



BLOOD ON THE RACIAL WALLS



An unidentified blood donor wonders what all the fuss is about.

Spending R90 million more per year to implement new HIV risk reduction measures for donated blood was 'unavoidable' because the health ministry refused to negotiate on the use of race as a valid risk indicator, says Professor Anthon Heyns.

The chief executive officer of the South African National Blood Transfusion Services (SANBS) told *Izindaba* that the average risk of a black South African being HIV-positive was 100 times greater than that of a white compatriot.

'Depending on the cohort you use, it could be up to 150 times higher and that is the basis for that part of the risk selection method we're using,' he added. He said that once the SANBS made it clear to Health Minister Manto Tshabalala-Msimang that her 31 January deadline to produce a 'reformed, non-racial' blood risk model was scientifically impossible, she had

extended this to early September.

In the meantime so-called 'racial profiling' in the acceptance of blood would continue, as it was the safest and best currently known *modus operandi*. Heyns told *Izindaba* that testing and validating a new blood risk assessment model was 'forced on us from a political point of view' – which he understood.

Deadly odds

However, if the SANBS was forced to treat all donors as equal and abort the risk management programme, HIV/AIDS transmission would leap from the current internationally acclaimed two infected recipients per year to 30. From there it would spiral out of control to a baseline rate of 100 infected recipients per year.

'I don't know how long that (100 per year) would take, but

that's what could result,' Heyns warned.

Forensic pathologist Dr David Klatzow waxed eloquent in his objection to the government move, saying the issue had 'nothing' to do with racial stereotyping.

Many prominent medical colleagues spoken to by *Izindaba* agreed with him, but only off the record, for fear of being branded racist. Klatzow said the issue was purely one of risk management. 'It is entirely to do with providing the safest possible blood products for everybody in this country, irrespective of race. To deny, in the approach to safe blood, that the AIDS incidence follows the socio-economic inequalities of the past, is to take one tragedy and convert it into a second tragedy, with the additional element of farce thrown in!' he said.

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blood from the new risk model they were working on would be 'relatively safe', but 'we simply cannot say at the moment because the jury is out. We're going to refine the model. The reality is that we can't scrap everything, so implementation will require putting in place various systems that ensure, above all, that we do no harm to the patient'.

The strongest risk indicator (race) had been removed by government and the SANBS was left with the next level down – 'donor status'.

'Achilles heel' of new model

The biggest challenge and a 'possible Achilles heel' of the new model would be to make sufficient blood safely available to meet the country's needs. This was because the proposed model prevented the SANBS from using blood from first-time donors, which makes up between 10% and 15% of the nation's total supply. 'I really can't say what the outcome will be – if we can address the question of shortage we'll be fine,' was all he would conclude.

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It was precisely because the SANBS knew its current donor population profile so well that it was confident in using blood from first-time donors. 'Now if we mix it with high and low prevalence groups and exclude usage from first-time donors we could face a shortage,' Heyns explained.

In future only plasma would be able to be used from a first-time donation – and then only after being placed in quarantine until the donor returned a second time and the fresh blood tested negative, thus eliminating the window period. This could not be done with red



blood cells, which created the potential 'Achilles heel' of blood shortage.

At pains to emphasise that he saw the SANBS as 'partnering with government', Heyns said he doubted that anybody in the medical community would debate that evidence-based medicine needed to be the ultimate arbiter in the controversy.

'Taking into account that we can introduce this new expensive test and that there are a couple of indicators that we can combine with new test technology, I want to be given an opportunity to see whether in fact there is an alternative or not. If there is, we'll have a win-win situation with government.'

Safety 'non-negotiable'

Asked where he would personally 'draw the line' if the alternative failed to pass muster, Heyns quoted the medical aphorism of 'first do no harm'. 'We want to come up with an acceptable solution within the context of South Africa but I will not compromise on the question of safety,' he asserted. Asked whether he might resort to the Constitutional Court, he said this was 'not on my horizon at this stage'.

'We will devise, test and validate, see what the outcome is and act accordingly. The Constitution says that all citizens should have access to appropriate health care, life and bodily integrity. Come the beginning of September, either swords will be drawn or there'll be eternal peace – but for now the jury remains out.'

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What helped fan the emotional cinders into a runaway blaze was a weekend newspaper revealing that blood donated by President Thabo Mbeki in Durban in 2001 was discarded. Mbeki failed to complete the mandatory health questionnaire.

Tshabalala-Msimang demanded an apology and accused the SANBS of failing to 'observe the principle of confidentiality' in its public discussion of Mbeki's records.



Professor Anthon Heyns, Chief Executive Officer of the South African National Blood Transfusion Services.

Heyns 'felt abandoned'

Heyns and his medical director, Dr Robert Crookes (who declined comment), have enjoyed sparse open public support from the medical community since then. Heyns said he felt abandoned by the South African Medical Association and at one stage had even considered resigning as a member. None of SAMA's senior managers had approached him or his colleagues for direct insight into the controversy before joining the fray.

SAMA chairman, Dr Kgosi Letlape, an arch critic of Tshabalala-Msimang, this time backed her, stating categorically that racial blood profiling was 'unacceptable and irresponsible'. He also demanded that the SANBS 'stop justifying the process and apologise to all South Africans'.

Letlape said SAMA supported the 'vigilant measures' the SANBS employed in screening blood for maximum safety and expressed the hope that 'satisfactory changes would be made to their policy to avoid upset'.

