

Separate but Equal: The Black Racial Classification in the Canadian Blood System

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DEDICATION

To my parents, Mundi Marie-Claire Ndaya Mpinda and Kalenga Pierrot Tshimilenda Mwamba.

We have come a long way from Mbanza Ngungu to arrive to this point.

We came with promise...

Je vous remercie infiniment. My life' journey is to make you proud.

Please accept this dedication as a small token of my gratitude.

Wafwa ko, Wafwa ko, Wafwa ko Papa

Twasakidila wa bungi Maman



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ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
ACLC	African Canadian Legal Clinic
ACB	African Caribbean and Blacks
ARC	American Red Cross
AABB	American Society of Blood Banks
BWBD	Black Women and Blood Donation
CBS	Canadian Blood Services
CBC	Canadian Broadcasting Corporation
CHS	Canadian Hemophiliac Society
CRCS	Canadian Red Cross Society
CTV	Canadian Television Network
CFDCP	Centers for Disease Control and Prevention
vCJD	Creutzfeldt–Jakob disease
CDA	Critical Discourse Analysis
DHS	Discourse Historical Approach
FDA	Food and Drug Administration
HQ	Héma Québec
HGP	Human Genome Project
HIV	Human Immunodeficiency Virus
HIV- O	Human Immunodeficiency Virus (Outlier)
MSM	Men who have Sex with Men
NOI	Nation of Islam
SCAAQ	Sickle Cell Anemia Association of Quebec
SCAO	Sickle Cell Association of Ontario
SCAGO	Sickle Cell Awareness Group of Ontario

ABSTRACT

In this thesis, I explore the African, Caribbean, and Black communities— as it pertains directly to the Black racial classification— and their place within the Canadian blood donation system. The aim is to explore the ways in which the legacy of risk, the Black racial classification, pathology, and associations with disease may be manifested in donation policies and procedures (current and retired). Precisely, my interest lies in the subtle and diffuse ways in which Negrophobia (and its variant racism) survive in blood donation in spite of putative efforts to neutralize it. I undertook this study with the aim to fill a noticeable gap in the literature, by providing knowledge on the ways in which racial stereotypes can be disseminated discursively through institutionalized health policies. As data sources, I used explicitly publicly accessible national (and international) document materials on blood donation. With a critical discourse analysis methodology, the evidence presented demonstrate that under the guise of value-freedom, blood donation guidelines have the ability to reinforce dangerous assumptions providing a rationale for Negrophobic beliefs, behaviours and policies within the blood system. Studying blood donation in this manner offers evidence for the ways in which health institutions continue to treat Black populations based on racial stereotypes. This exceptional attention to the Black racial classification in blood donation provides important insights into the understanding of the lasting and plagued relationship that Black peoples have had with the scientific community, illustrating that institutionalized Negrophobia may remain imbedded despite decades of sociopolitical and medical progress.

CHAPTER ONE: INTRODUCTION

People who have lived in certain regions of Africa, who may have been exposed to a new strain of the virus that causes AIDS (HIV-I Group O), are not eligible to donate blood...This is not based on race or ethnicity, but possible exposure to HIV-I Group O.

—Canadian Blood Services, “Geographic Deferral,” 2015.

Several Black women who would like to give blood are prevented from doing so because their hemoglobin¹ count is naturally lower than Héma-Québec’s eligibility criterion... Integrating these new donors would help us better meet the blood requirements of those in need within the Black community

—Héma Quebec, “Black Women and Blood Donation,” 2016.

Certain blood types are unique to specific racial and ethnic groups. Therefore it is essential that the donor diversity match the patient diversity.

—American Red Cross, “Blood and Diversity: Rare Blood Types,” 2016.

Immigrants from some countries are disallowed from giving blood. Africans are barred from donating due to HIV concerns.

—Tristen Hopper, “Canadian Blood Services calls for more blood from visible minorities.”
National Post, June 13, 2011.

Blood Donation-The Contribution of the Black Communities Has Increased Significantly, But the Need is Still Great: Héma-Quebec is making an effort to reach out to more donors in the Black communities. A human donation can save the life of another human being regardless of skin color or ethnic origin...chances of finding compatible donors are better in the case of donors of the same racial origin.

—Héma Quebec News Release, February 1, 2016.

Haitians should be, and are, allowed to donate blood in Canada provided they meet the existing selection criteria required of all blood donors. However, because of uncertainties currently surrounding this issue... recent immigrants from Haiti are being advised not to become blood donors at this time.

—Canadian Red Cross News Release, February 19, 1983.

The Blue Tag will identify the donated blood as having come from an African American, and Black donors, and it will be tested for special characteristics.

—American Red Cross, “More about the Blue Tag Program,” 2016.

More black blood donors needed, Héma-Québec urges in special drive.

—Matt Amours, *Canadian Broadcasting Corporation*, February 19, 2017.

People in need of blood are more likely to find compatible blood types among their own racial group.

—Ryan Remiorz, “Quebec blood agency urges black community to donate blood,”
Canadian Television Network, November 29, 2012.

My interest in the blood system began when I uncovered the first mentioned *Geographic Deferral*. With an established understanding that the human immunodeficiency virus (HIV) is exclusively transmitted through various *behaviours* involving transference of blood (and certain bodily fluids) from one human body to another—not through ethnicity, birthplace, or travel destination; the exclusion of eight sub-Saharan African—notably Black—nations within the Canadian blood system did not read equitably (Antoine, Laurinus, & Page, 1990, p.818). Armed with this piqued interest, I sought to empirically investigate the interplays of *Blackness* as a racial identity within the Canadian blood system. In this course of action, I uncovered additional blood policies and procedures (current and retired) which disproportionately implicate(d) Black populations.

In reference to the opening citations, immediately, it is imperative to establish and debunk the prevalent misconceptions of biologized racial differences as promulgated by the Canadian blood system (hereafter blood system). Humans cannot, and are not dividable into genetically identifiable racial groups. Biologically, there is a sole human race (Roberts, 2011, p.4). The concept of race is a socially constructed category used to classify and dominate human populations by virtue of common ancestry, reliant upon the differentiation of phenotypic characteristics (Winant, 2000, p.172; Henry & Tator, 2010, p.25).

In refuting the scientific categorization of race, it is simultaneously imperative to grasp that the consequences of race are nonetheless genuine (Finley, 2009, p.3). The reality of race is intelligible, and the idea that “one can experience race concretely despite the fact that it is not a biological ontology,” is a fact (p.3). To that end, the histories of Black populations are “superfluous with examples and consequences of race” (p.3).

Recently, with the advent of DNA technologies, biologized and/or geneticized operations of racial classifications have become increasingly prevalent in public discourse (e.g. genetic ancestry testing, race-specific pharmaceuticals, and forensic biobanks). In response, a number of sociologists, as well as other social scientists, who are primarily critical of the scientization of race—like Harriet Washington (2006) and her comprehensive retracement of medical testing on African American populations; Historian Keith Wailoo (1999, 2006) on biomedical sciences, race relations, genetics, and sickle cell anemia in America. As well, Bioethicist Dorothy Roberts (2011) on the concealment of racism through justifications of racial difference in molecular science, and medical anthropologist Sandra Soo Jin-Lee (2015) on race, science, and genomic technologies— have rigorously exposed a number of racialized practices in biomedicine as mere sociopolitical categories administered as biological ones (Roberts, 2011, p.x).

Accordingly, it is important to locate the experiences of Black populations with the blood system in the context of the well documented anti-Black atrocities historically committed by Western biomedical institutions (Washington, 2006; Roberts, 2011). That is, the race literature has repeatedly established that Black populations have long been constructed as deviants to the Western status quo (Washington, 2006; Feagin, 2010, p.45; Henry & Tator, 2010, p.57-59; Roberts, 2011, p.24). This means to say that by virtue of racial identity, Black stigmatization has been replete with notions of sub-humanity and inferiority, among various other intersecting discourses of difference, risk, disease, and denigration (Washington, 2006; Feagin, 2010, p.56; Roberts, 2011, p.24). Thus, in reading this thesis, recall that fundamentally, the general paradigms of Black racialization— inclusive of contemporary and classical representations— are rooted in dominant frames of explicitly racist observations of physical difference, which set

against a decrepit racial history have categorically contributed to numerous *maafas* (Yancy, 2016, p.xxxi).

Overview of Thesis

In this thesis I explore the Black racial classification and its treatment under the scientific (biomedical) gaze, in order to explore the ways in which race, “the legacy of pathology and association with disease is manifested in policies and procedures” (current and retired) of blood donation in Canada (Flatt, 2015, p.x). Much in the same manner as Michael Flatt’s (2015) dissertation—*Heterosexism and Institutionalized Homophobia in Tissue Donation in the United States*—this study addresses a gap in the knowledge of assumptions and stereotypes that are disseminated indirectly through institutionalized blood policies (p.x). Underlying this thesis are questions of whether there exist subtle and diffuse ways in which Negrophobia—the fear and aversion of Black peoples, which accounts for discourses or tropes that reinforce problematic notions of this racial group and their physicality (Thrasher, 2015, para. 4)—subsists in policies and procedures “in spite of the putative efforts to neutralize” them (Flatt, 2015, p.x). For data sources, organizational, regulatory, and media documents were analyzed. Jay Fiddler’s (2011) study—*Negotiating Trust in the Canadian Blood System: Governance and the Politics of Public Accountability in the Wake of the Tainted Blood Scandal*—notes that sources available for qualitative analysis of the blood system vary widely depending on the years under examination (p.57). With this in mind, for the sound analysis of “how blood is archived alongside race,” (Dryden, n.d., p.12), I relied explicitly on widely accessible sources of information such as: *The Commission of Inquiry on the Blood System in Canada* (hereafter Krever 1997), Canadian Blood Services (CBS) and Héma Quebec (HQ) websites (inclusive of donor questionnaires, pamphlets, handouts, annual reports, communiques, and etc.), other blood related organizational websites,

namely the Canadian Hemophilia Society (CHS), Sickle Cell Awareness Group of Ontario (SCAGO), the American Red Cross (ARC), AABB (formally the American Society of Blood Banks), and the Food and Drug Administration (FDA), supplemented with pertinent academic literature.

