled in a very positive and constructive way stressing that the BTS is concerned about the donor. In contrast, recipient safety could be achieved by eliminating blood after donation, if the correct information is given. In this way the issue of contaminated blood could be tackled separately from an overt elimination process. The BTS could then eliminate the blood on the basis of information provided by the donor and the negative message 'must not give blood' could be abandoned.

This approach to donor contamination could be achieved by using an anonymous self-completion questionnaire. For example, a modification of Edinburgh and South East Scotland Health Check for New Blood Donors might be suitable. (This is explored more fully in Appendix 4.) The questionnaire could then be linked with the donation by code numbers.

Secondly, the issue of AIDS should not be tackled in isolation but as part of the general process of monitoring donated blood.

A third possibility could be to offer donors a choice between whether their blood may be used for transfusions or only for research. This would avoid the problem of disinclination to self-eliminate and could be anonymous. Again, the donor's response could be linked with donated blood using a code number. Furthermore, although the AIDS information must be given, the material can approach the topic in a less offensive manner and does not need to suggest that people have AIDS. This possibility is also described more fully in Appendix 4.

However, although they reduce the salience of any embarrassment, none of these approaches can avoid the fact that donors have to confront very personal and morally sensitive issues. They still depend on the donor absorbing the information given and examining his private life and making some statement about it. Thus there is still a risk that donors would not consider it at a personal level and that the concept and the material would be discordant with the warm positive image of donating blood.

<u>Promoting the concept of donor responsibility and self-monitoring</u>: This approach would aim to raise awareness of the need for SNBTS to be informed about any possible blood contaminants and the donors' responsibility to convey that information. The former aspect would include, in particular, the

difficulty of detecting early contamination of the blood supply, which is not widely known. The latter aspect would include raised awareness of recipients of their blood.

Indeed, a more constructive policy to encourage empathisation with the recipients in all forms of media would be important, to go some way to counteract the tendency to 'hand over' blood to the SNBTS and to leave the responsibility for safe usage to the organisation. As noted above, this would also be a fruitful approach for publicity aimed at the general public to improve donation levels. This approach would include conveying thanks from recipients and information about the purposes blood was used for, for example general publicity, post-donation letters and newsletters (the recent publication given to donors has potential to facilitate this process).

In conclusion, all three of the alternatives discussed here may have potential and could be used simultaneously. The impact of AIDS on blood donation is complex and responses will need to be sophisticated and multifaceted. Success is likely to be gradual rather than immediate, and SNBTS thinking should therefore concentrate on long-term strategy rather than short-term tactics.

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APPENDIX 1: QUALITATIVE RESEARCH

1) DETAILED COMPOSITION OF GROUPS

Group No	Donor Status	Donor Type	Age	Sex	Social Class	Location
1	Donor	Donor Centre	18-24	Male	ABC1	Glasgow
2	Donor	Community Session	18-24	Female	C2DE	Glasgow
3	Donor	Donor Centre	25-44	Female	C2DE	Glasgow
4	Donor	Community Session	45-65	Male	ABC1	Glasgow
5	Lapsed/ ex-donor	Donor Centre	18-24	Male	C2DE	Glasgow
6	Non-donor	N/A	18-24	Female	ABC1	Glasgow
7	Donor	Community Session	18-24	Female	ABC1	Edinburgh
8	Donor	Community Session	18-24	Male	C2DE	Edinburgh
9	Donor	Donor Centre	25-44	Male	ABC1	Edinburgh
10	Donor	Donor Centre	45-65	Female	C2DE	Edinburgh
11	Lapsed/ ex-donor	Community Session	18-24	Female	ABC1	Edinburgh
12	Non-donor	N/A	18-24	Male	C2DE	Edinburgh
13	Donor	Community Session	18-24	Male	ABC1	Aberdeen
14	Donor	Donor Centre	18-24	Female	C2DE	Aberdeen
15	Donor	Community Session	25-44	Male	C2DE	Aberdeen
16	Donor	Donor Centre	45-65	Female	ABC1	Aberdeen

2) EXAMPLE OF LETTER SENT TO POTENTIAL RESPONDENTS

Dear

Attitudes to blood donation and AIDS

We are presently conducting a survey into donor recruitment, and why others do not donate blood. We are particularly interested in finding out whether the emergency of AIDS has affected people's attitudes to giving 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 services could be improved, and also ways of attracting new donors. All information associated with the research 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, pleast let us know by return of post, sending your letter (no stamp required) to ....

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

3) BRIEF FOR DISCUSSION GROUPS

The interviews will be deliberately loosely structured allowing respondents to select their own priorities for discussion. However, care will be taken to cover three main issues:

- general perceptions of AIDS and blood donation All the groups will begin with a general discussion in this area seeking spontaneous responses. Subsequently a number of specific issues will be probed, including perceptions and understanding of:

    - high risk (AIDS) groups;
    - the processes of AIDS transmission;
    - the risk from AIDS to blood donors;
    - the risk from AIDS to blood recipients, and the implications this has for donors;
    - the influence all these factors have on respondents' own blood donating attitudes and behaviour.

- the media treatment of AIDS and blood donation Respondents' knowledge and attitudes in this area will be sought with a view to a) examining what respondents see as good or bad treatments of the issue, and b) exploring awareness and opinions of SNBTS material.

- detailed response to the SNBTS campaign about AIDS and blood donation Two main aspects of this will be covered. Firstly, detailed response to the publicity material will be examined including its impact, clarity, comprehension and acceptability. Secondly, issues of implementation will be covered, including:

    - the ease with which leaflets can be read at donating sessions;
    - the practicality of anyone refusing to donate as a result of reading the material at a session;
    - the advantages and disadvantages of distributing leaflets by mail to regular donors.

