BLOOD DONATION AND DONOR RECRUITMENT

Original article

Exploring MSM blood donor profiles: a descriptive analysis of demographics, risk characteristics, and donation behaviors

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Background - The importance of addressing the blood donor population among men who have sex with men (MSM) is increasing with the global liberalization of blood donor deferral policies. Effective donor management, especially retaining existing donors and recruiting new donors, is essential for a safe and sufficient blood supply. Strategies to engage the broader blood donation population are well-established. However, the historical exclusion of MSM from blood donation, based on heightened HIV risk, has limited the understanding of MSM's unique behavioral and risk characteristics as potential donors. Characterizing these donors (and non-donors) will be useful for blood services to tailor outreach and engagement strategies effectively as deferral policies continue to evolve.

Materials and methods - Data from a national behavioral surveillance program of MSM in New Zealand were examined. We explored differences in demographic and risk characteristics associated with an increased risk of HIV across three groups (i.e., profiles) sorted by their donation history and recency: non-donors, non-active donors, and active donors.

Results - Clear characteristics associated with each donor profile emerged among the 3,225 MSM participants. Active donors (4.2%) were younger, students, less engaged with the LGBTQI+ community, reported fewer risk behaviors and were less sexually active. Non-active donors (36.9%) typically exhibited more characteristics associated with an increased risk of HIV. However, non-donor profiles (56.7%) were less clear in comparison, sharing demographic similarities with active donors but displaying risk characteristics similar to those of non-active donors.

Discussion - In this first study to describe MSM blood donor profiles, we have identified unique characteristics specific to MSM which blood services can use to pinpoint targets for engaging current, new, and previous donors. Future research should examine the factors affecting non-donor status among MSM, as they do not appear to be solely driven by demographic and recent behavioral risk factors.

Keywords: *blood bank, blood donors, risk factors, donor selection, men who have sex with men.*

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INTRODUCTION

The landscape of blood donation has recently been in flux, influenced by scientific advancements of HIV prevention and transfusion technology and increasing recognition of diversity within donor populations. Amidst this demographic diversity, men who have sex with men (MSM) have commanded substantial attention. MSM who have, or have not, donated blood may possess distinct demographic and behavioral risk characteristics that are relevant to deferral policies as many countries embrace more individualized risk assessments[1-3]. Blood services globally are now faced with questions about how to effectively attract and retain newly eligible MSM donors. In turn, this agenda requires an awareness of the characteristics of MSM who donate and do not donate.

Effectively managing prospective and existing donors is vital to ensuring a safe and reliable blood supply[4]. The need for donor retention becomes evident when considering the finite pool of eligible donors and the consequent need to rely on a small, dedicated group of non-renumerated individuals. More simply, it is critical that blood services both recruit new donors to keep up with increasing demands as well as maximize engagement among existing donors[4-6]. Returning donors are valuable to blood services as they ensure a consistent supply[5,7] and increase the safety of that supply, because they are more likely to have lower markers of transfusion transmissible infections[8]. In this light, blood services have a direct interest to adapt outreach, recruitment, and retention strategies in response to the evolving demographic composition of the eligible donor population.

More technically, blood services need the ability to create up-to-date donor profiles to keep donors engaged[9]. For example, it is plausible that strategies used to engage someone with a history of recent donations (often referred to as "active donors") would differ from those used among those who donated the same number of times but have not done so recently (referred to as "non-active donors"). Globally, data suggest that non-active donors report more obstacles to resuming donations than active donors[10] and become less likely to resume donations as more time elapses[11]. Reasons to not return include time constraints, medical reasons, negative physical reactions post-donation, or in the case for many MSM, having been temporarily deferred[12-15]. As deferral policies for MSM evolve, blood services find themselves presented with a unique chance to reconnect with temporarily deferred or non-active donors and reintegrate them into the blood donation system. However, achieving this will hinge on the ability to characterize MSM who have or have not chosen to engage with the blood donation system.