In the process of data collection, I uncovered a thematic assortment of blood donation narratives that disproportionately affect(ed) Black populations. In consequence, I was able to compile five distinctive accounts representing: *The Negro Segregation*, *The Haitian Voluntary Exclusion*, *The African Indefinite Deferral*, *Phenotyped Blood*, and *Black Women and Blood Donation*. Mapping such exhaustive “historical and cultural narratives of blood” and race, as presented in these cases, was imperative to the study, as it “allow[ed] for connections to be made, meanings to be explored and knowledge to be uncovered” (Dryden, n.d., p.11).

For the theory integration, I primarily use the symbolic risk analytics as initially advanced by Mary Douglas (1966) in *Purity and Danger*. This theory attempts “to ascertain the reason for the ubiquitous concerns for purity in various cultures” (Finley, 2009, p.16). In simple terms, the theory “suggests that *dirt* is a symbolic category that refers to *matter out of place* in taxonomies that order social systems to make the world intelligible” (p.16). More precisely, to deconstruct the race paradigms ascribed to Black populations, I integrate symbolic risk scholars who particularly engage key elements of the Black body politic; notably, scholar of African American religion, Stephen Finley (2009) in his chapter “Black Bodies In- and- Out-of-Place,” as outlined in his doctoral dissertation *Re-Imagining Race and Representation: The Black Body in the Nation of Islam*; as well as philosopher, Dana Berthold (2010) in *Tidy Whiteness: A Genealogy of Race, Purity and Hygiene*. These theories were selected because—in a race

context— they extend Douglas’s (1966) dirt, as “a universal theory that [can] make intelligible this ubiquitous concern for cleanliness and order” (Finley, 2009, p.36).

For Finley (2009), likewise to this thesis, his efforts also lie in an examination of Black bodies. He suggests that although historical moments have admittedly offered new challenges with changing sociopolitical and institutional realities, the Black body still remains and endures as a focus in many structures in society (p.1). Hence, his analysis of the Black embodiment provides a theoretical coherence to questions of how/why Black bodies are treated violently (both physically and/or symbolically) in society by the dominant culture and its institutions (p.1).

With a genealogical approach, Berthold’s (2010) efforts are more wide-ranging. Without concentrating on any specific racialized group, she suggests “that today’s supposedly innocuous preoccupation with hygiene is rooted in [a] racist heritage” (p.21). Her integration of the cultural risk theory infers that in contemporary Western societies, there is a “zealous preoccupation with hygiene,” that renders us “all lovers of purity” (p.1). Ultimately, for Berthold (2010), paramount is the connection between contemporary purity rituals and racism.

The collective of these theoretical modes— Douglas (1966), Finley (2009), and Berthold (2010) — help historicize and contextualize existing blood narratives, facilitating an exploration of different “roots and routes” of Black blood and bodies in the Canadian context, particularly as it relates to questions of purity and marginalization. In that, much in the same manner as OmiSoore Dryden’s (2010, 2015, 2016) scholarship on African Caribbean and Black (ACB) Men who have Sex with Men (MSM) and the Canadian blood donor history questionnaire (DHQ), this thesis also approaches blood and the Black racial identity through an interpretation that involves the engagement of blood with “connected genealogies” (Dryden, n.d., p.13).

For the data analysis, Dryden (n.d.) explains that in such a project, it is imperative to exercise a “method of analysis that reflects, takes up, and grapples with the complex unruliness of [B]lack... diasporic bodies and blood” (p.12). Accordingly, for this project, critical discourse analysis (CDA) serves as the broader methodological orientation, as it places focus “on the relationship of language to power and privilege” (Riggins, 1997, as cited in Flatt, 2015, p.5). Precisely, CDA “is an interdisciplinary set of methods through which language is studied as a form of social interaction that can illuminate social and political processes of dominance” (Caldas-Coulthard et al., 1996, as cited in Flatt, 2015, p.5). Distinct from “other forms of analysis... CDA does not take a neutral position in its analysis, but often promotes a politicized argument that is intended to illustrate the ways in which any interactional episode is situated within the larger macro-level societal context” (Flatt, 2015, p.9).

With CDA as the line of investigation, I furthermore embrace Riggins’s (1997) rationale that maintains that the “analysis of blood donation policies does not necessitate verifying that the claims made within these policies are actually true, but rather is done so that speculation may be made regarding the social impact of this discourse” (as cited in Flatt, 2015, p.3). As further elucidated by Flatt (2015), this means to say that the objective of the analysis “is not to verify whether the policy is based upon reliable, empirically supported data” (p.3). Instead, the predominant interests are rooted in “the social implications of the policy as it is written and operationalized in practice” (p.3). To that end, a CDA “is particularly suitable” for a sociological project, especially given the disciplines “longstanding history of identifying social injustices and hidden discrimination with the ultimate goal of eradicating the detrimental social effects” (p.8).

To recapitulate, I iterate that my interest lies in the policies that disproportionately impact and/or target Black populations to understand how they may reinforce racial assumptions, thus, creating a space for the maintenance and reproduction of Negrophobia within the blood operation, and consequentially society. I question whether blood donation guidelines and procurement practices—which claim to be rigorously objective and value-free—actually have the effect both in theory and practice of stigmatizing Black populations as biologically different, high-risk, vectors of disease “culminating from and resulting in the proliferation of stereotypes about this” population (pp.1-2). Thus, in orienting my research question, provided in more detail below, I restate that it is crucial to understand that the central focus of my thesis is primarily concerned with the discourse of donation policies irrespective of the statistical information on which they may be based.

Research Questions

For the main research question, I looked to Flatt’s (2015) study on MSM and tissue and blood donation, and refurbished his research question— “Is there evidence for institutionalized homophobia and heterosexism in regulatory policies of tissue donation?” (p.5)—within the context of the Black racial classification. Accordingly, my primary research question asks: **Does institutionalized Negrophobia exist in the regulatory policies and procedures of the Canadian blood donation system?**

Next, the sub-questions are indebted to Susan Lederer’s (2008) chapter “Race, Blood and Bodies” as published in her book *Flesh and Blood: Organ Transplantation and Blood Transfusion in the Twentieth – Century America*. I also reformulated her question, this time within a symbolic framework of risk, and ask:

- What is the role of the race and the assumptions about racial identity within the blood system?
- How does the Black racial classification –and the assumptions about its racial identity – factor into the blood system, as it pertains to the movement of blood between bodies, in its collection, and in its storage?

Lastly, I further orient the research with a risk question, asking:

- What is defined as a risk in this case, and who defines it?

Sociological Contribution

This thesis is a personal contribution to the *2015-2024 International Decade for People of African Descent*, as proclaimed by the United Nations. The decade is mandated to the *Recognition, Justice, and Development* of Afro-descendants (otherwise Black peoples) globally. Additionally, the current project is also a direct contribution to the literature of Black populations and health, which is an admittedly scarce body of scholarship in the Canadian context.

Moreover, alongside Dryden's (2016) doctoral dissertation—*Unrepresentable Blood: Canadian Blood Donation, "Gay Blood" and the Queerness of Blackness*— this study is only the second project that has attempted to examine how the language of donation guidelines (current and retired) may be complicit in the creation, maintenance, and reproduction of racial inequity in Canada (Flatt, 2015, p.6). With that said, to the best of my knowledge, this is the first and only study that details the comprehensive history of ACB populations within the Canadian blood operation, bringing to prominence yet another buried or an otherwise untold story of Black populations in Canada. In stating that, I assert that the official documentation of these Black

stories, by way of this thesis, is of great significance, as it not only provides a critical retrospect on a very recent and contentious racial history, but it also further serves as a means of legitimizing the frequently muted existence of Blacks and their histories in Canada. In that, I particularly echo Dryden (n.d.) and remark that the reading of Blackness in the Canadian context is an important liberatory project of disruption, which pushes against the narrow and normative Eurocentric structures entrenched in Canadian society (p.8).

Moreover, this thesis is also a direct contribution to the body of race scholarship, particularly for those interested in the ways in which institutions produce social inequalities by uncovering the unexamined assumptions about the ways in which meanings of race can maintain and reproduce social hierarchies (Moon, 2008, as cited in Flatt, 2015, p.8). Similar to previous research which have focused on the latent processes of large organizations, Flatt (2015) explains that the discourses of blood donation can contribute to the examination of “the ways in which medical policies and practices are presented as neutral and scientific, ignoring the social and cultural contexts” wherein they are fundamentally formed in (p.8).