APPENDIX 2: SNBTS AIDS-RELATED PUBLICITY MATERIAL

1) Risk categories
2) Example of pre-donation checklist - Glasgow and West of Scotland
3) Example of pre-session notes - Edinburgh and South East Scotland
4) SNBTS leaflet 'AIDS and Blood Transfusion'
5) Post-donation slip
6) Poster
7) NBTS/DHSS leaflet 'AIDS - What you must know before you give blood'

(1) RISK CATEGORIES

AIDS — PEOPLE WHO MUST NOT GIVE BLOOD

1. Anyone who has AIDS or the AIDS antibody.
2. Any man who has had sex with another man since 1977.
3. Anyone who has ever injected themselves with drugs.
4. Anyone who has lived in or visited Africa south of the Sahara at any time since 1977 and has had sex with men **or women** living there.
5. Anyone who has had **regular** treatment with blood products since 1977.
6. Any man or woman who has been a prostitute at any time since 1977.
7. Anyone who has ever had sex with a person in the above groups **even on a single occasion.**

MUST NOT GIVE BLOOD

If you are at all worried about **AIDS** please ask to speak to the doctor.

(2) EXAMPLE OF PRE-DONATION CHECKLIST

GLASGOW AND WEST OF SCOTLAND BLOOD TRANSFUSION SERVICE

Thank you for attending for blood donation. It is desirable that you should give blood only if you are in normal health. The age limits for donors are 18 to 65. A test for anaemia is made before each proposed donation.

Will you therefore please read carefully the following questionnaire, and inform the DOCTOR in charge of the Session if your answer to any of the questions is "YES". The doctor will then decide whether or not you may donate blood.

HAVE YOU:

(1) given blood during the past three months?

(2) ever been advised by a doctor **not** to be a blood donor?

(3) had any recent **unexplained** loss of weight and are you less than 8 stones (inclusive of clothes)?

(4) been in contact with, or recovered from, an infectious disease, for example:
MUMPS **SHINGLES** **GLANDULAR FEVER** **MEASLES**
CHICKENPOX **JAUNDICE** **GERMAN MEASLES**

(5) received any inoculation recently, for example:
TETANUS, or vaccination for **SMALLPOX!**

(6) had a serious operation in recent years?

(7) had any serious illness, in particular any of the following:
JAUNDICE
ASTHMA, HAY FEVER, NETTLE RASH
BLOOD DISEASES
CANCER
DIABETES
EPILEPSY (FITS)
GOITRE
BRUCELLOSIS (UNDULENT FEVER)
HEART DISEASE
HIGH BLOOD PRESSURE
KIDNEY DISEASE
MALARIA
RHEUMATIC FEVER
STROKE
TUBERCULOSIS

(8) Does your work or sport involve any unusual hazards? For example, at heights or depths.

(9) Are you a driver of a Public Service Vehicle?

(10) Have you heard of A.I.D.S. (Acquired Immune Deficiency Syndrome)? An explanatory leaflet is available at this session. If you have any doubts about giving a donation consult a **doctor at this session, your own G.P., or write in confidence to the Regional Director.**

Director:
RUTHVEN MITCHELL,
B.Sc., M.B., Ch.B., M.D., F.R.C.P.G., F.R.C.Path.

SCOTTISH NATIONAL BLOOD TRANSFUSION SERVICE

AIDS — AN IMPORTANT MESSAGE FOR BLOOD DONORS

THERE IS ABSOLUTELY NO DANGER OF GETTING AIDS BY DONATING BLOOD

Our primary concern is for your safety and for the safety of the patients who receive your blood donation. As a consequence, although you may not be aware, we have for many years checked all donors to ensure they are not anaemic and do not have unknown hepatitis or syphilis.

We want you to know that we have introduced an important addition to our donor health screening programme — all donations are tested to see whether you have been in contact with **HIV (HTLV III)** the virus which **may** cause AIDS. We would stress the word **may** because our tests, if positive, will only tell us you could have been in contact with the virus. **A POSITIVE TEST DOES NOT NECESSARILY MEAN THAT YOU HAVE AIDS OR INDEED WILL EVENTUALLY SUFFER FROM AIDS.**

In the unlikely event that your blood is positive for this HIV (HTLV III) test you will be contacted by medical staff at the Regional Transfusion Centre who will provide you with much useful and important advice. This is the same procedure we have used for donors found to be positive to our other health checks. As has always been our practice confidentiality of your medical records will be maintained.

AIDS — PEOPLE WHO MUST NOT GIVE BLOOD

1. Anyone who has AIDS or the AIDS antibody.
2. Any man who has had sex with another man since 1977.
3. Anyone who has ever injected themselves with drugs.
4. Anyone who has lived in or visited Africa south of the Sahara at any time since 1977 and has had sex with men **or women** living there.
5. Anyone who has had **regular** treatment with blood products since 1977.
6. Any man or woman who has been a prostitute at any time since 1977.
7. Anyone who has ever had sex with a person in the above groups **even on a single occasion.**

MUST NOT GIVE BLOOD

If you are at all worried about **AIDS** please ask to speak to the doctor.

HELP US KEEP BLOOD TRANSFUSION SAFE

When you come to the donor session you will be asked to sign a health check form which will include a statement that you have read and understood this important message. If you do not wish to have your blood **HIV (HTLV III)** tested, please do not donate blood at any session.