Heyns responded, 'I thought the medical fraternity would seek some

understanding from us first and then come out and support the health of patients and the minimising of risk. I could then have faced the issue feeling much more comfortable'.

Politicians lashed

Klatzow said he found it 'intolerable' that Professor Heyns, Dr Crookes and other experts in the field should be subjected 'to the political whims of people who in the past have shown themselves to be ignorant in the question of AIDS and AIDS policy'.

Political posturing would not achieve the behaviour change needed to address the pandemic and 'all the garlic and African potato' that Tshabalala-Msimang could provide, would not alter that.

One highly placed source in the blood transfusion world commented that 'Klatzow has hit the nail on the head. We need to use evidence-based, statistically significant data'.

Also siding with Klatzow and expressing empathy with the SANBS was Professor Trefor Jenkins, Professor Emeritus of Human Genetics at the National Health Laboratory Services/Witwatersrand University.

Heyns told *Izindaba* that if the new model flies in September, safe blood would cost 15% (or R100) more per unit to produce and cost the blood purchaser between 20% and 25% more. The SANBS currently accepts between 700 000 and 800 000 blood donations per annum.

The R90 million costing is made up of R80 million for the new testing procedures (nucleic acid technology screening) and R10 million for implementing a new donor recruitment strategy. Other safety criteria such as age, gender, socio-economic circumstances and geographic residence will be looked at afresh.

Professor Jenkins said the issue was 'about epidemiology and not individual medical care'. Because of that, SANBS policies were based on population frequencies and decisions were centred on protecting the maximum number of people from infected blood.





Racially sensitive counselling

Jenkins proposed longer counselling during which individual donors were told that if their blood tested positive, only the plasma would be used and the rest discarded. 'The donor is performing a noble act for the good of other people, so it's not an affront for a counsellor to say to them upfront that their blood cannot be accepted because they happen belong to a high-risk group.'

Jenkins said the SANBS needed to win over the donor and bypass politicians unskilled in making medical decisions. 'Whatever the politicians say, the doctor's first ethical duty is to do no harm – if I was prevented from ensuring safety to the best of my ability I'd either give up the job or do it surreptitiously,' he added.

He expressed deep concern that doctors could be 'bullied' into unethical practice. People who chose to be affronted by the SANBS' procedures could simply stop being donors.

Jenkins cited a black letter writer in a Johannesburg newspaper who said she cared way less for political correctness than she did for the opportunity for her little daughter to receive the safest possible blood. What was racist in the past was when the SANBS only gave blood donated by white people to white people and that donated by black people to black people, but this practice had long since been stopped.

SAMA experts divided

Jenkins is an expert observer on SAMA's Human Rights, Law and Ethics Committee, which debated the issue late in February. He proposed a motion that the SANBS be congratulated for sustaining such a low infection rate for so long, but was outvoted because this would be seen to clash with Letlape's public stance.

Asked if Letlape was accurately reflecting SAMA policy in his

comments, the chairman of SAMA's Health Policy committee, Professor John Terblanche said the controversy was being 'dealt with by other committees' and had not been before his.

The Chairman of SAMA's Human Rights, Law and Ethics Committee, Professor Andries Stulting, said Letlape's statement was made via the public affairs department 'and not through us – no, he didn't consult us, it was something they took up'. Stulting said it was up to Heyns to contact SAMA for support. 'As far as I know he never phoned anybody with the facts. It's a huge communications gap.'

His committee wanted 'to do what's best for patients in the long run – we're very much against racism'.

Race debate 'spurious'

Dr Judith Head, a senior lecturer in UCT's Department of sociology and co-convenor of the MPhil degree in 'HIV/AIDS in Society', said she believed race to be a spurious indicator and 'a red herring'.

Britain's census data and health statistics used socio-economic status criteria with occupation as a proxy. Morbidity and mortality for most diseases in Britain were highest among the least privileged – a situation analogous to South Africa. 'Race is a social construct and this controversy a legacy of apartheid thinking,' she said.

The government intervention was a 'golden opportunity' for the SANBS to look at some of its 'rather lazy assumptions instead of fighting a defensive rearguard action'.

While public safety was clearly of paramount concern, the controversy could end up building national unity instead of undermining it. 'It will be wonderful if this stimulates more rigorous research and reflection,' she added.

CURRENT BLOOD DONATION MODEL (as set out by SANBS CEO, Professor Anthon Heyns)

1. All donors are treated equally (with the necessary respect and courtesy). Blood is taken if they comply with health safety criteria for donor and recipient. Whatever 'colour' you are, blood is taken. If safety criteria are met, some part of the blood is always used.
2. Once the blood enters SANBS, 'the entire focus changes – it's about the recipient and we do everything to the blood that would satisfy their safety needs. This includes testing. We stratify the donation (nothing to do with the donor), in order to minimise the risk to the patient. This is where we use race as an indicator *not* a factor.' Four main safety indicators: race, donor status, gender, and the location of the clinic where the blood was taken (which, because of existing demographics is inherently racial). Blood is then classified and all donations are put into cohorts. The risk is classified and blood products are issued according to a strict hierarchy of safety.
3. The lowest-risk blood available is then issued indiscriminately. Heyns said of the new enforced measures: 'If you use a road safety analogy – it's like saying you may not discriminate in terms of speed. So you're left with just traffic lights, safety bags and safety belts'.

Chris Bateman