Methodologically, I again draw from Flatt (2015), and with this thesis, I also further demonstrate “how sociologists may benefit from using [CDA]... to conduct policy-oriented research,” because this method of analysis “allows for the documentation of supposedly scientifically objective discursive techniques, in order to identify the possible ideological purposes they may be serving” (p.8).

The Organization of the Study

The thesis is organised into six chapters. In this *Introduction* chapter, Chapter One, I have provided the sociological problem, outlined the research question, and justified the literary and methodological contributions. Next, Chapter Two is the *Review of Literature*. This section

provides operational and conceptual definitions for the pertinent themes at hand— the blood system, the definitions of blood, the Black biopolitic and its body politic— as they pertain to the Black populations of Canada. With these readings, the objective is to establish, contextualize and define the pertinent literatures that govern the themes of this thesis.

Chapter Three, the *Theoretical Framework* of the thesis starts with an overview of the contemporary race literature. Next, as mentioned in the introduction, the section primarily engages purity and contamination by way of the symbolic risk rationale, as first advanced by Douglas (1966), and consequential risk scholars of race, Finley (2009) and Berthold (2010), who respectively make Douglas (1966) intelligible in a race context.

Chapter Three, *Methods*, explains the qualitative methodology, CDA, and details the stages undertaken during the analysis.

The *Results and Analysis* section, Chapter Four, is divided into two parts. While Part I maps and justifies the five *Black blood* narratives uncovered in the data collection phase— The Negro Segregation, The Haitian Voluntary Exclusion, The African Indefinite Deferral, Phenotyped Blood, and Black Women and Blood Donation—Part II is entirely focused on the meta-themes identified from the said narratives, they represent: *Migration Waves and Policy Implementation Dates, Canada Follows American Directives, Social Movements and Policy Repeals, and the Racialization of Disease*. There, the findings are aggregated, highlighting the dominant themes, directing the reader to uncovered perspectives, potential gaps, limitations, and/or ignored or marginalized angles.

Chapter Five is the *Discussion* section of this thesis. In this chapter I build upon the aggregate of the data results, and provide a comprehensive explanation through a macrosocial integration of Erwin Goffman's (1956) dramaturgical theory, as outlined in his book *The*

Presentation of Self in Everyday Life. To supplement Goffman (1956), particularly in a contemporary racial context, I integrate the structural components of Leslie Houts's (2004) dramaturgical analysis on race titled *Backstage, Frontstage Interactions: Everyday Racial Events and White College Students*. With this marriage of the dramaturgical tools, I explore all the dimensions of the Black racial narratives (and meta-themes) as outlined in the data results, going beyond what the blood system wants us to consume; and it is with that, that I put forward the plausibility of a *spoiled performance* in the interaction order of the blood system.

Chapter Six, titled *Conclusion*, concludes and recapitulates the study, delineating the limitations, proposing solutions or recommendations for future research projects.

CHAPTER ONE: REVIEW OF LITERATURE

The Canadian Blood System

The formation of the voluntary non-remunerated anonymous patient-recipient blood collection system, as observed in Canada today, was erected in response to World War II (Smith, 2015, p.94). Initially founded in 1896 as a humanitarian organisation for domestic disaster relief and warzone healthcare, the Canadian Red Cross Society (CRCS) introduced its first transfusion program in January of 1940 (p.94). This marks a period whereby transfusion medicine was exclusive to military personnel (p.94). In 1947, the first peacetime donor clinics were established, dispersing services beyond the armed forces to also include civilians (p.94). As a result, CRCS was able to supply blood both nationally and internationally for treatments with blood components (p.94). In time, “the federal and provincial governments granted the CRCS an exclusive mandate as the sole operator of Canada’s blood system” (p.94). While the blood system appeared to be secure, what ensued in the late 1970s proved to be lethal to the integrity of the blood system and its recipients.

The late 1970s and 1980s mark a period of tragedy when the most enormous public-health catastrophe in Canadian history took place (Feldman & Bayer, 1999). As the medico-technologies were not equipped to detect the then unknown virus, an estimated 1100 Canadians were infected with HIV—the virus that causes acquired immune deficiency syndrome (AIDS) — through a series of contaminated blood transfusions. This event has come to be referred to as *The Blood Tainting Scandal* (Smith, 2015, p.94).

The conditions that made way for the HIV contaminations “resulted in the federal government’s establishment of the Krever Commission” (Smith et al., 2011, p.370). From 1993-

1997, the Krever Commission reviewed all Canadian blood systems to determine the *fundamentals* of the contamination scandal (p.370). The substantial report “singled out the ineffective and half-hearted... risk reduction strategies” on the part of the CRCS (p.370). Presented before the House of Commons in 1997, the inquiry issued a series of recommendations for “overhauling the collection, processing and management of blood” products (p.370). Krever (1997) found that by authorizing donations from populations presumed to pose contamination risks to the Canadian blood supply, the Red Cross had failed to soundly respond to the HIV crisis with sufficient competency (p.370). The commission asserted the primacy of safety, declaring that safety ought to “transcend all other principles and policies” (p.370). Thus, the use of “precautionary principles as the first line of defence against possible threats to the blood supply” came as a critical recommendation in the report (p.370).

In consequence, the CRCS was stripped of its authority to oversee Canadian blood donor systems and was replaced with two organisations contracted by the Public Health Agency of Canada (hereafter Health Canada); CBS and HQ (p.371). While HQ “collects, tests, manufactures, distributes, purchases, and supplies blood products” exclusively in Quebec, CBS performs the equivalent in the remaining provinces and territories (p.370). Note that both blood operators are subject to the same directives as mandated by Health Canada.

As directed by Krever (1997), the new blood operators implemented stringent deferrals and regulatory regimes, ironically creating new barriers for *some* populations (e.g. MSM). For Black populations, the consequences of the tainting scandal did not just create *new* barriers, according to Dryden (n.d.), it in fact refurbished and reinstated the already entrenched “colonial panic of miscegenation” (p.6). As a result, in the last thirty-five years, a number of policies have

targeted and continue to disproportionately impact Black populations in a manner that is not observed with any other racial groups.

Blood Donation and Black Populations

A review of the international literature suggests that of all Black diasporic communities, African Americans have gained the most academic and public attention when it comes to blood donation (Love, 1996; Washington, 2006; Lederer, 2008). The American literature is notable, citing several themes in donor recruitment, iatrophobia, and scientific racism, as well as mapping the ARC's initial Negro segregation (Love, 1996; Washington, 2006; Lederer, 2008).

For the Negro segregation, the American literature recurrently cites the ironies of Dr. Charles Drew, the African American director of the ARC at the time, a "man who was responsible for developing the blood bank... [yet] was denied access to it" because of his race (Love, 1996, p.xviii).

Beyond the United States, "studies of Black donation in multiethnic and multicultural societies are the exception rather than the norm" (Tran, Charbonneau & Valderrama-Benitez, 2013, p.510). In that, a small number of scholars outside North America have also published in this area, Grassineau et al., (2007) on Comorian migrants in France; Polonsky et al., (2011) on African migrants in Australia; and Merav and Lena (2011) on Ethiopian Jews in Israel.

In Australia, studies on sub-Saharan African populations and blood donation have reported sentiments of fears of discrimination and/or racism (Polonsky et al., 2011). In the study titled, *They Don't want our Blood: Social Inclusion and Blood Donation among African Migrants in Australia*, Polonsky et al., (2011) reported that informants believed "that their blood would be disqualified from the donation pool on the basis of race," premised on the suggestion

that blood banks and “White people don’t want African blood” because of stereotypes “that migrants were contagious and diseased if they were from Africa” (p.341).

Affirming the anxieties of the African informants in Australia, in the mid-1990s, the Israeli national blood services disposed of blood collected from African donors for a period of nearly five years. In a deceptive process, unbeknownst to Black donors, their blood was routinely discarded before it could reach the banking system (O’Neil, 2008, p.369). The basis of the policy was said to be premised on a fear of disease contamination. This led to “widespread protests by Ethiopian Jews who denounced the policy as racist,” headlines read: “Black Israelis riot over insult to their blood” (p.369). Further to that, it was later reported that African migrants were the only ethnic group required to be blood tested upon arrival in Israel. Case in point, this stuff really does happen!

The bulk of the Canadian literature, approximately twelve studies since 2010, have been published by Johanne Charbonneau and Nathalie Tran in collaboration with HQ. Their projects surround Black communities, namely Haitians (and sometimes ACB) in Quebec, studying particularly the intergenerational iatrophobia and the refusal to donate blood in the province. Most recently, as mentioned in the introduction, Dryden (2016) has taken a more critical approach to the study of Black populations by examining ACB MSM in the CBS DHQ.

Critically Examining Black Populations in the Canadian Blood System

Resonating with the body of Dryden’s (2010, 2015, 2016) publications, I too critically engage the history of the Black racial classification within society and in the blood system. In doing so, I recognise that in any investigation of blood donation and Black populations, particularly within the Canadian context, donor motivations, inclusions, and participation can

never be articulated in isolation of the historical patterns of race and racism, exclusionary policies, and the donor constructions which from the onset fundamentally disqualified and deterred many Black populations from equitable donor participation.