Blood is urgently needed to treat many ill patients. With your continued understanding and co-operation we will be able to supply sufficient safe blood for all patients, whatever **their needs.**

If you would like any more information, please telephone your local Transfusion Centre at:
Glasgow & West of Scotland Blood Transfusion Service — 041-226 4111

Revision 5
May 1987

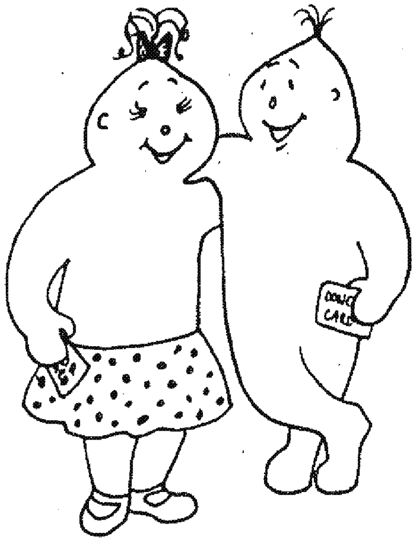
(3) EXAMPLE OF PRE-SESSION NOTES

TO SAVE YOU TIME

AIDS

1. Anyone who has AIDS or the AIDS antibody
2. Any man who has had sex with another man since 1977
3. Anyone who has ever injected themselves with drugs
4. Anyone who has lived in or visited Africa, south of the Sahara at anytime since 1977 and has had sex with men or women living there
5. Anyone who has had regular treatment with blood products since 1977
6. Any man or woman who has been a prostitute at any time since 1977
7. Anyone who has ever had sex with a person in the above groups even on a single occasion

MUST NOT GIVE BLOOD



SEBTS 5/87

HEALTH CHECK FOR DONORS

Reading this may save you an unnecessary journey.

Before we can accept you as a blood donor we must make sure giving blood will do you no harm. We must also make sure your blood is safe to give to patients. Below are SOME reasons for not giving blood.

You have been feeling unwell. Always wait until you are fully recovered even from minor illnesses like an upset stomach or a heavy cold.

You are regularly attending hospital, or awaiting tests or treatment.

You are on a course of antibiotics.

A tooth extraction in the last 3 days.

Had your ears pierced/been tattooed/received acupuncture in the last 6 months.

You are being treated for high blood pressure.

You have chest pains or breathlessness.

Ladies, you are pregnant or have a child under 1 year.

You have received a blood transfusion in the last 6 months.

You have had inoculations or vaccinations in the last 3 months.

Been abroad in a Malaria area in the past 12 months.

Had Jaundice or Hepatitis in the past 12 months.

People who are at risk of AIDS are listed overleaf and MUST NOT GIVE BLOOD.

IF YOU HAVE ANY QUESTIONS ABOUT YOUR HEALTH, PLEASE RING 031-229-2585 Extension GRO-C AND ASK FOR DOCTOR OR SISTER. ASK FOR THE DONOR OFFICE IF YOU HAVE ANY QUESTIONS ABOUT APPOINTMENTS etc OR RING 031-229-7291

SNBTS LEAFLET (4)

PEOPLE WHO MUST NOT DONATE

The categories of high risk activities which put people at risk are constantly being revised in the light of the latest scientific information. You will receive a copy of the current message about people who must not donate each time that you are called to a session or at the session itself, or you can ask at the local Donor Centre before you come.

If you have any doubt about whether you should give blood do not donate until you have discussed this privately with a sister or doctor either at the session or in the Blood Donor Centre. Any information you give will be treated in the strictest confidence. No information will be passed to any other person or agency without your express permission.

WHAT TO DO IF YOU ARE WORRIED ABOUT AIDS AND THEREFORE DOUBTFUL ABOUT GIVING BLOOD

If you want to know whether you have been infected, **please do not come to the Blood Transfusion Service.**

Here is a list of useful numbers which you can contact in confidence.

FOR INFORMATION AND ADVICE

NORTH OF SCOTLAND AIDS Hotline	**Inverness 222922**
GRAMPIAN REGION Grampian AIDS Line	**0224 574000** (Tues. & Frid. 7-10pm and 24 hour answerphone.)
EAST OF SCOTLAND Dundee Royal Infirmary Clinic	**0382 23491**
S. EAST SCOTLAND City Hospital Clinic	**031-447 0411** (Mon-Frid 9am-6pm.)
WEST OF SCOTLAND Jim Black, Social Worker, Ruchill Hospital	**041-946 7120** Ext. GRO-C
NATIONWIDE	
Scottish AIDS Monitor	**031-558 1167** (7:30-10pm) **041-221 7467** (Tues. & Thurs. 7-10pm)
Terrence Higgins Trust	**01-833 2971**
AIDS Line	**FREEPHONE 0800 555777**

For confidential testing contact your own doctor, the Genito-Urinary Medicine (GUM) Clinic at your nearest hospital, or any Sexually Transmitted Diseases (STD) Clinic (you should find the number in the phone book under "Venereal Diseases" or "V.D.").

AIDS and Blood Transfusion

A GUIDE FOR BLOOD DONORS

WHAT IS AIDS?

AIDS is short for Acquired Immune Deficiency Syndrome. It is a very serious disease caused by a virus (Human Immune Deficiency Virus–shortened to HIV) which reduces the body's resistance to infections and other illnesses. AIDS only develops in a proportion of people infected with the virus. All of those infected become virus carriers–healthy in themselves but able to infect others.

HOW IS IT SPREAD?

When a baby who had had a blood transfusion died of AIDS in 1983, it was realised that this disease could be spread by blood transfusion and that it was likely to be caused by a virus. We now know much more about the virus and the two main ways in which it is spread.

The first and by far the most common way is by any kind of sexual intercourse with a person infected by the virus. The second is by the transfer of blood from an infected person to someone else. This can be by sharing needles or syringes to inject drugs, or by transfusion of blood or blood products from an infected donor.

