

Mapping HIV-related figures of risk in Europe's blood donation regime

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Abstract

Grasping blood donation as contested grounds for enacting notions of belonging, responsibility and citizenship, this article analyses the role of donor deferral policies in the emergence of a European blood donation regime. We demonstrate how shifts in the moral economy of blood donation that followed from the outbreak of the human immunodeficiency virus (HIV) epidemic led to the prioritisation of donor deferral policies in efforts to enhance blood safety across Europe. We propose the notion 'figures of risk' – condensed figurations of those understood to pose risks of HIV infection to themselves and to others – to describe the categories of persons implicated in changing European donor restriction policies. We explore how the Council of Europe's annually revised *Guide to the preparation, use and quality assurance of blood components*, first published in 1992, came to legitimise and sustain increasingly contested deferral practices, which have produced shifting groups of persons as European 'figures of risk'. Qualitative analyses of the Guide's 19 editions reveal 3 dimensions through which these figures have become increasingly stabilised over time: in terms of their ontology, temporality and risk-related exceptionality. We conclude by asking how collectivising figurations of donors, framed through literature on 'profiling', shape notions of European citizenship.

Keywords

Blood donation, citizenship, Council of Europe, figuration, health policy, HIV, moral economy, risk

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Introduction

In 2017, German authorities issued guidelines newly enabling the following persons to donate blood: ‘men who have sex with men’, ‘persons who provide sex for money or other benefits’ and ‘heterosexual persons who engage in sexual risk behaviours, such as intercourse with frequently alternating partners’ (Bundesärztekammer, 2017: 19–20). Previously deferred indefinitely, these groups of persons are now able to donate blood if the listed behaviours did not occur within the previous 12 months. The guidelines also introduced a new category of would-be donors, ‘transsexual persons with sexual risk behaviours’, to be deferred under the same 12-month condition. A 2016 report explicating these changes referenced publications about human immunodeficiency virus (HIV) among trans populations, noting, ‘Nowadays transsexuals are considered a risk group that for a long time was not acknowledged as such’ (Bundesärztekammer, 2016: 13). This incorporation into groupings vulnerable to HIV, and also deferred from donation, underscores how being recognised as worthy of protection can also involve new forms of social exclusion.

As a realm through which recent social and political shifts have thus brought new forms of both inclusion and exclusion, blood donation deferral policies can be seen as contested grounds for the enactment of recognition, rights and belonging. Building on this observation, we ask in this article about how the emergence of and European responses to the HIV epidemic came to transform both the moral economy of blood donation, and the terms of inclusion and exclusion of donor deferral policies on a European level. To this end, we propose the notion ‘figures of risk’ to describe the categories of persons implicated in the changing donor restriction policies of a given blood donation regime. ‘Risk’ here refers to public health notions of risk, such as in the term ‘risk group’, which groups individuals based on criteria thought to increase the risk of a given infection. However, the concept is also intended to account for the repurposing of these groups as they are thought to put others at risk based on previous behaviours – even when not involving a possible route of transmission – and regardless of the presence of infection. As such, they become perceived vectors of illness by way of alleged risk rather than biological phenomena. In the context of blood donor restrictions, behaviours of the past, it might be said, come to define the body of an individual even more than the biological impact of those behaviours. Wim De Kort et al. (2016) thus reference ‘risk carriers’ rather than ‘pathogen carriers’ (p. 106).

In Germany, the systematic exclusion of persons at risk for HIV began in 1983 (Flegel et al., 1996: 42). In the first national donor regulations, ‘persons who consume drugs or abuse medication’ and ‘persons whose sexual behaviours or life conditions bear an elevated risk for the transmission of severe blood-borne infections (HBV, HCV or HIV) compared with the general population’ faced permanent deferrals (Bundesärztekammer, 2005: 12). A footnote specified, ‘homo- and bisexual men, drug addicts, male and female prostitutes, prisoners’. Persons who had ‘intimate contact’ with members of those groups in the previous 4 months were also excluded, as were those who, in the same 4-month time frame, had been imprisoned, or had visited so-called high-prevalence countries. Whereas the identity-based language and temporal qualities of deferral policies have thus changed in recent years for certain groups in Germany, the permanent exclusion of

persons who use drugs and the time-dependent deferral based on travel, imprisonment and partner behaviours continue in the current guidelines.