In that, again with Dryden (2010, 2015, 2016), I fundamentally refute much of the blood literature's position on Black diseases, particularly where they endorse contested notions of racialized diseases, namely sickle-cell disease, as not only fact, but as the means of justification for undertaking their respective research projects (Polonsky et al., 2011; Charbonneau & Tran, 2013). Sickle cell anemia is an "autosomal recessive disease that is caused by a point mutation in the hemoglobin beta gene HBB" (Soo-Jin Lee, 2015, p.35). In the 1920s hematologists became heavily engaged in research to confirm that sickle cell anemia was specific to "the Negro's blood" (Lederer, 2008, p.115). In reaction, a number of scholars, among them Wailoo (1999), Washington (2006), and Roberts (2011), have aptly contested the racialization of this disease; within a historical analysis, they demonstrate how it has been incorrectly constructed and promulgated as a Black ailment, in consequence to the scientific quest for racial difference (Lederer, 2008, p.114).

Note that reported incidences of the disease in other racial groups further corroborate that the disease is not restricted to Africa nor Blacks for that matter; in fact, research has demonstrated that much of the African continent is unaffected by the traits and the disease. Also note that the American Society of Hematology (2018) confirms that sickle cell disease and traits are also common in Hispanic-Americans from Central and South America, as well as people of Middle Eastern, Asian, Indian, and Mediterranean descent.

In response, scholars like Francine Small (2013), who wrote on the racialization of disease, race, and ethnicity in biomedical research, have found that attributing diseases to

particular racial groups, as is the case in the blood operation, “helps to create and reinforce existing social beliefs in racial difference and in the immutable fixity among races” (Medical Science and Racial Thinking, para.1).

Alongside Washington (2006), I too uncovered that in much of the existing blood donation literature, “even those who investigate the role of medical ethics and medical policy are trying to dissect and analyze the much decried African American [or Black] aversion to medical research without understanding the history that created that aversion” (p.66). In response, in the same manner as Dryden (2016), I also explore how the reification of race in the blood system, may reveal more about the pathology of racism, than the said racialized pathologies in of themselves. Hence, to be rigorous in a study of Black populations within a medical discourse, like blood donation in this case, as directed by Washington (2006), necessarily means to foremost be critical of the taken for granted assumptions associated to the racial classification. That is because, in particular to this racial group, representations are constituted in/through structural relations of authority and oppression, and thus, they can only be deconstructed with reference to those said material histories (p.66).

Blacks in Canada

The Definitions: Black(s) and Blackness

The terminologies *Black* and *Blackness* are tremendously ambiguous, as they amalgamate a variety of distinctive ethnicities into a single word. The *Employment Equity Act* defines “Black(s)” as visible minorities—“persons, other than Aboriginal persons, who are non-Caucasian in race or non-white in colour” (Statistics Canada, 2011, p.14)—with (in)direct ancestry to Africa. Thus, Blacks, Afro-descendants, or the Black diaspora includes African

Blacks, African American Blacks, Canadian Blacks, Afro-Latino Blacks, European Blacks, and Caribbean Blacks (Henry & Tator, 2010, pp.57-59; Statistics Canada, 2011, p.15).

Accordingly, the term Blackness incorporates the mosaic of the numerous Black ethnicities. Nonetheless, irrespective of actual or imagined ethnic relations among Blacks in Canada, it is in the Western tradition to reference Blacks as an all-encompassing single *ethnoracial* group. Thus, in its totality, Blackness is at once racial, just as it is ethnic. This means to say that by virtue of racial identification via physical demarcations, a shared historical legacy of slavery and resistance, as well as the impact of racism distinct from others affecting immigration, education, employment, health, the justice system, mass media, and culture—the conceivably isolated experiences of a single Black sub-group necessarily impacts the total Black population (African Canadian Legal Clinic (ACLC), 2012, p.3). Hence, in studying this population, an acknowledgement and specification of the distinctions among the groups are paramount without ever discounting the vital association of a common corporal characterization (Tran, Charbonneau & Valderrama-Benitez, 2013, p.510). This notion is essential to the understanding that Blacks encompass many different ethnicities, yet are perceived, understood, and represented as a monolithic group within the Canadian context, as well as across the West (Statistics Canada, 2011).

Black History in Canada

To understand the sociopolitical trends of Blacks in Canada today, it is vital to first recognise and appreciate their extensive history within the nation (ACLC, 2012, p.4). Black slavery existed in Canada spanning nearly 200 years, from 1628 until its abolition in 1834 (Milan & Tran, 2004, p.2; Henry & Tator, 2010, pp.57-59). During this time, Blacks fleeing from slavery and persecution in the United States (U.S.) found themselves either re-enslaved or living

in discounted versions of freedom in Canada (Henry & Tator, 2010, pp.57-59; Vickers & Isaac, 2012, p.81). Thus, the first Black immigrants were a combination of slaves, descendants of slaves, escaped slaves via the Underground Railway, ex-slaves freed by the British during the revolution of the War of 1812, and Loyalists (Henry & Tator, 2010, pp.57-59; Vickers & Isaac, 2012, p.81). On arrival, they found settlements in the provinces of Nova Scotia and Ontario, and later in western provinces with the opening of the frontier in the mid-1800s. From the abolishment of slavery until the late 1960s, racial segregation was the ruling race regime in Canada (Vickers & Isaac, 2012, p.81). To be precise, Blacks in Canada, had to contend with *de facto* segregation in housing, schooling, employment, health, and general exclusion from public spaces (p.82).

The Statistics Canada (2004) report titled *Blacks in Canada: A Long History*, states that the 1901 census of the population found that 17,400 persons or 0.3% of the total populations were classified as Blacks (p.3). In the ensuing decades, the number increased slowly to 32,100 in 1961, accounting for an even smaller percentage of the total population at 0.2% (Milan & Tran, 2004, p.3). Vickers and Isaac (2012) correlate this lacklustre growth to the widely expressed views of the era, “that Black immigration should be stopped, and that Blacks already in Canada should be strictly segregated or deported” (p.82). Such sentiments resulted in the federal government favouring a covert ban on Black immigration after 1899 (p.82). It was not until the *1967 Immigration Act*, which removed race as a legal binding requisite for admissibility that Canada’s complexion began to *darken* (p.83).

Eliminating the preference for immigrants of European origin naturally diversified immigration source countries, which consequentially and substantially increased the population of Blacks. In the late 1960s to 1980s, Caribbean nations took the lead with Jamaica and Haiti as

the most significant source countries for Black immigrants (Tran & Charbonneau, 2015, p.74). The increased Jamaican presence in Canada was the direct results of the post-World War II demand for domestic labour. As White women entered the workforce, the demand for domestic caregivers increased. Thus, through the *West Domestic Scheme*, the Canadian government aggressively recruited a large number of young Black Caribbean women to fill the employment gaps (Henry & Tator, 2010, p.70). In the 1970s and 1980s, the more racially inclusive policies continued to facilitate the immigration of Blacks, with the children and spouses of said caretakers reuniting in Canada.

In respect to Haiti, the island nation became a leading source country, following three significant events: the father and son Duvalier regimes of 1957, and 1971, and the takeoff of the Canadian, notably Québécois economy (Tran & Charbonneau, 2015, p.74). The first 1960s wave, included mostly professionals, while the second wave met a blue collar demand (p.74). The third Haitian wave, which came in the 1980s comprised of family reunification and refugees (p.74).

In the 1990s, the statistics demonstrate a drastic shift in the ethnicities of Black entrants to Canada. The 2001 census reports that 48% of Black immigrants who had arrived in the 1990s were directly from the African continent, virtually the same proportion as from the Caribbean (47%) (Milan & Tran, 2004, p.4). In retrospect, this proves to be an exponential increase from 1961, where a meagre 1% of Black immigrants derived from Africa (p.4). This exponential increase in African source countries is consistent with the shift in continental African sociopolitical climates. In the last 60 years, the continent has rapidly shifted from colonial rule to independence to rampant civil wars. As such, the vast majority of African migrants to Canada in the 1990s were refugees fleeing war, abject poverty, and sociopolitical instabilities in their respective sub-Saharan countries of origin. At the moment, continental Africans are reported to

be the third largest group of entrants to Canada, with an estimated 145,700 newcomers each year (Statistics Canada, 2011, p.15).

In its totality, the Black diaspora is the third largest racialized group in Canada—making up 15.6 % of the visible minority population— and makes up the largest racialized group in the province of Quebec (Statistics Canada, 2017, p.7). According to the results from the 2016 census, the Black population in Canada has now surpassed the one-million mark, bringing the number to 1,198,540 individuals, compared with 945,670 in 2011 (p.7).

To summarize, Blacks in Canada are originally from a multitude of countries, bringing together diverse ethnicities, immigration histories, and relationships with Canada as the host country (Milan & Tran, 2004, p.7). While some can trace their ancestry in Canada back several centuries, most have immigrated in recent decades and are just beginning to plant roots (p.7). Given this significant diversity, it would be unfeasible to consider Black Canadians as a homogenous population (Tran & Charbonneau, 2015, p.74). That is, the differences and similarities shared by the ACB communities play an integral role in understanding the relationship between their race, their ethnicities, as well as their health, particularly as it relates to the blood system in this case.

The Black Body: Health and its Body Politic

“The notion that Black people are human beings is a relatively new discovery in the modern West.”
-Cornell West

The Health of Black Populations

The Canadian literature on Black health is scarce. Massenat’s (2014) Ottawa study on HIV in ACB communities confirms this underrepresentation, going as far as to state that even

when they are undertaken, they are typically “equivocal with few exceptions” (p.13). In response, Canadian scholars have drawn upon the international literature on other Black populations from the United States, Britain, and Australia, where some parallels have been recognized between the findings in Canada.