YOU CANNOT GET AIDS BY GIVING BLOOD.

ARE ALL DONATIONS TESTED FOR THE AIDS VIRUS?

Since October 1985 every blood and plasma donation has been tested for AIDS antibodies because the presence of AIDS antibodies indicates that the donor is infected.

This antibody test is highly sensitive but very rarely it may fail to detect someone in the early stage of infection before they have formed antibodies to the virus. If this were to happen a donation of blood could cause AIDS in the patient receiving it, even though the test was negative. New and improved tests continue to be developed and will be introduced into routine use by the Transfusion Services when evaluated.

It is vitally important that people who want to know if they have been infected by HIV MUST NOT DONATE BLOOD to the Transfusion Service.

WHAT IF THE TEST IS POSITIVE?

We perform a number of tests on the blood you donate. The first thing we do when any of these tests is positive is to ask the donor for another sample to make sure it really is positive. If this second test is positive, **we ensure that the donor gets proper medical care in the strictest confidence.**

HOW CAN WE PROTECT PATIENTS FROM AIDS?

Because AIDS is such a serious disease we must do everything possible to see that *there is no risk to patients who need transfusions of blood or blood products*

(5) POST-DONATION SLIP

Dear Donor

Thank you for your donation. If there is any information that you think you should have given us, particularly if it is to do with AIDS, please telephone us as soon as possible.

During office hours 031-229-7291 (9am-5pm)
Outside office hours 031-229-2585 (5pm-9am)

All information will be treated as strictly confidential.

(6) <u>POSTER</u>

A.I.D.S.

This is a serious disease.

Please do <u>not</u> give blood if you are:

- **a homosexual or bisexual man**
- **a drug abuser who injects drugs**
- **a sexual contact of any of these people**

Donors cannot catch A.I.D.S. by giving blood.

[illegible]

(7) NBTS/DHSS LEAFLET

Remember,

AIDS

is a serious disease

Please do not give blood:

- If you are a man who has had sex with another man.
- If you are a drug abuser who has injected drugs.
- If you are a haemophiliac who has received unheated blood products.
- If you have lived in or visited Africa and have had sex with men **or women** living there.
- If you are a sexual contact of any of these people.

Anyone can discuss in confidence the information in this leaflet:

- with a doctor at the blood collection session
- with their own doctor
- with a doctor from their blood transfusion centre
- at any sexually transmitted diseases (STD) clinic.

A general booklet called **AIDS – What Everybody Needs to Know** is available free from Dept A, PO Box 100, Milton Keynes MK1 1TX. Up-to-date recorded information on AIDS is available on the Healthline Telephone Service: 01-981 2717 or 01-980 7222. If you are phoning from outside London you can phone 0345 581151 on local rates.

NBTS 1161

Prepared by the Department of Health and Social Security and the Central Office of Information for the National Blood Transfusion Service.

AIDS

What you must know before you give blood

THE NATIONAL BLOOD TRANSFUSION SERVICE

What is AIDS?

AIDS stands for Acquired Immune Deficiency Syndrome. It is caused by a virus which attacks the body's natural resistance to infections and other illnesses.

How is it spread?

The virus is spread mainly by sexual contact with an infected person, but it can also be passed on through blood. Most people who carry the virus do not even know they have been infected. But anyone who does have the virus can pass it on, even if they feel and look completely well. So it is important that anyone who may have been exposed to the virus should not give blood.

Is blood tested?

Donors are tested for anaemia before giving blood. Other tests are done on donated blood afterwards in the laboratory. These include a test for antibodies in the blood, which would indicate that a person has been exposed to the AIDS virus. The test is to find anyone who may have been infected without knowing. Donors are asked to agree to this test.

Although all blood donations are tested for antibodies to the AIDS virus, the test may not pick up early cases of infection. That is why people who may have been exposed to the virus – see the list opposite – must not go to donor sessions, even if they later receive another call-up card. The Blood Transfusion Service will not ask people why they do not go.

In the very unlikely event of a positive reaction to any of the laboratory tests, a donor is informed by a doctor from the blood transfusion centre so that extra confirmatory tests can be arranged. A donor's medical history is always kept in the strictest confidence.

Can donors get AIDS by giving blood?

Absolutely not. All the materials used for collecting blood are sterile and used only once. Neither AIDS nor any other disease can be caught from giving blood.

People who must not give blood

These are the people who are most likely to have been exposed to the AIDS virus. They must **not** give blood:

✖ Men who have had sex with another man at any time since 1978.

✖ Drug abusers, both men and women, who have injected drugs at any time since 1978.

✖ Haemophiliacs who have received unheated blood products at any time since 1978.

✖ People who have lived in or visited Africa south of the Sahara at any time since 1978 and have had sex with men **or women** living there.

✖ Sexual partners of people in these groups. This includes single contacts as well as regular relationships.

People who think they may have been exposed to the AIDS virus can get a blood test, in strict confidence, either through their own doctor or at a sexually transmitted diseases (STD) clinic. Clinics can be found in the phone book under 'venereal disease' or 'sexually transmitted disease'. People whose test is negative should still not give blood.

APPENDIX 3: QUANTITATIVE RESEARCH

1) Questionnaire

2) Computer printout

SECTION B - ASK ALL

Now I would like to ask you some questions about blood donation.

.1	Have you ever given blood? IF YES: When did you last give blood?	READ OUT....	No, never given blood	1
			Less than 2 years ago	2
			2 - 4 years ago	3
			More than 4 years ago	4
			Can't remember	Y

(16)

.2 Thinking about giving blood, is there anything that puts you off the idea, or not? PROBE Any other reasons? (17)

....

.... (18)

....