The landscape of donation deferral has shifted in other European countries as well. In Scotland and England, men who have sex with men, sex workers and people who have sex with 'high-risk' partners (from high-prevalence countries) can now donate if the deferrable practices did not occur in the previous 3 months (Great Britain. Department of Health and Social Care, 2017). This followed 2011 changes in England, Scotland and Wales, and in Northern Ireland in 2016, which reduced the lifelong deferral procedure for men who have sex with men to 12 months (Advisory Committee on the Safety of Blood, Tissues and Organs (SaBTO), 2017: 4). Although an advisory committee estimated that the most advanced tests can detect HIV up to 1 week after infection – a so-called 'window period' that varies based on infectious agent – they noted that one can never fully eliminate error in the detection of sexually transmitted infections (STI; SaBTO, 2017: 21–22, 31–32). The committee also considered relaxing restrictions for people who inject drugs, but concluded that such an adjustment would necessitate changes to European-level legislation (SaBTO, 2017: 100).

Against this backdrop of national policy shifts, which are also evident in various other European countries (Béguin et al., 2015; Belavusau, 2016; European Committee on Blood Transfusion, 2012), this article tracks the shifting figures of risk that have emerged in relation to HIV/AIDS as per European blood donation policies. Following from this interest in the cultural figures that take shape and are enacted through policy documents (Bennett, 2009; Chan, 2015; Epstein, 2007), we rely here on blood donor restriction recommendations and not on personal accounts from donation administrators, potential and actual donors, or blood donor activists. As a central institution in the European blood donation regime, the Council of Europe's (henceforth, 'the Council') *Guide to the preparation, use and quality assurance of blood components* (henceforth, 'the Guide'), which has been published on an almost annual basis starting in 1992, constitutes the core material for our analysis. European countries are expected to act under guidance by European bodies including the Council – created in the post-war period to enhance European unity and principles – which has increasingly come to collaborate with the European Union (EU) on donor restriction policies. Given ongoing debate about the politics of deferral policies that target men who have sex with men specifically (Mulholland, 2018; O'Loughlin, 2019), special attention will be paid to this and other groupings thought to engage in so-called 'high-risk' behaviours. Additional literature and European-level blood policies that have emerged around related debates will further contextualise and elaborate them, as will brief discussion of the closely related figures of the ideal donor and potential donation recipient, which are co-produced in relation to them.

In what follows, we first trace the emergence of what we have called a European blood donation regime, and the increasingly central role of the Council of Europe in shaping blood donor deferral policies on the European level. We then look at how the moral economy of donation has changed with the emergence of the HIV epidemic, noting in particular that it became entwined with notions of European belonging, responsibility and citizenship. Based on a critical qualitative analysis of all published *Guides* (from 1992 to 2017) by the Council of Europe, we then map shifts in the emergent European figures of risk by presenting three dimensions through which they have become

increasingly essentialised and stabilised over time: in terms of their ontology, temporality and risk-related exceptionality. We conclude by asking how collectivising and generalising figurations of donors, framed through the notion of 'profiling', contribute to notions of European citizenship.

The Europeanisation of blood donation

In 1953, shortly after the creation of the Council, mass injury from floods in the Netherlands provoked new awareness about the nation's limited supply of blood. Failed attempts by neighbouring countries to offer support through blood donation exposed a need for enabling the safe use of blood in one European country when it was collected according to the cultural logics of another. If the newly constituted Council was created in part to reduce intra-national barriers, these deficient transnational donation structures threatened its aims and purpose. Bernard Genetet (2001), a former member of the Council's Committee of Experts on Blood Transfusion and Immunohematology, offered this episode as central in a narrative about what he describes as the Council's 'transfusion project' (p. 5). Even if, according to Genetet (2001), 'it resulted in an acknowledgement of impotence', he described it as 'one of the first reactions of European solidarity', 'a positive gesture, powerfully authentic and deeply appreciated in the first postwar decade' (p. 9). Hence, the first Council agreement, which sought to harmonise collection practices, stated, 'it is most desirable that member countries, in a spirit of European solidarity, should assist one another in the supply of these therapeutic substances, should the need arise' (Council of Europe, 1958: 1).

Not just a means to enact European solidarity, Genetet understood blood donation to help clarify the Council's identity. Born after the Second World War, its founding instrument established health as 'a prime concern of the new European structure' (Genetet, 2001: 5). Shortly thereafter, the Council developed a committee of experts on public health precisely as donation experts demanded 'practical measures for the abolition of customs formalities in the case of therapeutic substances of human origin' (Genetet, 2001: 5). Blood donation offered a possibility to carve out space as a health authority within a landscape of international actors that already included the World Health Organization (WHO), the League of Red Cross and Red Crescent Societies, and the International Society of Blood Transfusion, each with their own institutional character and function. Genetet (2001) used the term 'transfusion Europe' to describe what was produced out of the 1958 and subsequent blood-related agreements (p. 17).