Note that across the West, the comprehensive results of Black health concede that “Blacks have higher all-cause mortality rates, lower life expectancies, and worse mental health than Whites or other racial groups” (p.13). More precisely, Black populations also exhibit disproportionate incidences of diabetes, cancer, lupus, hypertension, cardiovascular and cerebrovascular diseases (Washington, 2006, p.15).

In response to such dire trends, a number of scholars remark of the importance of deciphering that disproportionate incidences of illnesses are not born of racially specific genetic predispositions (Washington, 2006, p.15; Roberts, 2011, p.60). Instead, they are innate to social determinants, which are complex social interactions “among unhealthy environments, social pressures and limitations, lifestyle factors, and limited access to health care” (Washington, 2006, p.15). With figures, the literature articulates that irrespective of the “heavy emphasis on genetic ailments [,] among [B]lacks[,], fewer than 0.5 percent of [B]lack deaths...can be attributed to hereditary disorders” (p.12). Thus, it is imperative to denote that Blacks are not dying “of exotic, incurable, poorly understood illnesses nor of genetic diseases that target only them” (p.12). Rather, the literature on health equity has demonstrated that it is foremost the differential treatment in health systems, that creates inequities for the “common ailments that are more often prevented and treated among [W]hites than among [B]lacks” (p.12).

As alluded by Washington’s (2006) arguments above, the literature on Black health has conflicting units of analysis. One perspective is typically authored by the *hard sciences* and

characteristically focuses on the epidemiology—prevalence and frequency— of specific pathologies that are deemed disproportionate to Black populations, namely infectious, genetic, and exotic diseases (e.g. Ebola, thalassemia, sickle cell, and HIV-O) (Massenat, 2014). In contrast, the other side, the biopolitics of race, and its consequential biopolitics of the Black race (hereafter the *Black biopolitic*) is most in line with a sociological endeavour like this thesis.

Rooted in the intersections of critical race theories, and the sociology/philosophies of scientific knowledge, with strong emphasis on frameworks adopted from feminist philosophies of science, the biopolitics of race, on occasion cited as *critical race science studies*, generally queries the critical existence of race; the use of racial categories in genetic and medical research; or the history of scientific racism (Gowder, 2015, p.3157). As a consequential variant of the expansive biopolitic of race, what I have coined as the Black biopolitic, queries the same noted paradigms. However, the conceptions are exceptional to the Black racial classification, which are rooted in the discourses of the *Black body politic*. Thus, this means to say that to apprehend the Black biopolitic is to necessarily and soundly grasp the foundational conceptions of the Black body politic.

The Black Body Politic

A number of studies have revealed that the existing quintessence of Black representations— often reproduced implicitly today— are synonymous to classical constructions that inferiorize Blacks, and racializes them as inherently risky, among various other undesirable depictions such as violent, animalistic, threatening, sexual, criminal, unintelligent, physical, lazy, poor, and of particular interest to this study, diseased and/or contaminating (Finley, 2009; Yancy, 2016).

Revisiting the classics, as it especially concerns the constructions and representations of Blacks, the historical literature demonstrates that negative representations of African peoples date back to European contact (Washington, 2006; Goff, Eberhardt, Williams, & Jackson, 2008, p.292). With the first contact, taxonomies of sub-classifications almost immediately became superimposed onto human species, Othering Blacks (Goff et al., 2008, p.292). The race scholarship agrees on the significance of the seventeenth and eighteenth century, naming this epoch as the period wherein race was formally concretized as a biological and natural entity by Enlightenment scholars who stereotyped and (mis)measured physiological characteristics (Jackson, 2006, p.14). Henceforth, a global system of hierarchal human categorization was created, orientalisng the essence of the Negroid (Blacks), wherein they became racialized and relegated to the underclass, the nethermost locality of human classification, named as savages in juxtaposition to the normative civilized Caucasian (White) race (p.15).

In this process of race formation, nearly all of the esteemed classical intellectuals of various leading disciplines explicitly established the racialized *logic* of Black inferiority (p.15). The assemblage of their inferences permeated and developed as “uncontested truth claims: that all Blacks [were] intellectually, behaviorally, interpersonally and physically inferior, and as such should be treated as objects” (Jackson, 1999, as cited in Jackson, 2006, p.14). Finley’s (2009) dissertation on Blacks, religiosity and the Nation of Islam tells us that such constructions of denigration are rooted within the Manichean light/dark and good/evil philosophies, where these dualities were successfully superimposed to racial identities (p.32). In this great chain of being, Whites ascended as the “transcendental signified” race, the universal subjects, the most superior, and coveted, while Blacks as their antithesis were relegated as bestial, contaminating, perverted, uncivilized, diseased, and fundamentally dangerous (Jackson, 2006, p.19).

Scholars of the Black body politic have unpacked many historical and contemporary processes of racialization ascribed to the Black body, inclusive of the intersections of colourism; masculinity (Jackson, 2006); femininity (Hill Collins, 2000); sexuality (Dryden, 2010, 2015, 2016), and of particular interest to this study, health and disease (Washington, 2006; Wailoo, 2008; Roberts, 2011).

Two schools of thought are identified within this body politic. One side dictates that the Black body is in fact always already dangerous, inherently contaminating or risky (Finley, 2009, p.47). In this perspective, the Black embodiment is innately value-laden with negative stigmas, rendering it always already inferior, determined prior to experience in the world (p.48). Said differently, the Black body is confiscated, imbued with constituted meanings grounded in the “Western ontology of Black inferiority” (p.47). Here, the Black body *seen* makes it guilty of a prior offence, because of its *racial epidermal schema*, the evidence and presupposition of guilt lies in the Black skin colour (p.49).

American philosopher, George Yancy (2016) best captures this school of thought in his book *Black Face White Gaze*, in stating that “if you are Black... [w]ithin [W]hite racist North America, you must not even assume that you are taken to be human” (p.xxii). He adds that “Black bodies are [still] devoid of intrinsic value; their value is decided upon in terms of [W]hite forms of policing and stereotyping (p.xiv). This perspective emphasises the universality of the Black body as the apex of “problem bodies, dangerous, and unwanted bodies... strange bodies, curious bodies... and dark and mysterious bodies” (p.xiv). Thus, the fundamentality of this school of thought is that the Black essence necessarily precedes its existence.

The other group of the Black body politic advances more nuanced perspectives. They too recognise the risky representations associated with Blacks as fact. However, they intersect them

with the many implicit paradigms of contemporary race relations, contesting the categorical inherence of the Black body as risky, to be grand narratives that perpetuate gross overstatements (Finley, 2009, p.49). For that reason, in this line of thinking, the riskiness of Blackness is acknowledged insofar as it is perceived as a matter of context. For them, as interpreted by Finley (2009), the intellectual attention and scrutiny of the Black body politic is constituted by a myriad of interactions, that are the by-products of the exterior dynamics of the racial group, and the intersubjective relation is through which, and in which awareness the body is intelligible (p.23). In other words, how Blackness is viewed, perceived, and constructed is not merely a “solipsistic operation it is also a function of corporate and collective relations” (p.23).

From this wide-ranging body politic, there are two main points of understanding; (1) as cited above, is that “the notion that Black people are human beings is a relatively new discovery in the modern West,” and accordingly, “Black bodies are [always] constituted through a racist episteme” (Yancy, 2016, p.6). The next point of coherence is (2) the *Black exceptionalism* standpoint. Where the body politic concentrates its efforts on the physicality and representations of the body, the Black portion is exceptionalist in nature.

A Black exceptionalism standpoint supplements the examination of Black populations by calling out the persisting racial frame and its particular preoccupation or fixation with the Black racial classification in particular (Feagin, 2010, p.99). An exceptionalist standpoint necessarily finds that from the beginning, dominant frames have placed the anti-Black subframe at the heart of its framing (p.99). This is said without diminishing the tyrannies faced by other racialized populations. What this viewpoint means to expose is that unlike other racialized groups, the Black racial classification, as the antithetical race, has long been the central reference point for the racial standard against which the dominant racial group defines itself (p.99). In that, the

Black body politic points out that in the broad stroking of race (e.g. references to diversity, cultural communities and/or visible minorities) always notice that the Black racial classification is at the forefront as the archetype.

The Black Biopolitic

Scholars of the Black body politic have demonstrated that for Black populations, defining political and economic systems of race in biological terms has been a constant feature for them for centuries. The same can be said for contemporary health discourses; the literature finds that “the precise mechanism for re-creating [the Black] race have [also] changed to reflect current sociopolitical realities” (Roberts, 2011, p.11). According to Roberts (2011), arguably the most prolific scholar in the biopolitic of race, there are three central components to this biopolitic.

The first point speaks to cutting-edge genomic research, said to modernize old racial typologies that were classically created on observations of physical differences (p.11). In so many words, genetics has brought upon a different approach to the question *why* behind health inequities. The literature points out that the reconfiguration of race now centres on two fundamental concepts: statistical probability and geographic ancestry (p.99). Statistical probability is based on the premise that biologically related individuals are more likely than unrelated individuals to share genetic variants (p.93). The idea is that individuals belonging to the same race share more of their recent ancestry and therefore are more genetically similar to each other than to those of other races (p.93). In sociological terms, and by Robert’s (2011) definition, this means that racial differences are now said to be real at the molecular level, but constructed at the social level (p.13). To understand this first and integral point of the biopolitic of race, is also necessarily to grasp the conceptions brought out of the Human Genome Project (HGP).