Although evidence is only starting to emerge, it seems reasonable to suspect that MSM may exhibit distinct donor profiles compared to the non-MSM donor population. The historical exclusion of MSM from blood donation based on heightened HIV risk factors[16,17] has been, and continues to be, both controversial and perceivably stigmatizing to MSM[18]. For instance, deferral rules spotlight behaviors that are incidentally common among MSM such as recent anal sex[19] and pre-exposure prophylaxis (PrEP) use[20], and as a result, many MSM view these policies to be outdated, unfair, unscientific, and discriminatory[21,22]. Identifying potentially unique experiences within the MSM community will allow agencies to design more inclusive and respectful blood donation policies, and to develop tailored strategies for donor recruitment and retention. This will be important as more MSM become eligible to donate blood. However, while donor profiles are well-established for the general donor population (i.e., non-MSM)[5,23-25], the same cannot be said of MSM donors.

This paper contributes to this knowledge gap by providing a descriptive demographic and behavioral risk characterization of a large sample of MSM participants from a nationwide cross-sectional survey. Comparisons between three groups are presented. Using the Red Cross classifications for donor profiles[26], participants are grouped by donation status (never *vs* 1+ prior donations) and donation recency to create groups of non-donors, active donors, and non-active donors.

MATERIALS AND METHODS

Design

The Sex and Prevention of Transmission study (SPOTS) is a voluntary, confidential, online, cross-sectional national behavioral surveillance survey about sex between men, HIV prevention, and blood donation in New Zealand (NZ). Participants were recruited between April and August 2022 through advertisements on social media, gay dating mobile applications, pornography websites, national television and print media, via community organizations'

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mailing lists, and posters in public and gay-friendly venues across NZ. Consent was obtained prior to the online questionnaire hosted on Salesforce (San Francisco, CA, USA)/SurveyTitan. The study was funded by the Health Research Council of New Zealand(Ref 20/887) and was approved by the Health and Disability Ethics Committee (HDEC 2021 EXP 11450). Details of the behavioral surveillance program are reported elsewhere[27].

Participants

People were eligible if they were over 16 years old, lived in NZ, and identified as a gay, bisexual or non-heterosexual man (cis or trans) or reported having had sex with another man at least once. For the current analysis, participants were excluded if they did not provide a response to the first question of the blood donation section of the survey ("*Are you interested in donating blood?*") (**Figure 1**).

Measures

Demographics collected included age, ethnicity, region, education level, employment status, disability status, and sexual identity. For analysis, age was simplified into three categories (<30, 31-44, and 45+ years). Ethnicities were prioritized as per NZ Census Standards in the following hierarchical order: Māori, Pacific, Asian, Other, and NZ European[28].

A measure of MSM's social identity was asked using two questions: "*How much of your free time is spent with other gay, bisexual, takatāpui* (Māori term), *or other MSM?*" (A lot of time/Not a lot of time) and "*How open are you about your sexual orientation/sexual identity?*" (Out to most people/Not out to most people).

To determine whether general indicators of the risk characteristics of each profile were differentially