Modern forms of blood transfusion only became possible in 1901 with the identification of the first blood type (Alboek, 2001: 10). Without techniques to determine the presence of blood-borne infections, early assessments relied on visible symptoms and self-reporting of medical histories. The 1958 Council agreement hence stated, 'Donors must be in good health and, in particular, free of any communicable disease' (Council of Europe, 1958: 10). The Council also strongly advised that blood donation be voluntary. As Erik Alboek (2001) has written, 'voluntary, non-remunerated donors who gave blood for altruistic reasons were regarded as more reliable than paid donors who had an economic incentive not to reveal their true health condition' (p. 459). Based on this notion of altruism, Richard Titmuss (1997) has famously described blood donation as a 'gift'

(pp. 123–145). Infused with meaning about social life and connectedness, the gift of blood thus became a means for constituting a given subject (as healthy) and that subject's (altruistic) relationship to others. Provoked by a growing world of policies on transfusion, that gift also became a way to enact one's sense of belonging to a national or even European community.

These early practices of implicit rather than explicit deferral from blood donation, relying on assumptions about the relationship between class, health and the social, constitute an ongoing point of contention among European policymakers. 'Paid blood is poor blood', wrote Sherry Glied (1999) polemically as an intervention into these debates, 'precisely because it is drawn from poor people' (p. 326). Moreover, these practices anticipated other securitisation strategies of the AIDS-era, which came to create desirable and abject blood donors, and which are based more on a set of values than on technical capabilities or scientific evidence. The moral investments embedded in this amalgam of blood donation logics – altruistic, voluntary, non-remunerated donation as enactment of European solidarity – were also mobilised in the fortification of the burgeoning notion of European citizenship. As per one European Parliament member, 'Giving blood is a positive act of citizenship' (European Parliament, 2001). However, as the next section shows, the (mis-)management of HIV provoked a radical transformation in the moral economy that governs the logics of donor selection and thus also the contours of European citizenship.

HIV and the moral economy of blood donation

As the first European body to provide a policy response to the epidemic, the Council's Committee of Ministers (1983) issued a 1983 recommendation that warned of 'a new and severe health hazard, Acquired Immune Deficiency Syndrome . . . caused by an infectious agent transmissible by blood and blood products' (pp. 1–2). As a result, the Committee advised introducing measures to prevent transmission from 'affected blood donors to patients receiving blood or blood products' (Committee of Ministers, 1983: 1), and suggested providing donors 'in risk groups' with information about AIDS so that they could 'refrain from donating'. Based on the brief genealogy presented earlier, and in the absence of an effective HIV test, this call to self-deferral was consistent with earlier strategies for managing risks of transmission through transfusion.

Examples of 'risk groups' were included in a leaflet appended to the document. Initially developed by the American Red Cross, the notice identified groups thought to threaten the safety of donation recipients, and who were thus asked to refrain from donating. Not yet adapted to the dynamics of the emerging European epidemic, the list included – in addition to 'persons with symptoms and signs suggestive of AIDS', 'sexually active homosexual or bisexual men with multiple sexual partners', 'present or past abusers of intravenous drugs' and 'sexual partners of persons at increased risk of AIDS' – 'recent Haitian entrants into the United States' (Committee of Ministers, 1983: 2). Figurations from the first European AIDS-related policy thus reflected the imagery of 'risk groups' as had been depicted in the United States, which became the vehicle through which the first figures of risk were introduced into European-level deferral policies.

From the logic of this norm-setting institution, it might be said that this first European-level policy followed from a heightened sense of responsibility for securing public health in the context of an emerging threat rather than from an obligation to safeguard social equality. Whatever the intentions, the flyer's language reflected certain prejudices of the time, and led to the (re-)production of an initial set of figures of risk in Europe based on race, sexuality and national origin. 'They were created, *qua* groups', wrote Gerald Oppenheimer (1988) of these early groupings, 'to signify their potential status as carriers of tainted blood and as contaminators' (p. 283). Analysing the social consequences of these risk group constructs, Paul Farmer (1992) thus describes HIV an 'epidemic of discrimination' (pp. 212–228).

Despite these efforts, highly mediated incidents of HIV transmission through the transfusion of blood during the 1980s and 1990s provoked outcry from transfusion recipients, haemophilia societies and the general population (Bovens et al., 2001; Farrell, 2012; Feldman and Bayer, 1999; Tylor and Power, 2016). Given governmental missteps, and with no stigmatised behaviours to blame for infections, trust in the state was reduced (Farrell, 2012; Rabinow, 1999: 80). These various 'blood scandals', as they came to be known, provoked consequences ranging from compensation to the impeachment of political figures (Farrell, 2012). Related analyses have further amplified a sense of crisis, employing terms such as 'blood collection catastrophe' (Bennett, 2009: 57) and 'international iatrogenic catastrophe' (Bayer and Feldman, 1999: 2) to describe the factors motivating this diminished trust in the moral economy of blood transfusion.