....

PROBE Anything else?
....

....

B.3 SHOW CARD
Now, thinking about AIDS and the AIDS virus, can you tell me how likely, or not, you think the following are. Please use one of the phrases on this card.

READ OUT. ROTATE ORDER. CODE BELOW

		Very likely	Quite likely	Not very likely	Not at all likely	Don't know	
a)	People in Scotland could catch the AIDS virus from giving blood	1	2	3	4	Y	(19)
b)	People in Scotland could catch the AIDS virus from receiving a blood transfusion	1	2	3	4	Y	(20)

Thank you for your co-operation in answering these questions.
The Scottish National Blood Transfusion Service, for whom the survey is being conducted, has asked us to assure you that there is no danger of contacting the AIDS virus from giving blood.

COLUMNS 21 - 28 BLANK

(2) COMPUTER PRINT-OUT

SOS X87

SCOTTISH OPINION SURVEY – BLOOD DONATION

NOVEMBER 1987

TABLE 1

B.1 WHEN LAST GAVE BLOOD

BASE: ALL RESPONDENTS

		SEX		AGE						CLASS				AREA			DONOR STATUS			
	TOTAL	MALE	FEMALE	15–24	25–34	35–44	45–54	55–64	65+	AB	C1	C2	DE	WEST	EAST	NORTH	CURRENT DONOR	LAPSED DONOR	EX-DONOR	NON-DONOR
Total (unwtd.)	976	467	509	171	252	177	130	113	133	103	206	305	362	461	287	228	108	56	157	639
(wtd.)	976	459	517	205	176	156	137	137	166	146	205	283	342	465	287	224	98	50	156	650
	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Never given blood	650 67%	272 59%	378 73%	159 78%	103 59%	92 59%	84 61%	103 76%	109 66%	84 57%	136 66%	190 67%	240 70%	312 67%	187 65%	151 67%	0 –	0 –	0 –	650 100%
Less than 2 years ago	98 10%	56 12%	42 8%	27 13%	28 16%	22 14%	16 11%	2 2%	3 2%	13 9%	28 14%	36 13%	21 6%	42 9%	31 11%	25 11%	98 100%	0 –	0 –	0 –
2–4 years ago	50 5%	25 5%	25 5%	11 5%	18 10%	9 6%	8 6%	3 2%	0 –	10 7%	9 4%	17 6%	14 4%	20 4%	14 5%	16 7%	0 –	50 100%	0 –	0 –
More than 4 years ago	156 16%	96 21%	60 12%	0 –	26 15%	31 20%	29 21%	24 17%	46 28%	29 20%	27 13%	39 14%	62 18%	79 17%	48 17%	28 13%	0 –	0 –	156 100%	0 –
Can't remember	23 2%	10 2%	12 2%	8 4%	1 *	3 2%	0 –	4 3%	8 5%	11 8%	5 3%	2 1%	4 1%	12 3%	7 2%	4 2%	0 –	0 –	0 –	0 –

