can be assessed using standardised questionnaires, among those a 2019 questionnaire developed by a multi-organisational Task Force. However, this questionnaire includes multiple stigmatising questions—examples of which can be found in the appendix (p 1)—that are barriers to inclusion for marginalised and disenfranchised donor groups, including gay, bisexual, and other men who have sex with men, and people of African heritage. Screening questions assessing for high-risk sexual behaviour should be gender neutral (see example in the appendix p 2) to avoid further contributing to stigma against donation from men who have sex with men, an eligible but largely untapped donor pool.[2–4] Additionally, asking donors if they have any associations with the continent of Africa, or if their sexual contacts have African heritage, is discriminatory, contributes to systemic racism, exacerbates historic mistrust between African ancestry populations and health-care systems, and interferes with efforts to address racial disparity in access to unrelated donors for patients with African ancestry.[5]

Screening for risk factors for transmissible diseases is warranted pre-transplantation; although donors undergo a battery of pre-transplantation infectious disease tests, they can still contract window-period infections. Nevertheless, such screening is of restricted value at the time of recruitment as behavioural risk factors change over time. Moreover, these questions are not a substitute for detailed medical, sexual, and social histories obtained by the transplantation physician at the time of donor selection and evaluation. Similarly, screening questions about incarceration and sex work do not contribute substantially over and above this detailed history, are needlessly stigmatising, and disproportionately affect specific minority populations who are needed as donors.

Overall, health equity needs to be prioritised alongside donation safety. Recommendations and screening questions should protect donors and patients, while also minimising stigma, bias, and discrimination against donors from marginalised groups. Applying an equity lens to the development of future donor suitability recommendations will help to build a more inclusive transplantation system.

I declare no competing interests.

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1 Worel N, Aljurf M, Anthias C, et al. Suitability of haematopoietic cell donors: updated consensus recommendations from the WBMT standing committee on donor issues. *Lancet Haematol* 2022; **9:** e605–14.
2 Fingrut W, DeGurse N, Hrycyshyn A, et al. Towards a more inclusive unrelated donor registry. *Bone Marrow Transplant* 2022; **57:** 688–90.
3 Hatkar R, Sano L, DeGurse N, et al. Saving lives with Pride: development and evaluation of multimedia resources to engage gay, bisexual, and queer men in Canada as stem cell donors. *Blood* 2021; **138** (suppl 1)**:** 3017 (abstr).
4 Rosenfeld A, Baribeau O, Berscheid K, et al. "Building a more inclusive blood system in Canada": a mixed-methods evaluation of a workshop to guide medical students to develop as health advocates through advancing health equity in blood product donation for gay, bisexual, and queer men. *Blood* 2021; **138** (suppl 1)**:** 2975 (abstr).
5 Fingrut W, Gyurkocza B, Davis E, et al. Racial disparities persist in the era of "Donors for All". *Blood Advances* 2022; published online June 8. https://doi.org/10.1182/bloodadvances.2022007814.

Authors' reply

We thank Warren B Fingrut for his interest in our Review[1] and for highlighting the important issue of health equity alongside donation safety. The authors concur on the paramount importance of ensuring that both donor wellbeing and product safety remain central to the process of haematopoietic stem-cell donation. A major component includes minimising the risk of blood-borne infectious disease transmission from product to recipient using donor health screening questionnaires that are largely synchronous with and adapted from established guidelines for blood transfusion donation.

Fingrut has pointed out the need to re-evaluate some donor questions, so that all potential donors are treated equally on the basis of individual risk factors and without regard to their sexual orientation or gender identity. This approach was powerfully highlighted by the American Medical Association (AMA) in January, 2022, when it called on the US Food and Drug Administration (FDA) to remove its discriminatory ban that prevents many gay and bisexual men from becoming blood donors.[2]

The AMA argues that the current 3-month deferral period for gay and bisexual men singles out blood donors on the basis of their inherent attributes rather than risk factors. As a result of the HIV/AIDS crisis, the FDA established a lifetime ban on donations by men who have sex with men in 1985. This ban was subsequently modified to a 1-year deferral in 2015 and finally shortened to 90 days in 2020. This timeline not only illustrates the need for regular re-evaluation of such potentially contentious criteria, but the importance of ensuring that safety is not compromised. Such re-evaluation must be based on scientifically sound and objective findings. One effort is the Assessing Donor Variability And New Concepts in Eligibility (ADVANCE) study, which is being conducted by US blood centres—including the American Red Cross—with the hope that the results, when available, will help to shape future FDA donor-eligibility requirements.[3] The AMA have also proposed a change to the restrictions on donation of human cells and tissues by men who have sex with men.