Anne-Maree Farrell (2012) has suggested that the adverse public response to blood contamination led to the adoption of the 'precautionary principle' in European blood donation (pp. 166–197). Initially applied to environmental and food policies, this principle guides responses to unquantifiable risks to health by taking preventive action in the face of uncertainty, and shifting the burden of proof of non-harm to the advocates of a particular activity (Farrell, 2012: 168). As such, it justifies exclusionary measures considered discriminatory in the name of the greater good of society, and enables the continuity of exclusions until their inclusion has been established as harmless. In the field of blood donation, however, Farrell (2012) suggests that applications of the principle were all but reduced to the fortification of donor screening, selection and deferral (pp. 166–197). Early critical responses of gay-rights activists – claiming that such policies were not based on science and violated their rights to non-discrimination and privacy (Belavusau, 2016; Bennett, 2009; Krip, 1999; Santos, 2013: 159–160; Voegtli, 2016: 235–240) – did little to sway policymakers who sought to demonstrate an adequate response. Moreover, even once testing became available, donation authorities were slow to update operationalisation of the principle and adjust deferral policies accordingly.

Mapping figures of risk

Starting with the aforementioned first European-level policy engagement with AIDS, the Council has adopted numerous blood-related policies, which established increasingly stringent standards for donation authorities, the testing of donors (once HIV-antibody tests were made available in 1985) and donor selection criteria. One of the most influential milestones was the *Guide on the preparation, use and quality assurance of blood*

components. First published in 1992, the *Guide* has been revised nearly annually, and has become increasingly influential in shaping regulations of blood donation in the member states of both the Council and EU (Farrell, 2012: 45–49). Although its name has remained remarkably stable, the *Guide* has significantly increased in size (from 129 to 545 pages), its scope has expanded, and its technical precision has been enhanced. Among the issues of growing importance are the donor deferral criteria – that is, the norm-setting information that gives shape to what we call European ‘figures of risk’.

Rather than grasping these *Guides* as reproducing pre-existing categories of personhood, we follow John Law (2009) in ‘Seeing like a Survey’ to ask how surveys work to create, through their assumptions and messages, the realities that they seek to describe (pp. 239–256). ‘Seeing like a Guide’ thus involves unravelling the *Guide’s* performative function, and exploring how it came to produce shifting groups of persons and legitimise deferral practices. Of interest here are both the figures themselves, and also the terms through which these figures have shifted. To identify the patterns of these figures and shifts, we took up a reflexive thematic analysis (Braun and Clarke, 2006; Charmaz, 2006) of all *Guides* and the published documentation of *Guide* development and refinement, which involved the extraction and interpretation of themes through the coding (with MAXQDA) of all materials.

Risk ontologies

First, the succession of *Guides* demonstrates the enhanced precision with which persons and behaviours were grasped and assessed for deferral. The language of several early Council policies exemplified the categorical terminology used to describe persons thought to be at an elevated risk of HIV, and therefore also thought to pose a risk to the general population. The Council’s aforementioned 1983 Recommendation, for example, simply replicated US figures of risk. Although not blood donation specific, a subsequent Recommendation depicted locally produced figures that, nonetheless, also grouped people into categories without reference to life histories or risk-reduction efforts: ‘intravenous drug users, men with homosexual contacts, prostitutes, customers of prostitutes, “sex-tourists”, haemophiliacs, the prison population, adolescents, people staying in or traveling to areas with a high prevalence of AIDS’ (Committee of Ministers, 1987: 4).

The first *Guides*, alternatively, reflect a shift promoted by WHO – now largely associated with Global Programme for AIDS founder Jonathan Mann (Mann et al., 1994: 6–93) – from the language of ‘risk groups’ to an at-first diffuse emphasis on behaviours that are thought to pose a risk of infection. Given the ongoing shifts in knowledge about the epidemic in Europe at the time, the authors of the earliest *Guides* did not delineate particular figures of risk, but rather adopted a generalised language of risk and safety. As such, the first *Guide* explained, ‘All blood donors should be provided with accurate and updated information on AIDS so that those with unsafe sex practices or other risk behaviours exposing them to potential infectious sources will refrain from donating’ (Council of Europe, 1992: 14).