The contemporary literature on race concedes that the amplified attention to race in genetics is the consequence of the HGP (Satzewich & Liodakis, 2007, p.148; Roberts, 2011). In brief, the results of the HGP have generated copious amounts of literature relating to the existence of race, and in consequence, racial differences have taken a renewed vigour (Satzewich & Liodakis, 2007, p.148). In this vastness, two schools of interpretation have been deciphered; the 99.9 percenters in contrast to the 0.1 percenters. The 99.9 percenters include the constructivists and anti-essentialists. Most aligned with sociological endeavours, these perspectives broadly argue *the big picture*. The collective of their inferences finds that the disproportionate amount of similarities discovered among humans (99.9%), confirms that race is either an empty (constructivist) or unreliable (anti-essentialist) biological concept (p.148). For them, the remaining 0.1% in variations, cannot be used to set up definitive racial categories (Satzewich & Liodakis, 2007, p.148; Fausto- Sterling, 2012, p.3; Soo-Jin Lee, 2015, p.27). Thus, the fundamentality of this perspective infers that we are rooted in a societal system that favours a racial discourse of difference over similarity, historically this has always been the accepted trajectory for substantiating race, particularly the Black race (Satzewich & Liodakis, 2007, p.148). Accordingly, in these times of genomes, without much deviation from classical race making trajectories, the biopolitics of race reveals that the majority of societal structures again elect “to label those genetic differences as race” (p.149).

While the biopolitics of race finds that “the genes for traits deemed racial are scientifically real;” it argues that “there is no racial aspect of these genes which is scientifically real” (Soo-Jin Lee, 2015, p.31). In contrast, scholars of the essentialist penchant, who adhere to reductionist perspectives, find that there is something biologically real and relevant about race (Satzewich & Liodakis, 2007, p.148; Fausto- Sterling, 2012, p.3). Hence, they sequester the

remaining 0.1 % as the significant cite of alleged genetic variations and the notable foundations for differences in skin colour, physiognomy, and the disposition toward disease, and of particular interest to this thesis, blood traits (Satzewich & Liodakis, 2007, p.148).

In this reductionist model, “cultural variants such as race are subsumed within a genetic epistemology” (Soo-Jin Lee, 2015, p.35). In other words, things like phenotypic characteristics are “relegated to mental or cognitive constructs that are unchanging and essentializing,” understood to be “static list[s] of attributes associated with particular groups” (p.35). Not surprisingly, the sociological literature refutes the reductionist approach to the geneticization of race. The primary critique is that reductionist science “leads to a decontextualized... approach to ethnic or cultural identity” because of its fundamental reliance on a “unity of knowledge that suggests an opposition between culture and science... that privileges genes as a fundamental basis for human behavior” (p.35).

The second theme questions the roles of biotechnologies, and pharmaceutical industries in racializing products that are developed and marketed according to assumptions of genomic racial difference (Roberts, 2011, p.11). For example, BilDil, the heart disease prevention drug made for Blacks, marketed as personalized (or otherwise racialized) Black medicine.

Last of all, the third point speaks directly to “the imprimatur of objectivity in science,” and how it necessarily involves a colour-blind paradox (Soo-Jin Lee, 2015, p.28). Roberts (2011) infers that policies that are officially colourblind, in practice, favour institutional interests while simultaneously imposing various forms of punitive regulations on racialized populations (p.12). A number of scholars in this field have called for the examination of seemingly universalizing practices, which according to scholars like Roberts (2011), operate as “dehumanizing policies of surveillance” and coercive control, that are made to obscure to the

general population “the emerging genetic understanding of race that focuses attention on molecular difference, while concealing the impacts of racism” (p.12).

Still in the context of the colour-blind paradox, scholars have also critiqued the arbitrary nature of racial classifications. In that, the use of racial or ethnic categorizations based on sociopolitical visible groups has come into question, particularly where Black populations are concerned (Washington, 2006). Scholars like Small (2013) explain the fundamentality of this argument by inferring that currently, biomedical institutions use “the same seemingly antiquated and potentially useless categories for race-based medicine” (p.18). This then brings about “gross assumptions and generalizations” about “racial/ethnic groups even in a system designed to rigorously control and exclude such conjectures” (p.18). Moreover, a number of studies have revealed that Caucasian groups are deemed the norm, and non-White races, particularly Blacks, are the comparator used to investigate differences in outcomes (Washington, 2006).

At its fundamentality, the Black biopolitic reveals inequities in policy and procedures that go unnoticed, appearing acceptable to the majority, who according to scholars like Feagin (2010) and Roberts (2011) already hold an intrinsic national consciousness that racial differences in Blacks are validated biologically. Roberts’ (2011) comment sum it best, where she states that as race consciousness intensifies at the molecular level, it fades at the social level (p.13).

In summing the three components, for the emerging Black biopolitic, the “recent surge in human genetics research through the development of high-throughput technologies and the deciphering of the genomic alphabet into meaningful categories of risk...where the color line is inscribed beyond the surface of the skin” is paramount to this literature (Soo-Jin Lee, 2015, p.27). Leading scholars of this biopolitic, Washington (2006) and Wailoo (2008), infer that for Blacks, biological theories of race are being resuscitated throughout contemporary health

discourses, revealing that “science is redefining race as a biological category written in [Black] genes” (Roberts, 2011, p.11). In the same manner, Soo-Jin Lee (2015) agrees and adds that with racial science, the “search for differences revisits classical notions of ‘race’ as embedded in the physical body” (p.30).

It is important to note that this literature is new and emerging. In the recent past, the biopolitics of race (and its variants), along with other humanistic “[d]isciplines... have been marginalized; [and] at best treated with suspicions, at worst denigrated for being ‘soft’ and non-practical” (Lupton, 1995, p.2). Historically, patterns of grant and research allocations were inclined to valorize empirics, “statistical measures, cost-effectiveness, and the evaluation of measurable effects,” often neglecting the critical analysis of sociopolitical disparities that are so central to this biopolitic (p.2). Note that this de-valorization was also evident in the blood operation. As Dryden (n.d.) points out, in the aftermath of the tainting scandal, blood and blood donation was brought under federally commissioned scientific, medical, and legal reviews across the globe (p.6). In contrast, no such reviews were ever commissioned for the language and culture of blood and blood donation (p.6).

The article *Critical Race Science and Critical Race Philosophy of Science*, speaks to this lacklustre notoriety of the biopolitics of race. In it, Gowder (2015) likens it to the fact that this race literature has yet to unify into a consolidated school of scholarship that would provide a level of authority, and credibility that can inform the general ideas about race and empirical research (p.3157). In response, Gowder (2015) calls for the emulation of the feminist philosophies of science; precisely stating that the formalized and streamlined nature of their research project would catapult the biopolitics of race to a more bonafide sub-discipline (p.3157). Other scholars like Soo-Jin Lee (2015) have also acknowledged fragments in this body

of literature, more aptly reasoning it to “[t]he imprimatur of objectivity in science [that] occludes from view an infrastructure that is built on assumptions and stock knowledge of how and why populations differ from one another”(p.28).

Nonetheless, the biopolitics of race— inclusive of social medicine, medical sociology, medical anthropology, bioethics, among many other cross-disciplinary approaches within the humanistic frameworks that place importance on cross-disparities and social variances, questioning racism (and its variants) in health and medical-related discourses (ACLC, n.d., p.1)—has increasingly established an authoritative body of literature in the social sciences and beyond. So much so that in 2017, Social Scientist Dr.OmiSoore Dryden was awarded a \$400,000 grant from the Canadian Blood Services (by proxy of the Federal Government) to study the equitability of the blood donation screening practices as they relate particularly to Black MSM populations in Canada (CBS, 2018). In a two year project, her research team will investigate specifically how ACB MSM are negatively impacted by some questions on the blood donor questionnaire from a humanistic perspective. A clear triumph for the Black biopolitic, especially in respect to the underrepresentation of studies of Black health in Canada.

In summary, it is imperative to distinguish that the biopolitics of race does not “deny that differences between and among human groups exist. Clearly, they do” (Soo-Jin Lee, 2015, p.27). In accordance with Soo-Jin Lee (2015), the biopolitics of race vehemently contests the validity of biological differences between populations that are linked to race, reinforcing “that race emerges through a historically grounded context and is best understood as fluid and reactive to historical and political conditions” (p.30). This line of argumentation maintains that within the various health-related discourses, like blood donation, the geneticizing of race has become an important factor that is “increasingly salient in understanding disparities in the health status of

[racialized] population groups,” again, this is especially evident where Blacks are concerned (p.31). In that, the contemporary biopolitics of race dictates that the current deployment in race making— “when ideas about race become the dominant explanatory model for understanding phenomena in the world”—is especially rooted in the discourse of human genetics (p.27).

Thus, with these conceptions, the intent is to analyze how the discourses of blood, race, the Black racial classification in this case, and biomedical practices like blood donation, are also interpreted and impregnated with social meanings, meanings that may reveal ideologies of difference, that are so critical in determining how the perception of difference manifests itself in human experience, that may then be rendered significant in places like the blood system, and therefore blood (p.27).