Other countries have already made changes informed by evidence-based reviews. The UK announced a landmark change to blood donation eligibility rules in 2021 and abolished its restriction from voluntary blood

For the **2019 questionnaire** see https://www.aabb.org/news-resources/resources/donor-history-questionnaires/haematopoietic-progenitor-cell-apheresis-and-marrow-donor-history-questionnaire

See **Online** for appendix

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donation for any man who had sex with a man in the last 3 months. The new criteria will now allow men who have sex with men in a monogamous relationship to donate blood and is a historic move to make blood donation more inclusive, while maintaining blood safety. Additionally, the question of if "you or your partner has had sexual contact in Sub-Saharan Africa" has been removed. The changes follow an evidence-based review into individualised criteria by the For the Assessment of Individualised Risk steering group (known as FAIR) led by the UK National Health Service's Blood and Transplant service.[3]

We authors acknowledge that such evidence-based reviews are urgently needed in the field of haematopoietic stem-cell donation. The aim for a more inclusive, unrelated donor registry will benefit this field enormously, because it has long been recognised that minority ethnic groups are under-represented in unrelated registries and have an a increased attrition rate caused by various factors.[4] All of these features lead to a reduced probability of finding a suitable match for patients belonging to minority ethnic groups, affecting equitable access to haematopoietic stem-cell transplantation.[5]

This Review by the donor issues committee of the Worldwide Network for Blood and Marrow Transplantation (WBMT) aims to provide recommendations that will be useful and implemented internationally.[1] We authors recognise the worldwide diversity of political systems, religious beliefs, and societal differences and that continuing re-evaluation—together with evidence-based findings—are necessary to guarantee that guidelines are clear, prevent misinterpretation, and do not allow for discrimination. The stance of the Worldwide Network for Blood and Marrow Transplantation is clear: equal respect of all individuals, including all patients and donors.

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1 Worel N, Aljurf M, Anthias C, et al. Suitability of haematopoietic cell donors: updated consensus recommendations from the WBMT standing committee on donor issues. *Lancet Haematol* 2022; **9:** e605–14.
2 Harmon GE. The FDA must lift its discriminatory blood-donor policy. Jan 26, 2022. https://www.ama-assn.org/about/leadership/fda-must-lift-its-discriminatory-blood-donor-policy (accessed Sept 4, 2022).
3 FAIR steering group. Blood donor selection policy: More people now able to give blood. May 11, 2021. https://www.blood.co.uk/news-and-campaigns/news-and-statements/fair-steering-group/ (accessed Sept 4, 2022).
4 Fingrut W, DeGurse N, Hrycyshyn A, et al. Towards a more inclusive unrelated donor registry. *Bone Marrow Transplant* 2022; **57:** 688–90.
5 Anthias C, Shaw BE, Bruce JG, et al. Role of race/ethnicity in donor decisions about unrelated hematopoietic progenitor cell donation: exploring reasons for higher attrition among racial/ethnic minorities. *Biol Blood Marrow Transplant* 2020; **26:** 593–99.

Blueprint for greater security of immunoglobulins for patients in Canada

I read with interest the Editorial in *The Lancet Haematology* describing the interim report of the UK's Infected Blood Inquiry.[1] The Editorial correctly noted that the contaminated blood scandal "spurred the creation" of Canadian Blood Services. It is a tragic history that has shaped and guided our organisation. I too assert that individuals affected by this history deserve justice. The mistakes of the past must not be repeated.

However, I would like to address two inaccuracies. The Editorial stated that "paid-for systems are widely regarded as being less safe than those in which blood is altruistically given".[1] This is misleading. Modern technology has made plasma products safe, regardless of whether the donor is provided an incentive. There has not been a single case of transmission of hepatitis B, hepatitis C, or HIV through plasma products in several decades.

The Editorial also noted "it was recently announced that the plasma collection [of Canadian Blood Services] is to be sold to a foreign pharmaceutical company and turned into a for-profit system".[1] This is fundamentally incorrect. Canadian Blood Services has announced a plan to increase and protect the supply of plasma for immunoglobulins in Canada. These actions are informed by a risk-based decision-making analysis[2] that generated recommendations for collaborative action across the broader blood supply system, including to act with urgency and leverage both not-for-profit and commercial sectors. The plan includes an agreement with Grifols, a global leader in producing plasma medicines. Under the agreement, both Canadian Blood Services and Grifols will collect plasma that will be manufactured into immunoglobulins for patients in Canada. Purchasing immunoglobulins from the commercial plasma sector has been part of the organisation's practice for more than two decades. This agreement provides essential protections for the national blood supply system, including controls to prevent negative effects on our current and future network of blood and plasma donor centres; ensures plasma donated in Canada is used to make immunoglobulins in Canada, for patients in Canada; and enables a domestic end-to-end supply chain for immunoglobulins.