A short model questionnaire asked, ‘Have you been involved within the last twelve months in any of the risk behaviours defined (e.g. unsafe sex, intravenous drug-abuse)?’ (Council of Europe, 1992: 20). This first sample risk assessment of the *Guide* thus

produced a concept of 'risk' that was, at a minimum, defined by sexual practices and drug use, but its specific operationalisation was left to the discretion of donation administrators. In other words, the notion of 'risk' was not yet defined in relation to a particular gender, sexuality or occupation (men who have sex with men and sex work were not targeted explicitly). Furthermore, although reference in the question was only to intravenous drugs, and the word 'abuse' implied particular assumptions about the meaning and moment of harm, an additional subsection of the chapter implicated a broader range of drugs in deferral criteria, stating, 'illicit drug taking if admitted or suspected should debar' (Council of Europe, 1992: 16).

While effective antiretroviral therapy became available and the quality and accessibility of epidemiological data in Europe increased significantly in the mid-1990s (Steffen, 2012), subsequent *Guides* were only slightly modified. Only in 1999 was it stated under the category 'AIDS': 'the information provided may vary between countries according to the local epidemiological data' (Council of Europe, 1999: 19). While this statement might suggest that figures of risk should vary in conjunction with local epidemiological data, an enhanced variety of figures became decipherable for the first time in the same *Guide* as the sample questionnaire was rendered more categorical. There was thus a presumption of varying epidemics across the region, each with its own conceivable categories of risk, just as there was an expansion in the number of figures meant to guide *all* Member States. In particular, the newly formulated questions read (Council of Europe, 1999: 39–40):

Have you ever injected drugs?

Have you ever accepted payment for sex, in money or drugs?

For men:

Have you ever had sex with another man?

For women:

To the best of your knowledge has any man with whom you have had sex during the past 12 months had sex with another man?

During the past 12 months:

Have you had sexual contact with:

a partner who is HIV positive or has hepatitis?

a partner who has injected drugs?

a partner who receives payment for sex, in money or drugs?

The umbrella categories used in the previous *Guide*, such as 'unsafe sex' and other 'risk behaviours', were thus further concretised. 'Unsafe sex' became, specifically, the act of

sex between men, accepting payment for sex, or sex with: a person living with HIV or hepatitis, a person who injects drugs, a person who exchanges sex for money or drugs, and a man who has never had sex with a man. Just as in the previous *Guides*, in other words, risk was defined in terms of practices rather than identities – practices that, nonetheless, emerged in relation to particular fields of identification already circulating in Europe's social and political landscape (Hacking, 1999), including in Council policy documents (Committee of Ministers, 1987). Moreover, a heading in the 2001 *Guide* entitled 'Questions related to lifestyle risk' (Council of Europe, 2001: 48), which continued until 2004, reveals how the notion of risk in relation to HIV/AIDS was linked, not just with behaviours, but also how it was equated with what were understood to be forms of life and ways of living.

A final shift took place in 2015 when the sample questionnaire was significantly expanded. Even if the authors acknowledged that it 'is not possible to provide a generic questionnaire in this Guide' and 'blood establishments should develop a questionnaire that is appropriate for local circumstances' (European Directorate for the Quality of Medicines & HealthCare (EDQM), 2015: 450), behaviours targeted for deferral came to be condensed into particular groups of people: A question asking about payment for sex was placed under the heading 'sex worker', and the questions about 'male to male sex' were discussed in relation to previously unnamed groups of impacted people, namely 'men who have sex with men' and 'female partners of men who have sex with men' (EDQM, 2015: 458). The progression of *Guide* publications thus translated into a shift from imprecise, and therefore, also more flexible and non-essentialising notions of 'unsafe sex practices' and other 'risk behaviours' to the explicit articulation of figures of risk ontologically – that is, in terms of pre-existing and universalising categories of persons.

The expansion and fortification of figures of risk that resulted from the increased precision of *Guide* questionnaires also involved a shift in the type of citizen that it relied upon and further shaped. Imposed deferrals within the context of AIDS were initially not mandated, relying instead on a system of self-deferral that was consistent with earlier donation standards, and which compelled potential donors to be informed, self-aware and responsible for the protection of fellow citizens (Waldby and Mitchell, 2006: 35–58). As the questionnaire became increasingly confessional, potential donors were no longer expected to assess risk themselves and then refrain from donation on their own; instead they were guided through the world of risk by the administrators of the questionnaire, and were denied or awarded the right to donate by an external authority. We are thus talking about an increasingly passive (compliant) rather than active (responsible) citizen.