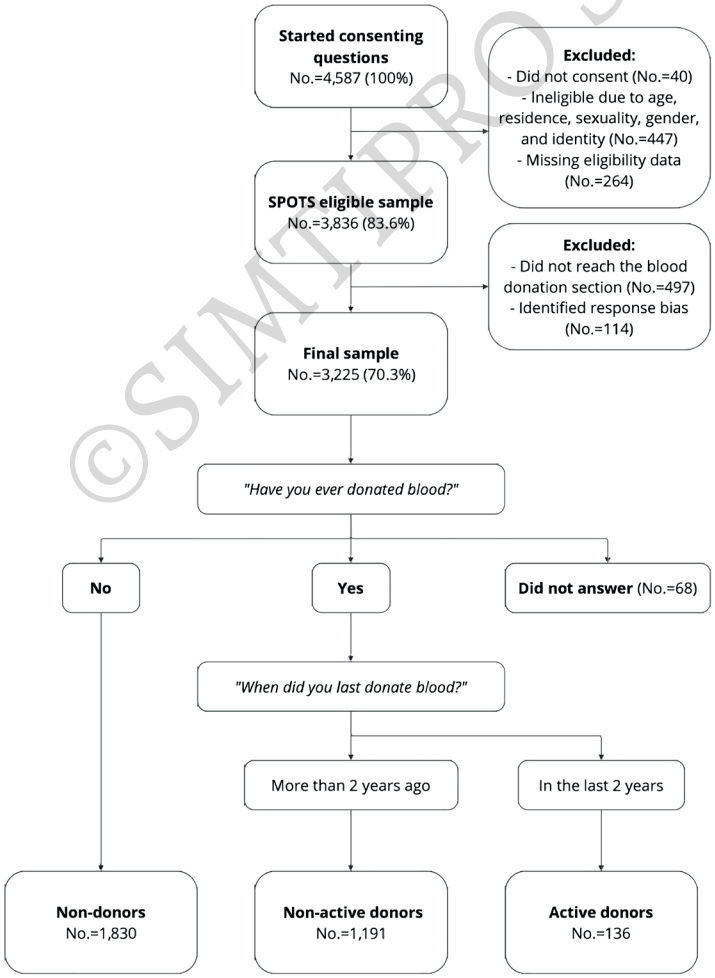


Figure 1 - Participants flow chart

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associated, we assessed a series of behavioral characteristics relevant to assessing their blood donation eligibility. We examined deferrable behaviors associated with a higher risk of HIV transmission (the following responses were dichotomized as Yes/No): engagement in sex work in the last 3 months, a history of injecting non-prescription drugs, diagnoses of any sexually transmitted infections (STI) in the last 12 months, or a history of being diagnosed with syphilis or hepatitis C. We categorized recent participation in chemsex as individuals reporting engagement in the use of "drugs for the purpose of sex (e.g., chemsex, party'n'play, wired sex)" in the last 6 months. Individuals were categorized as using PrEP if they had taken at least one dose in the last 3 months. Additionally, participants also reported the result of their last HIV test (negative, positive, and never tested), the number of recent partners in the last 3 months (none/never had sex, one, or 2+), and their current relationship status (No partner/Partnered with someone for longer than 3 months).

Participants provided information about prior donation behavior (ever donated, and year of the last donation) and whether they were interested in donating (Yes/No). Participants were also asked if they were aware of the three deferral rules (Yes/No) most relevant to MSM around recent anal/oral sex with another man, PrEP use, and permanent deferral of people living with HIV.

Analysis

Data were analyzed using IBM SPSS Statistics 27 (IBM, Armonk, NY, USA). Three donor profiles were established based on participants' reported history of donation and the recency of their donation prior to survey participation: non-donors are those who had never donated blood and amongst those who have donated at least once, active donors are those who recently donated in the two years, and non-active donors are those who have donated once but more than two years ago.

Categorical variables were described using frequencies and proportions. We used Pearson's chi-square tests and p-values to tease out distinct characteristics associated with each donor profile. For all statistically significant chi-square associations, we performed *posthoc* tests while employing a Type I error rate of 5% and Bonferroni corrections to describe significant pairwise differences between donor profiles.

RESULTS

Of 3,836 participants in the SPOTS study, 3,225 participants were eligible for this analysis (**Figure 1**). Participants were excluded when they had not reached the first question of the blood donation section of the questionnaire or where the same number for all items within the section were given (e.g., all 1s, 5s). This uniform response pattern indicated the presence of response bias, and 114 responses were removed from the analyses. Then, participants were divided into three donor profiles. Non-donors made up 56.7% (No.=1,830) of the sample. Among those who had donated previously, 4.2% (No.=136) had actively donated in the previous two years and 36.9% (No.=1,191) had donated more than two years prior to participation.

Demographic differences in donor profiles

Differences in demographic characteristics among the three donor profiles are summarized in **Table I**. Active donors were more likely to be students (33.1%) and aged under 30 (68.9%). Conversely, non-active donors more commonly reported being employed full-time (74.7%), having postgraduate degrees (24.6%), and being older than 30. Participants who had never donated were more likely than non-active donors to report having a long-term disability. There were no differences in ethnicity or regional residence across the three donor groups.

MSM social identity

As seen in **Table II**, the sample predominantly identified as gay (62.6%) and reported spending significant time with other LGBTQI+ individuals (68.0%); most (58.1%) were "out" about their sexuality to most people. However, compared the non-active donors and non-donors, a greater proportion of active donors identified as bisexual (38.2 *vs* 17.2 and 17.4%) and were not "out" to most people (35.0 *vs* 58.2 and 60.3%); more active donors reported not spending a lot of time with other LGBTQI+ people (46.3 *vs* 30.9 and 31.6%).

