Reviewer’s report

Title: Gay and Bisexual Men’s Views on Reforming Blood Donation Policy in Canada: A Qualitative Study

Version: 0 Date: 13 May 2019

Reviewer: Bridget Haire

Reviewer's report:

This paper provides important perspectives on how a diverse sample of gay, bisexual, queer and other Canadian men who have sex with men (GBM*) respond to current restrictions on blood donation, and whether they think a shift from a 12 month to a 3 month deferral for MSM* would improve matters. It is a timely paper, given that blood donation deferrals for MSM are being reviewed both in Canada and internationally. The purposive sampling for diversity is well considered, and the qualitative methodology appropriate for eliciting rich data of participant views. My key criticisms of the paper relate to the framing of the Canadian context regarding blood donation, and specifically to the framing of risk - particularly HIV risk - for the Canadian blood supply.

BMC Public Health is an international journal, so in the introduction some space needs to be allocated to providing some basic national HIV epidemiology to give some perspective to the framing of HIV risk for GBM. (I am from Australia, another high income country but one with an HIV epidemic that is more significantly concentrated in GBM than Canada's, but I had to do my own research to see how comparable the epidemics are.) An understanding of the epidemiology is needed to evaluate the argument that 'a fair and safe policy would be one that is "the same for everybody"' - i.e. gender/sexuality blind. The introduction also needs to briefly say which other groups/individuals are deferred and how blood is treated after a donation - is each donation separately tested for the full range of BBVs using antibody and RNA tests, or does some part of this happen with pooled samples. Again, this help evaluate whether the whole issues could be resolved by blood screening.

The methodology section is clear and the results section rich and well-written.

In the discussion, I have a number of suggestions and recommendations.

At the end of the first paragraph, the authors make a point that individuals with the GBM population group can be significantly lower risk than people currently eligible to donate blood. This is an important point. There is a Dutch study that investigated this: Van Bilsen WPH, Zaaijer HL, Matser A, et al. Infection pressure in men who have sex with men and their suitability to donate blood. Clin Infect Dis 2019; 68(6):1001-8, and my colleague and I wrote a commentary on it: Haire BG, Kaldor JM. Prevalence of Transfusion-transmissible Infections, Not "Infection Pressure," Should Dictate Suitability to Donate Blood. Clinical Infectious Diseases. 2018;68(6):1009-10. Van Bilsen's data showed that Dutch GBM who met Dutch blood donation criteria other than the MSM factor did not have a higher prevalence of transfusion-
transmissible infections (TTIs), though they did have a higher 'infection pressure' prevalence. Essentially, van Bilsen's article shows some evidence that in an GBM population broadly comparable to Canada's there was a cohort of 'low risk' GBM who didn't have higher rates of TTIs. Our commentary argues that this is highly significant, and should not be overshadowed by the 'infection pressure' measure. I think that reference to this evidence would strengthen your argument about GBM at low risk - within the van Bilsen piece, you can find the kinds of screening that can separate the low risk GBM from those at higher risk, even in an MSM-concentrated HIV epidemic.

In the second paragraph of the discussion, the authors quote Kesby et al. the quote makes a good point, but it is couched in unnecessarily complex language. I'd highly recommend paraphrasing it.

On page 31, there needs to be some critical analysis of the 'gender blind' screening proposition. In Haire B, Whitford K, Kaldor JM. Blood donor deferral for men who have sex with men: still room to move. Transfusion. 2018;58(3):816-22, we provide a critique of Italy's 'gender blind' screening:

We note that: Since the introduction of this policy in 2001, the absolute number of blood donations that test positive to HIV infection has tripled in 2009 and in 2010 compared to 1999 (while the donor pool has approximately doubled). However, among blood donors found to be HIV positive, the proportion of MSM donors was not significantly different between the two periods.

In addition: The problem with models that consider only behavior and not the gender of the sexual partner in the Australian context is that, in view of the highly MSM focused epidemiology of the Australian HIV epidemic, the gender of a sex partner is highly relevant to calculating risk. Thus in Australia such an approach is likely to greatly overestimate the risk in heterosexual donors, as it would exclude many heterosexual people who had had multiple sexual partners but do not pose a risk, and potentially underestimate the risk in MSM where even a single sex partner with an unknown sexual history could pose an appreciable risk.

In the conclusion, your results suggest not only that Canada needs a fair and evidence-based approach to donor screening (and the 12 month deferral for MSM simply does not make sense) but also that there needs to be community education about how and why some screening practices are likely to continue. As stated in your article, it is important that any new regime is well understood and accepted, in order for it to work optimally.

*The authors use the more descriptive and inclusive 'GBM' when talking about their sample, and 'MSM' when talking about how this population is described by the blood industry. I have adopted the same usage.

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If not, please specify what is required in your comments to the authors.

Yes
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