Figuration through temporality

Second, the succession of *Guides* manifests a shift in the temporal dimension of deferral. Indeed, in light of the changes discussed at the opening of this article, it is remarkable that the first *Guides* encouraged permanent deferral only for persons who used drugs. It was recommended that all other behaviours described as 'unsafe' lead to deferral only if occurring in the year prior to donation. As of 1994, WHO (1994: 44–45) had issued its Requirements for blood donation, which prescribed the permanent exclusion of 'past or

present intravenous drug abusers'; 'men who have had a sexual relationship with another man'; 'men and women who have engaged in prostitution'; and 'sexual partners of any of the above'. Although the first *Guide* pre-dated the WHO publication, its deferral time frame continued to deviate from WHO norms for over a decade. The decision to defer only based on 12 months was, in retrospect, particularly significant given that the publication of this initial *Guide* took place in the aftermath of scandalised reports about HIV infections through donation, as the spread of the epidemic increased across Europe, and also before antiretroviral therapy began to prove effective. Only in 2006 were 'Persons, whose sexual behaviour puts them at high risk of acquiring severe infectious diseases that can be transmitted by blood' (Council of Europe, 2006: 37), included among those necessitating permanent deferral. While this change put the Council in line with WHO policy, it was likely particularly influenced by a 2004 EU Directive on the implementation of technical requirements for blood donation, which stated that 'Persons whose sexual behaviour puts them at high risk of acquiring severe infectious diseases that can be transmitted by blood' (the same wording as in the 2006 *Guide*) warrant permanent deferral (Commission of the European Communities, 2004: 32).

Given the 3–6-month 'window period' of the earliest HIV tests, the institutional discrepancies between the 12-month and permanent deferral recommendations demonstrates that applications of the precautionary principle varied based on policy-making bodies, which were impacted by the degree of influence of their policies, the political pressures they faced and the amount of residual risk of infecting donation recipients they were willing to accept. From this perspective, the 2006 shift in the temporality of deferral contributed to the harmonisation of the logics guiding blood donation policies, which translated into the further fortification of the European blood donation regime. For certain practices, however, this shift to lifelong deferral runs contrary to the possibilities afforded by the growing precision of HIV tests (Laperche, 2005; Rekha and Neelam, 2014: 2–3). Here again, this move towards aligning precautionary logics came into tension with the conviction that local conditions and available technologies should inform local deferral practices.

Figuration through (de-)exceptionalisation

As presented earlier, the initial *Guide* followed from an economy of distrust that emerged around scandalised events of HIV infection. Hence, the *Guide* came into existence in relation to the exceptional status of HIV and the perceived risks with which it was associated. Yet, it also documents what is either the progressive de-exceptionalisation of the virus, or the repositioning of other infections to the exceptional status of HIV. The shifting figures of risk imagined in relation to HIV became gradually blurred together with those persons thought to be at an elevated risk of other blood-borne illnesses – first with hepatitis B and C, and then with syphilis and the Human T-lymphotropic virus.

For example, the first *Guide* advised providing prospective donors with accurate information on AIDS, and only this information was referenced in the sample questionnaire. Already in the second *Guide*, the authors suggested providing 'up-to-date information on the risk activities which may be associated with hepatitis transmission to provide the opportunity for self-exclusion' (Council of Europe, 1995: 28). As of the 1997 *Guide*, a

sample questionnaire grouped both conditions together, asking if prospective donors ‘read and understood the information on AIDS and hepatitis’ so that those who consider themselves ‘a potential risk candidate for the recipient’ could refrain from donating (Council of Europe, 1997: 37). Similarly, the 2001 *Guide* introduced a section entitled ‘Questions related to HIV/HBV/HCV infection risk’ (Council of Europe, 2001: 47).

In gradually grouping these three conditions together, one sees that the authors began to think about HIV together with hepatitis B and C, and indeed that they came to equate the recommended questions to ask in relation to each virus, and thus, also their routes of transmission and perceived figures of risk. With these changes, we see a gradual de-exceptionalisation of HIV (Smith and Whiteside, 2010) as the primary condition structuring deferral. Given that both hepatitis B and C had pre-existed HIV/AIDS, and donation authorities did not adopt this expansive screening policy to attempt their elimination from transfused blood, one might also describe this shift as one in which hepatitis B and C became newly exceptionalised. Indeed, just as HIV/AIDS began to enter public health discussion in the United States, the European Health Committee published a 1981 report evaluating the risk of transmitting a variety of infectious diseases through blood donation, which included consideration of hepatitis, but not yet HIV. Although this report analysed the breakdown of these conditions across Europe, Marie-Angèle Hermitte (1996) noted that, at the time, ‘it seemed impossible, politically, to draw all of the morally embarrassing conclusions from the social and geographic distribution of “risk groups”’ (p. 160) reflected in the data. In short, just prior to the emergence of HIV as a public health issue in Europe, ‘no categorical exclusions were advised following these bitter findings’ (Hermitte, 1996: 161). This observation makes particularly apparent that hepatitis B and C became exceptionalised on the European level only after HIV came to provoke the creation of figures of risk as an advised tool for managing the possible transmission of infections through donation.