Deferral policy-related characteristics

The number of sexual partners in the past six months differed across the donor profiles (see **Table III**). Active donors more commonly reported having no recent sexual partners or a history of never having had sex (30.4%) compared with the other two groups (12.1 and 8.1%). Non-active donors (60.3%) and non-donors (57.9%) were

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more likely to report 2+ recent partners than active donors (43.7%). Active donors were also most likely to not have a current regular male partner. The groups did not differ in reported chemsex in the last six months, engagement in sex work in the last three months, or ever injecting non-recreational drugs.

Table I - *Demographic factors across donor profiles*

Variables	1. Non-donors		2. Non-active donors		3. Active donors		Total sample		Chi-square statistic (df)	p-value	*Post hoc* comparisons (Bonferroni corrections)
	No.	(%)	No.	(%)	No.	(%)	No.	(%)			
	1,830	(58.0)	1,191	(37.7)	136	(4.3)	3,157	(100)			
Age											
<30	816	(49.6)	356	(32.6)	82	(68.9)	1,254	(43.9)	129.23(4)	<0.001	3>all**; 1>2**
31-44	559	(34.0)	420	(38.5)	28	(23.5)	1,007	(35.3)			2>all*
45<	269	(16.4)	315	(28.9)	9	(7.6)	593	(20.8)			2>all**; 1>3*
Ethnicity											
NZ European	1,308	(72.0)	853	(72.5)	97	(71.3)	2,258	(72.1)	5.99(6)	0.425	n.s.
Maori	254	(14.0)	143	(12.1)	14	(10.3)	411	(13.1)			
Asian	162	(8.9)	108	(9.2)	14	(10.3)	284	(9.1)			
Other ethnicities	93	(5.1)	73	(6.2)	11	(8.1)	177	(5.7)			
Region											
Urbanized regions	1,406	(85.3)	928	(85.4)	1.6	(89.8)	2,440	(85.5)	1.85(2)	0.397	n.s.
Non-urbanized regions	242	(14.7)	159	(14.6)	12	(10.2)	413	(14.5)			
Education											
No University degree	978	(53.4)	518	(43.5)	75	(55.1)	1,571	(49.8)	36.98(4)	<0.001	1>2**; 3>2*
University degree	527	(28.8)	380	(31.9)	42	(30.9)	949	(30.1)			
Postgraduate degree	325	(17.8)	293	(24.6)	19	(14.0)	637	(20.2)			2>1**; 2>3*
Employment											
Employed full-time	1,114	(67.8)	817	(74.7)	65	(55.1)	1,996	(69.9)	62.86(6)	<0.001	2>all**; 1>3*
Employed part-time	144	(8.8)	95	(8.7)	5	(4.2)	244	(8.5)			
Student	238	(14.5)	102	(9.3)	39	(33.1)	379	(13.3)			3>all**; 2<1**
Other	147	(8.9)	79	(7.2)	9	(7.6)	235	(8.2)			
Long term disability											
No	1,360	(83.1)	942	(86.6)	101	(86.3)	2,403	(84.6)	6.25(2)	0.044	2>1**
Yes	276	(16.9)	146	(13.4)	16	(13.7)	438	(15.4)			2<1**

Note: some cells may not equal to 100% due to missing values. *p<0.05; **p<0.001.

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Table II - *Community social affiliation factors across donor profiles*

Variables	1. Non-donors		2. Non-active donors		3. Active donors		Total sample		Chi-square statistic (df)	p-value	*Post hoc* comparisons (Bonferroni corrections)
	No.	(%)	No.	(%)	No.	(%)	No.	(%)			
Community attachment											
Not a lot of time spent with LGBT+ people	576	(31.6)	366	(30.9)	63	(46.3)	1,005	(32.0)	13.60(2)	0.001	3>all*
A lot of time spent with LGBT+ people	1,244	(68.4)	819	(69.1)	73	(53.7)	2,136	(68.0)			3<all*
Outness											
Not out to most people	698	(41.8)	435	(39.7)	78	(65.0)	1,211	(41.9)	28.57(2)	<0.001	3>all**
Out to most people	971	(58.2)	662	(60.3)	42	(35.0)	1,675	(58.1)			3<all**
Sexual identity											
Gay	1,112	(61.7)	776	(66.6)	55	(40.4)	1,943	(62.6)	54.77(4)	<0.001	3<all**
Bisexual	311	(17.2)	203	(17.4)	52	(38.2)	566	(18.2)			3>all**
Other identities	380	(21.1)	187	(16.0)	29	(21.3)	596	(19.2)			2<all*

Note: Some cells may not equal to 100% due to missing values. *p<0.05; **p<0.001.