SCOTTISH OPINION SURVEY – BLOOD DONATION

TABLE 2/1

B.2 IS THERE ANYTHING THAT PUTS YOU OFF IDEA OF GIVING BLOOD

BASE: ALL RESPONDENTS

		SEX		AGE						CLASS				AREA			DONOR STATUS			
	TOTAL	MALE	FEMALE	15–24	25–34	35–44	45–54	55–64	65+	AB	C1	C2	DE	WEST	EAST	NORTH	CURRENT DONOR	LAPSED DONOR	EX-DONOR	NON-DONOR
Total (unwtd.) (wtd.)	976 976 100%	467 459 100%	509 517 100%	171 205 100%	252 176 100%	177 156 100%	130 137 100%	113 137 100%	133 166 100%	103 146 100%	206 205 100%	305 283 100%	362 342 100%	461 465 100%	287 287 100%	228 224 100%	108 98 100%	56 50 100%	157 156 100%	639 650 100%
Possibility of catching Aids	53 5%	26 6%	27 5%	21 10%	8 4%	9 6%	7 5%	4 3%	4 2%	6 4%	15 7%	13 4%	19 6%	39 8%	4 2%	10 4%	1 1%	2 4%	9 5%	41 6%
Frightened of needles/ injections	114 12%	44 10%	70 13%	41 20%	32 18%	28 18%	3 2%	8 6%	2 1%	14 10%	24 12%	35 13%	40 12%	50 11%	38 13%	26 12%	3 3%	3 6%	5 3%	102 16%
Any specific mention – dirty needles	8 1%	4 1%	4 1%	2 1%	2 1%	2 1%	1 1%	0 –	1 1%	2 2%	1 1%	1 *	4 1%	7 2%	0 –	1 *	1 1%	0 –	3 2%	4 1%
Poor health/medical reasons (except blood disorders)	91 9%	30 6%	62 12%	10 5%	14 8%	12 7%	15 11%	21 16%	20 12%	14 9%	17 8%	23 8%	37 11%	37 8%	23 8%	31 14%	2 2%	6 12%	16 10%	67 10%
Anaemic/HBP/other blood disorder	65 7%	12 3%	53 10%	8 4%	7 4%	10 7%	17 12%	13 9%	10 6%	14 9%	11 5%	15 5%	25 7%	34 7%	21 7%	10 5%	0 –	3 5%	9 5%	54 8%
Hepatitis/jaundice	24 2%	9 2%	15 3%	0 –	3 2%	6 4%	8 6%	3 2%	3 2%	6 4%	9 4%	5 2%	4 1%	5 1%	6 2%	13 6%	0 –	0 –	3 2%	21 3%
Underweight	20 2%	1 *	19 4%	3 1%	7 4%	5 3%	2 1%	1 1%	2 1%	5 3%	3 1%	6 2%	7 2%	15 3%	4 1%	2 1%	0 –	1 1%	3 2%	17 3%
Any health reasons	198 20%	52 11%	146 28%	21 10%	30 17%	32 21%	42 31%	38 27%	35 21%	39 26%	38 19%	47 17%	74 22%	89 19%	55 19%	54 24%	2 2%	9 19%	31 20%	156 24%
Had bad experience before/ would feel ill/heard bad reports	49 5%	21 5%	28 5%	10 5%	9 5%	10 6%	6 5%	10 7%	3 2%	10 7%	9 4%	15 5%	16 5%	28 6%	10 4%	11 5%	5 6%	4 9%	11 7%	27 4%
Too old/too young	70 7%	39 8%	31 6%	12 6%	0 –	0 –	2 1%	10 7%	46 28%	11 8%	12 6%	14 5%	33 10%	41 9%	13 4%	16 7%	3 3%	1 2%	20 13%	42 6%
Personal/religious reasons	12 1%	4 1%	8 2%	0 –	2 1%	0 –	3 3%	4 3%	2 1%	4 3%	0 –	3 1%	4 1%	5 1%	2 1%	4 2%	0 –	2 3%	2 1%	6 1%
Any specific reasons for not going	460 47%	175 38%	284 55%	94 46%	75 43%	75 48%	61 44%	66 49%	88 53%	80 54%	92 45%	120 42%	168 49%	230 49%	117 41%	113 50%	15 15%	18 37%	74 47%	345 53%
Happy to go/go regularly	28 3%	19 4%	9 2%	5 3%	3 2%	5 3%	9 7%	1 1%	4 2%	9 6%	4 2%	5 2%	9 3%	11 2%	7 2%	10 4%	17 18%	2 4%	7 4%	0 –
Intend to go in future	19 2%	5 1%	14 3%	5 3%	6 3%	2 1%	1 1%	3 3%	1 1%	5 3%	1 *	7 3%	6 2%	9 2%	4 1%	6 3%	0 –	1 1%	1 1%	17 3%
Used to go but don't now	18 2%	9 2%	8 2%	3 2%	6 3%	2 1%	2 1%	1 1%	4 2%	3 2%	3 1%	5 2%	7 2%	5 1%	4 1%	9 4%	1 1%	2 4%	11 7%	1 *
Never bothered/no time/not got round to it	94 10%	52 11%	42 8%	18 9%	19 11%	16 11%	17 13%	11 8%	12 7%	18 12%	26 13%	27 10%	23 7%	49 11%	17 6%	28 12%	1 1%	2 5%	13 8%	76 12%
Never thought of it	50 5%	28 6%	22 4%	10 5%	5 3%	3 2%	4 3%	15 11%	12 8%	3 2%	8 4%	18 6%	21 6%	22 5%	8 3%	21 9%	0 –	1 1%	1 1%	48 7%
No/nothing off-putting	316 32%	175 38%	141 27%	69 34%	66 37%	52 34%	42 31%	37 27%	50 30%	26 18%	72 35%	105 37%	113 33%	139 30%	127 44%	49 22%	*57* *58%*	*25* *50%*	*47* *30%*	*183* *28%*

SCOTTISH OPINION SURVEY – BLOOD DONATION

B.2 IS THERE ANYTHING THAT PUTS YOU OFF IDEA OF GIVING BLOOD

BASE: ALL RESPONDENTS

		SEX		AGE						CLASS				AREA			DONOR STATUS			
	TOTAL	MALE	FEMALE	15–24	25–34	35–44	45–54	55–64	65+	AB	C1	C2	DE	WEST	EAST	NORTH	CURRENT DONOR	LAPSED DONOR	EX-DONOR	NON-DONOR
Total (unwtd.)	976	467	509	171	252	177	130	113	133	103	206	305	362	461	287	228	108	56	157	639
(wtd.)	976	459	517	205	176	156	137	137	166	146	205	283	342	465	287	224	98	50	156	650
	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Other general comments	8	6	2	1	3	2	0	1	1	1	2	3	2	2	1	5	1	0	1	5
	1%	1%	*	1%	2%	1%	–	1%	1%	1%	1%	1%	1%	1%	*	2%	1%	–	1%	1%
Don't know	21	8	13	5	3	2	2	4	5	5	6	6	4	14	6	2	7	1	3	2
	2%	2%	2%	3%	2%	1%	2%	3%	3%	4%	3%	2%	1%	3%	2%	1%	7%	3%	2%	*