Similarly, the initial *Guides* included a section on those ‘infectious diseases’ that were thought to necessitate ‘a quarantine of at least two weeks following cessation of symptoms’ (Council of Europe, 1992: 15, 1995: 27). The sample questionnaire from 1997 began to suggest that administrators ask if donors have had an STI, and then in 2004 syphilis was introduced for the first time explicitly as a condition mandating deferral up to ‘one year after having been declared cured’ (Council of Europe, 2004: 43). The most recent *Guide*, alternatively, which provides elaborate explanations as to why particular questions are relevant, justified the question about ‘male to male sex’ by explaining that it is ‘associated with a higher risk of HIV. This group also has a higher risk of syphilis, gonorrhoea, as well as infection by hepatitis B and hepatitis A viruses’ (EDQM, 2017: 458). Which condition functions, from a biomedical perspective, to justify the deferral based on existing testing technologies and the effectiveness of available treatments is of less interest. Instead, what becomes apparent is that these conditions come to be entangled in their association with particular figures of risk, and that they each contribute to the production or re-fortification of these figures as and through risk.

When viewed from the European level, these expansions have been dissimilar across contexts – as certain guidelines include data about syphilis or *Treponema pallidum* in the tabulation of an acceptable ‘window period’ for the figures of risk that were borne out of the early HIV era – and create the impression that the conditions variously grouped

together pose the same risk to donation safety. But how do levels of acceptable risk change based on the futurity of an illness (e.g. curability)? And how do earlier moral economies influence our understanding of the conditions that have become associated with HIV in donor screening guidelines? Whatever our answers, it is clear that in the context of European blood donation regulation, HIV-related figures of risk came, over time, to apply to each of the viruses indiscriminately. This process of developing a particularly robust health-governing structure in response to HIV, and then expanding that structure to other, also previously existing illnesses, can be observed in other contexts of health management in Europe as well (Steffen, 2012).

Figures of risk in the making

Pressure from various groups excluded from donation, especially gay-rights activists, helped to influence the aforementioned national changes in deferral criteria. Simultaneously, ambiguity in the EU Blood Directive, which demanded temporary deferral for ‘risk’ and permanent deferral for ‘high risk’ sexual behaviours, led to unclarity about how administrators should triage prospective donors (Commission of the European Communities, 2004: 32–33). Responding to both of these catalysts, a Council working group convened to harmonise interpretations of ‘temporary versus permanent deferral and, based on evidence, evaluate a possible differentiation of high risk behaviours’ (European Committee on Blood Transfusion, 2012: 2). A 2012 Memorandum provides insight into how a variety of resources and rationalities, at times with conflicting assumptions and implications, come to produce the shifting figures of risk as presented in previous sections.

Particularly influential was the relative abundance of available data on HIV, which justified the group’s all but singular focus on that virus. While the presented figures indicated that ‘heterosexual sex’ was the second most common cause of HIV infections in Europe, the only populations to be permanently deferred due to their sexual behaviours were men who have sex with men and sex workers. Regarding heterosexual individuals, the authors concluded that data were not readily available on specific types of behaviours, such as with regard to purchasing sex, or ‘having preferences for certain sexual techniques’ (European Committee on Blood Transfusion, 2012: 10). The recognition of and insistence on the internal diversity of prospective heterosexual blood donors likely follows from the conviction that one could not defer from donation such a significant portion of society. In other words, the heterogeneity of the ‘heterosexual population’ as such was seen to be a potentially injurious but irreconcilable reality of life that should not inhibit their inclusion into this performative act of citizenship.

In contrast, the same logic was not applied when assessing deferral for sex workers and men who have sex with men, both of whom were located ‘at the upper end of the “imaginary scale” of risk’ (European Committee on Blood Transfusion, 2012: 12). For sex workers, unanswered questions in existing data about the extent to which sex work ‘per se is linked to HIV transmission in Europe’ provided justification for the continued permanent deferral of all persons who sell sex, even as the internal diversity of sex worker populations with respect to behaviours and HIV vulnerabilities was recognised (European Committee on Blood Transfusion, 2012: 10):

For example, a person who is forced to exchange sex for money or drugs on the street in a foreign country has a different risk of acquiring an STI than a person who selects clients themselves and only has 2-3 clients per week and can insist on condom use.

Here one can see why the burden of proof of non-harm in possible policy shifts under the precautionary principle has been described as ‘paralyzing’ by some of its critics (Sunstein, 2005: 4): Regardless of whether moralisms, reasoning or evidence provided the stronger foundations for policies in the name of precaution, the principle encourages the continuity of policies of the past under continued conditions of uncertainty – both in distinguishing ‘risk’ from ‘high risk’, and concerning the limitations of available data on HIV prevalence.