Active donors were more likely than participants in the other two groups to report never testing for HIV outside of donating blood (28.0%) and were the least likely to report taking PrEP in the last three months (7.5%) (see **Table III**). While the proportion reporting at least one sexual health test in the past 12 months was similar, non-active and non-donors were more likely to report at least one STI (17.5 and 17.3%) in contrast to active donors

Table III - *Deferral policy-related risk characteristics across donor profiles*

Variables	1. Non-donors		2. Non-active donors		3. Active donors		Total sample		Chi-square statistic (df)	p-value	*Post hoc* comparisons (Bonferroni corrections)
	No.	(%)	No.	(%)	No.	(%)					
Ever injected non-recreational drugs											
No	1,597	(96.3)	1,050	(95.8)	116	(97.5)	2,763	(96.2)	1.06(2)	0.589	n.s.
Yes	61	(3.7)	46	(4.2)	3	(2.5)	110	(3.8)			
Ever diagnosed with hepatitis C											
No	871	(96.6)	623	(97.5)	46	(100)	1,540	(97.0)	2.58(2)	0.275	n.s.
Yes	31	(3.4)	16	(2.5)	0	(0.0)	47	(3.0)			
Ever diagnosed with syphilis											
No	1,609	(90.0)	1,030	(89.6)	129	(96.3)	2,768	(90.1)	6.02(2)	0.049	3>2*
Yes	179	(10.0)	119	(10.4)	5	(3.7)	303	(9.9)			3<2*
Any diagnosed STI (<12 months)											
No	1,499	(82.7)	973	(82.5)	124	(93.2)	2,596	(83.1)	10.21(2)	0.006	3>all*
Yes	314	(17.3)	206	(17.5)	9	(6.8)	529	(16.9)			3<all*
Diagnosed with gonorrhoea (<12 months)											
No	1,694	(92.6)	1,094	(91.9)	131	(96.3)	2,919	(92.5)	3.57(2)	0.168	n.s.
Yes	136	(7.4)	97	(8.1)	5	(3.7)	238	(7.5)			
Chemsex' participation (<6 months)											
No	1,344	(81.4)	885	(80.7)	104	(87.4)	2,333	(81.4)	3.20(2)	0.202	n.s.
Yes	307	(18.6)	212	(19.3)	15	(12.6)	534	(18.6)			
Recent engagement in sex work (<3 months)											
No	1,592	(96.3)	1062	(97.2)	113	(95.0)	2,767	(96.5)	2.58(2)	0.275	n.s.
Yes	62	(3.7)	31	(2.8)	6	(5.0)	99	(3.5)			
Taken PrEP at least once (<3 months)											
No	1,353	(77.2)	814	(72.2)	124	(92.5)	2,291	(76.0)	30.53(2)	<0.001	3>all**; 2<1*
Yes	400	(22.8)	314	(27.8)	10	(7.5)	724	(24.0)			3<all**; 1<2*
HIV status											
Last tested negative	1,450	(81.1)	1008	(86.8)	93	(70.5)	2,551	(82.8)	63.67(4)	<0.001	2>all**; 1>3*
Last tested positive	70	(3.9)	62	(5.3)	2	(1.5)	134	(4.4)			
Never tested	267	(14.9)	91	(7.8)	37	(28.0)	395	(12.8)			3>all**; 1>2**
Number of recent sexual partners (<3 months)											
None/Never had sex	218	(12.1)	94	(8.1)	41	(30.4)	353	(11.4)	62.32(4)	<0.001	3>all**; 2<1*
1	542	(30.0)	369	(31.6)	35	(25.9)	946	(30.5)			
2+	1,044	(57.9)	704	(60.3)	59	(43.7)	1,807	(58.2)			3<all*
Relationship status											
No partner	902	(50.6)	534	(46.2)	95	(69.9)	1,531	(49.8)	28.16(2)	<0.001	3>all**
Partnered for at least 3 months (husband/boyfriend)	882	(49.4)	621	(53.8)	41	(30.1)	1,544	(50.2)			3<all**

Note: some cells may not equal to 100% due to missing values. *p<0.05; **p<0.001.