Blood

“Power speaks through blood”

-Keith Wailoo

The Definitions of Blood

According to blood operators, blood is a liquid tissue made up of key components— approximately 40-45% red blood cells, 55% plasma, and 1% platelets and white blood cells— pumped through the body by the heart through blood vessels (HQ, 2018). As a delivery system for oxygen, minerals, hormones, nutrients, among other critical materials to the organs, blood also aids in clearing the body of waste. By way of this definition, blood is admittedly a biological substance with well calculated physical proponents (Nelkin,1999, p.274).

According to symbolic scholars of blood, such a definition is precisely the object of the modern sciences, it categorically disenchant the fluid eliminating all of its mystical nature and

its symbolic charge so that it may be considered exclusively for its biological and quantifiable features (Attali, as cited in Charbonneau & Tran, 2013, p.172). The symbolic power of blood is vast, and a number of disciplines have taken an interest in it, notably, history, the arts, religious studies, anthropology as well as sociology. In so many words, this literature coheres on an understanding that blood is a malleable space-time contingent property, which is at once a social fluid and a cultural entity, fundamentally reflective of the complex social meanings placed on the body in direct association to the structures and strains of social relationships (Nelkin, 1999, p.275).

As it relates to blood in blood donation, a number of scholars have explored the system figuratively (Antoine et al., 1990; Nelkin, 1999; Kent & Farrell, 2015; Charbonneau & Smith, 2015; Dryden, 2010, 2015; Hannabach, 2015). Particularly, the literature on MSM is robust, and a number of scholars have written about the “symbolic elements of homophobia as a discursive framework utilized in the surveillance of” MSM (Flatt, 2015, p.118). In that, the MSM literature has been integral in demonstrating that “[s]ymbols, rituals and metaphors relating to blood have not disappeared” in the transfusion system (Charbonneau & Tran, 2012, p.1). Much in the same manner, studies of blood donation in the ACB communities in Quebec, have also determined the same, declaring that “science and reason have in no way succeeded in erasing the many myths associated with blood” and race, surmising that “symbolic representations of blood are hardly the sole province of ancient or primitive peoples” (p.1).

For this thesis, I draw particularly upon Cathy Hannabach (2015)—who studies “how blood is visualized, mobilized, and circulated among medical practices, military policy, and popular media”—and her two-pronged definition of blood (p.2). Her exact articulation is as follows:

Blood is a slippery substance: both matter and idea, both a viscous material entity and a collection of visual and linguistic metaphors. Blood transports oxygen, pathogens, ideologies, affects, and norms. It signifies life when pumping through arteries and death when draining out of wounds. It is both hypervisible in horror films and battlefields, and hidden beneath the opaqueness of our skin. Blood epitomizes the messy, corporeal experience of being a body in the world. Blood slips by us, through us, around us, and we come to know ourselves and each other through its circulations. (Hannabach, 2015, p.2).

Acknowledging both the physical and mystical proponents of blood, I read blood as a fluid that is always already “material (blood donation, banking, transfusion, testing and typing)” just as it is always already symbolic (kinship, war, violence, purity, risk, race, and etc...)” (p.5). With this definition, and as per the collective of the symbolic scholarship on blood, reading blood in this manner, renders it a substance that is *always already* political (p.6).

Blood Donation, Safety Logics, and Race

To properly navigate through the institution of blood donation, it is first imperative to reference Richard Titmuss (1970) and his anthropological study of “socio-cultural meanings and ethics of blood donation” titled *The Gift Relationship*. As the seminal work in the field of blood relations, it conceptualized the process of blood donation as a gift relationship “involving altruistic, non-remunerated blood donation to anonymous patient recipients” (Farrell, 2012, p. 5). With strong appeals to the universality of blood and donation, Titmuss (1970) maintains the importance of “promoting social solidarity within industrial societies” (as cited in, Farrell, 2012, p.5).

In the aftermath of the various worldwide tainting scandals, blood system literature has transcended from *altruistic* discourses towards more critical examinations whereby predominant interests lie within the politicized dynamics of blood-related issues (Farrell, 2012, p.6). These politicized discourses generally examine the economies of “blood product distribution and regulation, the behaviours of healthcare institutions in their efforts to assure the safety of the blood supply, the claims and expectation of HIV-infected individuals, and the public perceptions of the nature and causes of the HIV disease” (Nelkin, 1999, p.275).

Kent & Farrell (2015) corroborate this shift stating that blood donation has become a “highly politicized” phenomenon, whereby tensions arise specifically when certain social groups are excluded as donors (p.30). They speak precisely of donor deferrals premised on risk and *safety logics* (Hoeyer, 2010), maintaining that deferral policies and practices warrant “critical scrutiny” as they are too often obscured by the more traditional discourses of universality, citizenship, solidarity, and altruism (Farrell, 2012, p. 5).

The analysis of safety logics principally studies how national blood systems have instituted policies of donor deferrals for “a range of scientific, social and institutional reasons” (Kent & Farrell, 2015, p. 31). In other words, safety logics explore how “potential donors are refused permission to donate blood for reasons that may vary across [social] boundaries, regulatory regimes or cultural mores” (p.31). As mentioned previously, this perspective maintains that the exclusion of particular groups is “frequently obscured by a discourse of universality of blood donation” (p.31). For Valentine (2005), as cited in Kent & Farrell (2015), the universal possibilities of donation are *implicitly* and *explicitly* equated to the failure to account for the intersections of social variances such as gender and sexuality (p.31). More precisely, they posit that “contemporary theorising raises a number of questions about how

[differences in gender and sexual orientations] are enacted in blood services through material and discursive practice[s]” (p.33). For them, the gendered bodies of women and the sexual identities of MSM render them the Other who inherently transgresses the essence of the heteronormative White male donor subject. In lieu of gender and sexuality, again like Dryden (2015), I explore race in the context of the Black racial classification.

In their own rights, each of these three scholars also recognise that similar to gendered bodies, racialized bodies are also naturalized and made to be either invisible or hypervisible in a discourse which draws heavily on equalizing effects (Kent & Farrell, 2015, p.33). In this line of argument, the idea that donated blood is an equalizing social product, and that all donations are equally valued, is false (p.33). For them, this falsehood is demonstrated through policy restrictions that generate categories which absolutely construct an ethnic and racialized Other by situating racialized bodies in contrast to the preferred heteronormative White male donor subject (p.33).

Speaking exclusively to racialized bodies in the blood system, particularly Black bodies, Dryden (n.d.) states that “blood safety is used to facilitate the nationalist boundaries formed through the imagination of political community” (p.7). Furthermore, she asserts that “historical and contemporary blood stories and practices depend upon a physical legibility of identity and on the surveillance of these bodies to ensure that Othered bodies— those considered impure, “bad” foreign, and dangerous” like Africans (or otherwise Black) — “remain readily identifiable as the Other, and therefore perpetually out of place in both the nation and the national blood supply” (p.7). Important to note that these remarks are necessarily rooted in the symbolism of blood in association to matters of lineage and race.

According to the article *Medical Science and Racial Thinking, "The Negro Problem," Continued Classification*, since at least the sixteenth century, blood has been central to the belief in the heredity of social status (para.4). In this epoch, blood was not yet associated with physical traits or a racial type. Therefore, the notion of blood suggested "a fixity of difference" entrenched in broader social qualities believed to be transmitted biologically (para.4).

Note that the eighteenth century marks the period wherein racial and physical traits became prominent in scientific and social thinking; this was the time where "the physical, cultural, and social differences between racial groups" began to be superimposed to differences in the blood (para.4). In that, the constructed hierarchal differences between Whites and Blacks in terms of physical, intellectual, and cultural characteristics, indeed reflected a difference in blood as well (para.4). This logic was useful in reinforcing notions of biological difference beyond physiognomy, which helped to lay the groundwork for the numerous discourses that began in the nineteenth century about the Negro's susceptibility for diseases said to be innate to their blood (para.4).

In "Race, Blood, and Bodies," Lederer (2008) provides a detailed retracement of race and the Black racial classification that is specific to the history of the transfusion system in America. In that, Lederer (2008) advances that in the twentieth century, the once universal red fluid became an increasingly specific fluid (p.137). The centrality of her analysis endorses that though race has always been unknowable to blood, refusing to reveal itself even when subject to microscopic examinations, particularly where Blacks are concerned, blood has retained the "power to provoke and to provide opportunities for redrawing and reinscribing the limits of community, the dimensions for safety, the desires for purity, and the drama for peril" (p.137).

In the same manner, Dorothy Nelkin (1999), symbolic blood scholar, also reveals how blood has historically been politicized within racial frameworks (p.275). She too, like Lederer (2008) ascertains the twentieth century as the period wherein the Black racial categorization—among other racial groups—was repeatedly substantiated using false ideas of blood, disease, and racial inferiority through policies like *one drop of blood rule*, *blood quantum laws*, and *miscegenation laws* (p.275). For Nelkin (1999), such racial blood policies were rooted in and reified empirical parameters that equate that “races have unique blood characteristics—and these can be correlated with both physical appearance and social behaviour” (p.285).

Integrating the blood system to her analysis, Nelkin (1999) determines that the symbolic nature of blood, and its infinite associations— inclusive of “purity and contamination, vitality and death, [just as] community and corruption... life and energy [or] violence and danger— has facilitated racist proxies and mythologies, which historically, have been administered within blood systems via clinical concepts connected to physical health, framed in hierarchal binaries of (im)purity in opposition to contamination (p.285). For Nelkin (1999) it is the “historical meanings associated with blood,” like racial (im)purity, that “have helped define... the problem of HIV contamination, shape[d] systems of blood donation, and influence[d] the focus of responsibility and blame” on specific populations (p.276).