Among men who have sex with men, alternatively, about whom exists the largest amount of data, justification for preserving the permanent deferral was based on their existence as a group or network of risk, rather than on behaviours of risk. Given the concentrated epidemic among men who have sex with men in many European states, ‘even MSM who do not change partners more frequently than heterosexual men bear a far greater risk of infection . . . Therefore, in order to minimise the risk for undetected infectious donations, sexually-active MSM should be deferred from donating blood’ (European Committee on Blood Transfusion, 2012: 20–21).

While it is beyond the scope of this article to analyse the biostatistics behind these calculations of risk, the logics analysed here underscore that the boundary work involved in producing particular concepts of risk can be subjective, imperfect and variable. In other words, there are ways of assessing people with deferral guidelines that do not rely on the production of collectivising figures. This may be of particular interest when one considers the *Guides* of the Council, in which the logics of figuration have become firmly anchored, with their ontology made increasingly precise and explicit, with the gradual elimination of the time-dependent assessment of behaviours, and an increase in the number of health conditions mobilised to justify their existence.

Discussion: profiling figures of risk

The development of blood donation policies has served to establish a European blood donation regime, which has been inscribed with the name ‘transfusion Europe’ in the political imaginary. In its (re-)creation of an altruistic European subject, it has been suggested that the act of donation constitutes a particular type of European citizenship. While the protection of recipients of blood components has increasingly become a responsibility of European policymakers, an enhanced responsibility for securing blood safety has been placed on donation administrators rather than prospective donors. This is reflected in a shift away from self-deferral towards increasingly stringent screening procedures, and the confessionalisation of pre-donation assessments. At the same time, advised screening processes depend on the responsibility of the donor to be self-aware, risk-aware and truthful about their medical histories and practices that locate them within a particular group pre-identified as risky. Hence, rather than grasp potential donors through individualised *practices* of risk, they become grasped through *categories* to which they are assigned, and thus, become conflated with what we have called figures of risk: men who have sex with men, people who use drugs, sex workers.

What does it mean for concepts of European citizenship that the advised deferral practices of the Council are based on collectivising and generalising figures where they could be based on individual practices? The notion of ‘profiling’ is instructive here because it helps to grasp the logics through which prospective donors are labelled, categorised and administered within the context of blood donation. In the field of public health, the term ‘epidemiological profiling’ is used to describe efforts at ‘determining the expected level of complexity of a disease, such as the distribution and the pattern of transmission of the disease, the variability of the pathogen, etc.’ (Bordier et al., 2015: 242). By extracting from the epidemiological profiling of an epidemic to then single out and defer potential blood donors, it leads to a form of social profiling that more closely resembles the racial and sexual profiling that has been problematised in the field of public health, including in relation to HIV/AIDS. For example, Steven Epstein (2007) has suggested that:

By approaching health from the vantage point of categorical identity, they ignore other ways in which health risks are distributed in society. By valorizing certain categories of identity, they conceal others from view. By focusing on groups, they obscure individual-level differences, raising the risk of improper ‘racial profiling’ or ‘sex profiling’ in health care. (p. 11)

In the case of blood donation, practices of the past constitute the grounds for deferral, based on the possibility of undetected biological conditions (HIV, hepatitis, etc.) with which they have become essentially associated through the notion of risk. The process of identifying deferrable donors, or the ‘profiling of figures of risk’, involves assigning membership to groups that are defined through types of practices that yield distinct categories of exclusion. Because these categories also largely align with existing social, cultural and political forms of identification, they risk encouraging the belief that sex workers, people who use drugs and gay men constitute groups that are social threats in their essence (Chan, 2015; Treichler, 2006; Watney, 1987), undervaluing the variability of safer sex and harm reduction strategies that are taken up by members of these communities.

Despite this diversity of implicated figures and communities, discussion about the limitations of ongoing donor restriction practices have been largely limited to a focus on gay and other men who have sex with men, and they tend to centre the issue of discrimination and national level policies. This article demonstrates that, first, these figures concern a much more vast collection of persons – including sex workers, persons who use drugs and persons living with HIV – which points to a need to consider the implications, impact and importance of donor policies intersectionally and across community groups. Moreover, the history of blood donor policy development itself suggests that deferral in the form of any time frame might not only be grasped through the structural logics of discrimination, but that it also concerns the possibility to enact solidarity and contribute to a (European) community. Nonetheless, the contours of community belonging remain conditional and based on persistent, though somewhat shifting, distinctions, norms and values. The pursuit of inclusion into the pool of blood donors can thus involve re-shaping the terms of inclusion and exclusion, but also buttressing the broader structures and logics through which participation and membership are defined.

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