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Table IV - *Blood donation characteristics across donor profiles*

Variables	1.Non-donors		2. Non-active donors		3. Active donors		Total sample		Chi-square statistic (df)	p-value	*Post hoc* comparisons (Bonferroni corrections)
	No.	(%)	No.	(%)	No.	(%)	No.	(%)			
Interest in donating blood											
No	401	(22.1)	148	(12.5)	4	(2.9)	553	(17.6)	66.47(2)	<0.001	3<all**; 1>2*
Yes	1,417	(77.9)	1,038	(87.5)	132	(97.1)	2,587	(82.4)			3>all**, 1<2*
Awareness of deferral rules											
Deferred for 3 months after last sex with a man											
No	548	(30.5)	330	(28.2)	8	(6.0)	886	(28.6)	37.06(2)	<0.001	3<all**
Yes	1,246	(69.5)	842	(71.8)	126	(94.0)	2,214	(71.4)			3>all**
Deferred for 3 months after last dose of PrEP											
No	1,356	(76.0)	846	(72.4)	57	(42.5)	2,259	(73.2)	71.50(2)	<0.001	3<all**
Yes	429	(24.0)	322	(27.6)	77	(57.5)	828	(26.8)			3>all**
Deferred permanently if you are living with HIV											
No	406	(22.6)	212	(18.2)	19	(14.2)	637	(20.6)	12.14(2)	0.002	2<1*
Yes	1,389	(77.4)	956	(81.8)	115	(85.8)	2,460	(79.4)			2>1*

Note: some cells may not equal to 100% due to missing values. *p<0.05; **p<0.001.

(6.8%). No differences were observed across the groups regarding recent diagnoses of gonorrhea or a history of hepatitis C, although a smaller percentage of active donors reported ever having syphilis (3.7%) compared to non-active donors (10.4%).

Blood donation characteristics

As shown in **Table IV**, interest in blood donation was generally high across the groups, but active donors reported the highest level of interest (97.1%), followed by non-active donors (87.5%). As would be expected, non-donors reported the least interest (77.9%). Overall, active donors reported having the highest awareness of the deferral rules regarding sex with other MSM (94.0 *vs* 69.5 and 71.8%) and the requirement to defer donation for three months since the last dose of PrEP (57.5 *vs* 24.0 and 27.6%). The proportion of non-active donors who were aware that people living with HIV are permanently deferred (81.8%) was higher than those who had never donated blood (77.4%).

DISCUSSION

Understanding the profiles of the MSM community is essential for inclusively optimizing the safety and supply of blood as more countries transition toward an individualized risk assessment approach. These findings help blood services understand the existing MSM donors they wish to retain, offer insights into re-engaging non-active donors, and likewise, engaging non-donors who are likely to become eligible to donate blood for the first time as deferral policies liberalise[29]. The current report provides a detailed description of the demographic and behavioral factors that characterize three distinct MSM donor profiles.

The strength of this paper lies in our ability to highlight MSM donors who are currently 'invisible' to blood services. The existing literature on MSM donors has focused on the self-reporting non-compliance[30-32] or of those who have tested positive for infections[33], or in studies conducted before the wide introduction of biobehavioral measures available for HIV prevention[34]. Our findings have identified and provided insight into self-reporting successful MSM donors (e.g., those who have not reported deferral behaviors) who have previously gone unnoticed in this evolving policy space.

The primary limitation in this analysis stems from the cross-sectional nature of the SPOTS survey. Mainly, we must emphasize that the period over which participants reported behavioral risks (within the last three to 12 months) may not necessarily align with the timing of their last donation (less than or more than two years ago). For example, a participant may have donated blood 12 months ago then tested positive for HIV 3 months prior to survey. While it is potentially concerning to see some

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active donors reporting deferrable behaviors linked to a higher risk of HIV acquisition, such as intravenous drug use, chemsex, and historical syphilis diagnosis, these profiles serve as a general indication of those who may present, or be deemed eligible, to donate blood in the future.