System Three Scotland,
16, York Place, Edinburgh

TABLE 3

B.3 HOW LIKELY THINK FOLLOWING ARE

BASE: ALL RESPONDENTS

			SEX		AGE						CLASS				AREA			DONOR STATUS			
		TOTAL	MALE	FEMALE	15–24	25–34	35–44	45–54	55–64	65+	AB	C1	C2	DE	WEST	EAST	NORTH	CURRENT DONOR	LAPSED DONOR	EX-DONOR	NON-DONOR
Total (unwtd.) (wtd.)		976 976 100%	467 459 100%	509 517 100%	171 205 100%	252 176 100%	177 156 100%	130 137 100%	113 137 100%	133 166 100%	103 146 100%	206 205 100%	305 283 100%	362 342 100%	461 465 100%	287 287 100%	228 224 100%	108 98 100%	56 50 100%	157 156 100%	639 650 100%
PEOPLE IN SCOTLAND COULD CATCH THE AIDS VIRUS FROM GIVING BLOOD																					
Very likely	(4)	37 4%	13 3%	24 5%	12 6%	5 3%	2 1%	7 5%	8 6%	3 2%	0 –	5 3%	14 5%	18 5%	23 5%	13 4%	1 *	5 5%	0 –	1 *	31 5%
Quite likely	(3)	150 15%	64 14%	86 17%	34 17%	21 12%	26 16%	19 14%	23 17%	28 17%	20 14%	16 8%	41 15%	72 21%	77 16%	44 15%	29 13%	2 2%	4 8%	16 10%	122 19%
Not very likely	(2)	262 27%	126 27%	137 26%	58 28%	55 31%	36 23%	40 29%	32 23%	41 25%	44 30%	70 34%	65 23%	83 24%	142 30%	55 19%	66 29%	28 28%	15 29%	43 27%	171 26%
Not at all likely	(1)	464 48%	232 51%	232 45%	91 45%	89 51%	88 56%	63 46%	57 42%	76 46%	81 55%	99 49%	145 51%	138 41%	199 43%	144 50%	121 54%	62 63%	31 62%	87 56%	277 43%
Don't know		63 6%	24 5%	39 8%	9 4%	6 4%	5 3%	8 6%	17 13%	18 11%	1 1%	14 7%	18 6%	30 9%	24 5%	32 11%	7 3%	2 2%	0 –	11 7%	48 7%
MEAN STD. DEV. STD. ERR. ERR. VAR.		1.74 .87 .029 .001	1.67 .83 .040 .002	1.79 .91 .042 .002	1.83 .93 .072 .005	1.65 .80 .051 .003	1.61 .80 .061 .004	1.76 .89 .081 .006	1.85 .96 .097 .009	1.72 .85 .078 .006	1.58 .72 .072 .005	1.62 .75 .054 .003	1.71 .91 .054 .003	1.90 .95 .052 .003	1.83 .90 .043 .002	1.71 .92 .057 .003	1.59 .73 .050 .002	1.48 .77 .075 .006	1.46 .65 .086 .007	1.52 .70 .058 .003	1.85 .92 .038 .001
PEOPLE IN SCOTLAND COULD CATCH THE AIDS VIRUS FROM RECEIVING A BLOOD TRANSFUSION																					
Very likely	(4)	113 12%	44 10%	69 13%	24 12%	17 10%	20 13%	16 12%	15 11%	20 12%	10 7%	22 11%	30 10%	52 15%	67 14%	36 12%	10 4%	9 9%	2 4%	14 9%	88 14%
Quite likely	(3)	322 33%	140 31%	182 35%	75 36%	51 29%	43 27%	37 27%	51 37%	65 39%	39 27%	46 22%	92 32%	146 43%	155 33%	99 35%	68 31%	12 12%	15 31%	48 31%	241 37%
Not very likely	(2)	326 33%	169 37%	157 30%	72 35%	74 42%	55 35%	53 39%	34 25%	38 23%	62 42%	97 47%	94 33%	73 21%	170 37%	69 24%	86 39%	46 47%	20 41%	58 37%	193 30%
Not at all likely	(1)	162 17%	84 18%	77 15%	27 13%	27 15%	34 22%	26 19%	21 15%	28 17%	33 22%	27 13%	55 19%	48 14%	51 11%	66 23%	45 20%	30 30%	12 23%	29 19%	88 13%
Don't know		53 5%	21 5%	32 6%	7 4%	7 4%	4 3%	4 3%	15 11%	15 9%	3 2%	13 7%	13 5%	23 7%	22 5%	16 6%	14 6%	2 2%	0 –	7 4%	39 6%
MEAN STD. DEV. STD. ERR. ERR. VAR.		2.42 .92 .030 .001	2.33 .90 .043 .002	2.50 .92 .042 .002	2.49 .87 .068 .005	2.35 .87 .056 .003	2.32 .97 .074 .005	2.33 .92 .082 .007	2.50 .92 .092 .008	2.52 .94 .085 .007	2.18 .86 .086 .007	2.33 .85 .061 .004	2.36 .92 .054 .003	2.63 .93 .050 .003	2.54 .88 .042 .002	2.39 1.00 .060 .004	2.21 .83 .057 .003	2.00 .89 .086 .007	2.16 .83 .111 .012	2.31 .89 .073 .005	2.54 .91 .037 .001

APPENDIX 4: EASING THE PROCESS

Possible approaches to ease the screening process

1) Self-administered questionnaire

2) Self-administered allocation of donated blood for transfusion or other purposes.

1) SELF-ADMINISTERED QUESTIONNAIRE

This would be part of checking all relevant aspects of health but including the areas related to AIDS.

The donor is not eliminated immediately at the session but donated blood can be traced and appropriate action taken, re blood and donor depending on the information given. Thus there is less potential for embarrassment. It is also anonymous, using code numbers rather than names.

This approach is less offensive and does not suggest so strongly that people have AIDS. It also avoids the negative approach, ie. 'DO NOT GIVE BLOOD IF...'. Furthermore, it does not single out AIDS as a high profile issue, rather treating it in a more matter of fact manner.

The material is marginally more likely to be read more carefully if donors have to put a tick for each response.

The current proforma for the Edinburgh and South East Scotland 'Health check for new blood donors' might be suitable for modification in this way (see below), although further research would be required into this,

For example:

- Modify the introductory paragraph - second sentence to read 'It is also important that we know whether your donation contains anything harmful to the patients receiving it, eg. medicines or viruses.'
- Modify Section F
    - heading -> SCREEN FOR OTHER DISEASES
    - change categories into questions and provide Yes/No boxes
    - change the order of the statements/questions, eg. move the first one to the end in order to avoid 'switch-off' effect due to prominence of the specific AIDS category.