A clear pattern differentiated recent donors (active donors) from MSM who have not donated recently (non-active donors and non-donors). Notably, active donors exhibited a higher prevalence of bisexuality, potentially indexing a lower frequency of sexual activity with men. Although possible, this interpretation is less likely as active donors also reported low sexual activity, having no current partners, and being single. It is thus possible that successful MSM donors represent a younger and, possibly, a more behaviorally conservative segment of the MSM population as characterized by their lower sexual activity and lower community identification compared to less engaged donor groups. The byproduct of such "conservatism" implied in this profile makes them prime candidates for recruitment efforts among MSM blood donors, given their lower risk to the blood supply.

Conversely, our findings indicate that non-active past donors may have multiple barriers preventing them from donating blood recently. Similar to non-MSM populations, MSM with postgraduate degrees, those in full-time employment, and older individuals may face time constraints that interfere with donation despite their willingness[10]. In addition, however, these MSM would have been ineligible to donate as they were the most sexually active donor group and also reported the highest number of deferral behaviors (including multiple recent partners, a history of syphilis diagnosis, and PrEP usage). For blood services to re-engage lapsed MSM donors, clear communication with MSM about their fluctuating risk profiles and how this impacts their eligibility will be important. Such men may be eligible to safely donate with extended periods of no sexual activity, if revised deferral policies have shorter stand-downs periods or focus in on specific practices in context (e.g., anal intercourse with new or multiple partners) rather than broad-based behaviors (e.g., any anal intercourse).

However, it is more difficult to distinguish MSM non-donors from other donor groups by their demographic and risk profile. These men shared similarities with active donors, tending to be younger and more educated. Yet, similarities also emerged in comparison to non-active donors concerning recent behavioral risk factors and higher community identification. As such, our findings suggest that the initiation of donation behavior for MSM cannot solely be defined by their recent behaviors. Instead, previous research suggests that it could be due to other general traits such as "impure" altruism[35], benevolence[36] or civic mindedness[37], or for MSM, specific attitudes towards blood services due to perceived discrimination[21]. Exploring these factors among those who have never donated can uncover targets for advertising and could be harnessed to increase the donor supply. Such insight into donor motivation and behavior becomes important when developing an inclusive and effective strategy in response to evolving eligibility criteria, partial advertising and countries liberalize blood donation policies for MSM.

Our results highlight some potential points of tension ahead for blood services as they seek to engage with those MSM individuals who may not have been eligible previously. Firstly, these groups are characterized by their higher social connections within the LGBTQIA+ community. Previous studies suggest that MSM in this group, who have never donated, may hold negative attitudes towards deferral policies[21,22]. If blood services are to successfully engage with these potential donors, we must remember that initial experiences play a crucial role in encouraging repeat donations[38]. As such, acknowledging historical deferrals when communicating policy changes to MSM may be beneficial in re-igniting trust in the services. Secondly, the limited awareness of PrEP deferral rules may pose an issue. Despite widespread belief among MSM that PrEP provides protection against HIV[39], recent evidence indicates that PrEP may mask rare instances of a breakthrough infection[40-42]. In light of this emerging evidence, those on PrEP remain deferred under the current individualized risk assessment frameworks at the time of writing[1-3]. Moving forward, we emphasize the need for clear and comprehensive communication strategies as blood services navigate evolving policy landscape.

CONCLUSIONS

These findings address a crucial research gap as countries expand blood donation to more MSM. By understanding the profile of these current and potential future donors, this report aligns with blood services' overarching goals

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to ensure a safe and secure blood supply. Future research should explore psychosocial factors influencing MSM's blood donation behavior, guiding tailored recruitment and retention strategies for the growing presence of eligible MSM donors.

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AUTHORS' CONTRIBUTIONS

KTS conceptualized the paper, conducted the literature review, analyzed the data, and wrote the first draft. PS designed the Sex and Prevention of Transmission Study survey and collected the data. KTS, NS, and PS edited the manuscript and approved the final draft.

ETHICAL CONSIDERATION

The study was approved by the New Zealand Health and Disability Ethics Committee (Approval number: HDEC 2021 EXP 11450). Written informed consent was obtained from each participant for study participation and data publication.

The Authors declare no conflicts of interest.

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