EDINBURGH AND SOUTH-EAST SCOTLAND BLOOD TRANSFUSION SERVICE

EALTH CHECK FOR NEW BLOOD DONORS — Before we can accept you as a blood donor we must make sure giving lood will do you no harm. We must also ensure the donation does not contain anything harmful to the patient receiving it, g. medicines or viruses. Every donation of blood is tested for Hepatitis B, Syphilis and AIDS antibody. If you do not want to tested, please do not give blood.

LEASE READ THESE QUESTIONS AND TICK THE ANSWER THAT APPLIES TO YOU

GENERAL QUESTIONS

Have you ever been rejected as a blood donor? YES ☐ NO ☐
Are you under 18 or over 65 years of age? YES ☐ NO ☐
Are you under 8 stone in weight? YES ☐ NO ☐
Ladies, are you pregnant or do you have a child under 1 year? YES ☐ NO ☐

SAFETY FOR YOU AND OTHERS

Do you drive a public service vehicle or a heavy goods vehicle? YES ☐ NO ☐
Are you involved in unusual hazards of heights or depths? YES ☐ NO ☐

SCREEN FOR INFECTION

Have you had a tooth extraction in the last 3 days? YES ☐ NO ☐
Have you been in contact with any infectious diseases in the last 3 weeks? YES ☐ NO ☐
Have you received any vaccinations or injections in the last 3 months? YES ☐ NO ☐
Have you had malaria? YES ☐ NO ☐
Have you been abroad in a malaria area in the past 12 months? YES ☐ NO ☐
Have you had jaundice or hepatitis in the past 12 months? YES ☐ NO ☐

SCREEN FOR HEPATITIS CONTACT — In the past SIX MONTHS have you:—

Been exposed to, or lived in the same house as a hepatitis patient? YES ☐ NO ☐
Had your ears pierced/been tattooed/received acupuncture? YES ☐ NO ☐
Have you received a blood transfusion? YES ☐ NO ☐

SCREEN FOR GENERAL HEALTH

Have you been unwell recently? YES ☐ NO ☐
Have you visited your Doctor/Hospital/Clinic recently? YES ☐ NO ☐
Have you ever had a serious illness or operation? YES ☐ NO ☐
Do you suffer from chest pains? YES ☐ NO ☐
Do you have a persistent cough? YES ☐ NO ☐
Are you breathless on slight exertion? YES ☐ NO ☐
Do you have kidney trouble? YES ☐ NO ☐
Do you have diabetes? YES ☐ NO ☐
Do you have asthma or any allergies? YES ☐ NO ☐
Do you have fits or fainting spells? YES ☐ NO ☐
Do you take medicines or tablets (apart from the contraceptive pill)? YES ☐ NO ☐
Have you lost weight recently (not dieting)? YES ☐ NO ☐
Have you had recurrent infections, night sweats or persistently swollen glands recently? YES ☐ NO ☐

AIDS — PEOPLE WHO MUST NOT GIVE BLOOD

Anyone who has AIDS or the AIDS antibody.

Any man who has had sex with another man since 1977.

Anyone who has **ever** injected themselves with drugs.

Anyone who has lived in or visited Africa south of the Sahara at any time since 1977 **and** has had sex with men **or women** living there.

Anyone who has had **regular** treatment with blood products since 1977.

Anyone man or woman who has been a prostitute at any time since 1977.

Anyone who has ever had sex with a person in the above groups **even on a single occasion.**

2) SELF-ADMINISTERED ALLOCATION OF DONATED BLOOD FOR TRANSFUSION OR OTHER PURPOSES

This approach also provides an alternative to not donating, making it possibly easier for some people to co-operate, for example, persons possibly in AIDS risk groups but not acknowledging it yet to their peers, colleagues, family.

Requirements:

- Inform potential donors of current AIDS risk categories - prior to session and at session. If using the current material it should be modified in order to make the tone less negative, in particular removal of the 'MUST NOT GIVE BLOOD' elements and substitution of the suggestion that risk group members should either not donate or allocate blood only to studies.
- Request those in the risk groups either to not give blood or to allocate blood for studies and not for transfusion by completing a confidential form.
- Ensure confidentiality:
    - privacy stations to allow completion of form and sealing in envelope
    - unique code number on envelope, linked with donation.

An outline of the possible format for a confidential form is given on the following page.

A similar procedure is described in Pendyck et al (1) as part of overall screening procedures:

- 97% declared their blood suitable for transfusions
  1.4% excluded themselves
  1.6% did not respond

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(1) Pendyck J, Waldman A, Zang E, Oleszho W, Lavy M, Bianco C (1985) Measures to decrease the risk of acquired immunodeficiency syndrome transmission by blood transfusion. Transfusion, Vol 25, No 1.

Possible format for confidential form

(Further research required into Scottish donor acceptability)

THE FOLLOWING GROUPS OF PEOPLE ARE AT RISK OF CARRYING THE HIV (HTLV III) VIRUS (AIDS)

Anyone who had AIDS or the AIDS antibody.

Any man who has had sex with another man since 1977.

Anyone who has EVER injected themselves with drugs.

Anyone who has lived in or visited Africa south of the Sahara at any time since 1977 AND has had sex with men OR WOMEN living there.

Anyone who has had REGULAR treatment with blood products since 1977.

Anyone man or woman who has been a prostitute at any time since 1977.

Anyone who has ever had sex with a person in the above groups EVEN ON A SINGLE OCCASION.

THERE IS THEREFORE A RISK THAT THEIR BLOOD COULD HARM A PATIENT RECEIVING IT.

SNBTS would be grateful if you could select one of the following options (tick box).

'My blood donation should only be used for studies' ☐

'My blood donation may be used for transfusion' ☐