Note that even recent publications from both Canadian and American scholars like Hannabach (2015) and Dryden (2016) still continue to mirror Nelkin’s (1999) past results. Partial to the Black racial classification, Dryden (n.d.) explains that blood is a complex system that is learned and utilized in varying degrees to communicate hierarchal information (p.5). In that, she concludes that blood still continues “to mark race-specific bodies... in the narratives of sex, miscegenation, kinship, and sexual citizenship,” and the material of blood, has been used to

define and categorize bodies and construct identities, and in turn, bodies have impacted and informed how blood animates these very categorizations (Dryden, n.d., pp.4-5). Hannabach (2015) agrees with Dryden (n.d) also aligning with Nelkin's (1999) previously said. She instructs that investigating the complexities of blood and race, is necessarily to examine the fundamental reflections and manifestations of *contemporary* "[W]hite supremacist eugenicist [ideology] that there is some visible and biological difference between blood from differently racialized bodies" (p.20).

In sum, the collective of the critical understanding of blood donation within the essence of Hoeyer's (2010) safety logics maintains that it is with the complex social meanings of blood, that "blood systems... produce differences through the development of categories for sorting, screening, testing, matching and evaluating donor... bodies" (Kent and Farrell, 2015, p.33). As such, those who adhere to safety logic paradigms, like myself, cohere on the notions that donor categorizations and policy representation undoubtedly construct social hierarchies that exclude and segregate blood along ethnic and racial lines.

Lest we Forget: Blacks and Scientific Racism

"It was cheaper to use Niggers than cats because there were everywhere and cheap experimental animals."

-Neurosurgeon Harry Baley, M.D, 1960s

In considering the implications of the discourses of racial science, particularly as it relates to differential treatment in blood donation, "it is prudent to keep in mind the lessons learned from the history of scientific racism in medicine" (Soo-Jin Lee, 2015, p.32). The international literature is replete with such accounts, delineating how the malpractice of the biomedical and

social sciences has “resulted in the exploitation of racially identifiable population in the name of scientific and medical progress” (p.32). In North America, this body of literature has generated notable scholarship on the various elements of the American—and to a lesser extent Canadian — eugenics movements, in relation to anti-immigration paradigms, mass sterilization, and miscegenation laws (p.33). Beyond that, there is a broader and robust international literature on “the German program of *Rassenhygiene*, or racial hygiene,” as it relates to the Holocaust (p.33).

Of particular interest to this study is the marriage of Black populations, “scientific racism [,] and national political agendas [that] has led to their unfair treatment as ...socially and politically vulnerable racial minorities” (p.33). As noted by Washington (2006), in the West, Black populations have been subjected to exploitative abuses and involuntary experimentations at a rate higher than any other ethnic groups (p.65). Echoing her spirit of Black exceptionalism, it is imperative to recognize that the contemporary archetype of scientific racism—*The Tuskegee Study of Untreated Syphilis in the Negro Male* conducted by the United States Public Health Service—explicitly targeted Blacks as its subjects. This experiment is cited as one of, if not *the*, longest single study involving the exploitation of human subjects in the biomedical field (Soo-Jin Lee, 2015, p.33). Over a fifty year span (1932-1972), more than 300 Black males afflicted by syphilis were actively recruited under the pretence of treatment of *bad blood* (p.33). Deceptively, the men did not receive proper treatment even after penicillin became available as an effective therapy in 1943 (p.34).

In response, scholars like Chinua Achebe (the father of African literature) retort that in the West, “racism against Africa” (and Afro-descendants) “is such a normal way of thinking that its manifestations go completely unmarked” (Achebe, 1975, p.1789). To contextualize Achebe’s (1975) remarks, I again draw from Washington (2006) and Roberts’s (2011) publications, where

they respectively recount the manifold instances of science and how the many cases of abuse have been directed at Black populations. Note the examples.

Sarajite Baartman (1810), *the Hottentot Venus*. Her genitalia, buttocks, and skeleton were exhibited in the Musée de l'Homme in Paris until 1976. After nearly three decades of political and legal activism, her body was reluctantly repatriated to her native South Africa in 2002. Much in the same manner, Ota Benga (1906), a central African male, native to a pygmy tribe was exhibited in the Bronx Zoo for a number of years. Alongside Ms. Baartman, Mr. Benga symbolises the countless Black peoples exhibited in Wildlife parks throughout Western countries; Anarcha, Betsy, and Lucy (1845), pseudonyms of enslaved Black females, the objects of J. Marion Sims's (the father of modern gynaecology) surgical experimentations (conducted *sans* anaesthesia) for the extremely painful condition of vesicovaginal fistula; and most recently, Henrietta Lacks (1950s) known for the HeLa cell line, the unauthorised cloning, harvesting, and publishing of her medical records and cervical cells.

These “ethically unjustified” experiments epitomize “a powerful metaphor that has come to symbolize racism in medicine” (Soo-Jin Lee, 2015, p.34). Beyond the wider scope of racism, of particular significance to studies of Black populations, is that Black specific racism is rooted in a Negrophobic hierarchy of biological and antithetical difference, again, categorically unique to Black populations (Feagin, 2010, p.99). Accordingly, following the Black exceptionalist stipulations of the United Nation's Report—titled *Report of the Working Group of Experts on People of African Descent on its mission to Canada*—I too suggest a move beyond the broad stroking of race and racism that “obscure the degrees of disparity faced by different ethnic groups and fails to fully account for the specific human rights of Black Canadians” (The Globe and Mail, 2017).

In recapitulation, recall that in the name of scientific and medical progress, racial science, the gateway to scientific racism, has a well-established history of exploitation and malpractice in a manner that is particular to Black populations. As such, the noted calamities provide a structural understanding, a demonstrated comportment of the subordination and expulsion of the Black identity that is entirely enmeshed within the original logic of racial inferiority, impurity, and/or disease, as explained by the Black body politic and the Black biopolitic. Historically, with the Negro blood segregation, we know this to have occurred in the blood system as well. Thus, once more, echoing the likes of Roberts (2011), I urge that in considering the theoretical, racial, and blood implications of this study, keep the noted examples at the forefront of one's attention, and recall that history is discursively recurrent... *nihil novi sub sole*.

CHAPTER TWO: THEORETICAL FRAMEWORK

This chapter begins with a focused commentary on the pertinent tenants of the contemporary race literature, particularly in the context of *implicit race bias* and *structural racialization*. Next, with a particular attention to symbolic risk theory, in the ensuing sub-sections, I introduce various symbolic risk theorists who marry the theory with pertinent conceptions, the body politic and blame (Lupton, 2013), racial purity (Berthold, 2010), and the Black racial classification (Finley, 2009).

Theories of Race and the Contemporary Race Project

The race literature is notably expansive, within it, researchers generally distinguish two periods of scholarship. The classical period (late nineteenth to the mid-twentieth century) and its well-established perspectives, *functionalism*, *conflict theory*, and *symbolic interactionism*; in contrast to the contemporary phase, starting in the mid-twentieth century to date (Clair & Denis, 2015, p.858).

In classical times, with the advent of race studies, the foci of scholarship was placed on the discourses of direct and/or explicitly racist attitudes and actions (with the exception of W.E.B Du Bois) between individuals (p.858). This phase focused on the “direct relationship between racism and racial inequality,” with a substantial emphasis placed on the interpersonal and the direct consequence of the open nature of racism of that era (p.858). This narrowed the concerns of racial inequities within binary sets of interpersonal interactions of explicit hostility (p.858). Naïvely, classical theorists presumed that *interracial interaction* was the panacea for racism and all of its consequential derivatives (e.g. domination, segregation, violence, inequality, and etc.)

(Allport, 1954 as cited in Clair & Denis, 2015, p.858). The contemporary phase, inclusive of this moment, marks the succeeding stage of the sociological study of race.

The current literature is remarkably even more diffuse—comprising of themes of colour-blind egalitarianism, interraciality (mixed race), migration and citizenship, critical race theories, as well as Whiteness studies—integrating interdisciplinary methodologies, concepts, and theories. The scope of this literature generally “coheres on the point that macrostructural processes, as opposed to individual acts, provide more meaningful explanations [for] contemporary racial inequality” (Bonilla – Silva, as cited in Clair & Denis, 2015, p.860). More precisely, current research centres on the critical examination of the interconnectedness of the multivariate by-products of structural inequality and discrimination, as it *may* relate to racism (Satzewich & Liodakis, 2007; Clair & Denis, 2015).

Simply stated, in this era of “declining overtly racist attitudes,” race theorists have inferred that racism has transformed into more implicit forms (Clair & Denis, 2015, p.858). Thus, today’s race research projects predominantly “centre on explaining the well-documented persistence of racial inequality and racial discrimination in an era of declining overtly racist attitudes” (p.858). Accordingly, contemporary race projects generally transcend the conception of *explicit attitudes*, critically naming the interplays of implicit structures of bias as the processes wherein racial inequities are “constructed, sustained and enacted at both micro-and macro-levels” (p.858).

Race theorists, Matthew Clair and Jeffrey Denis (2015) — in *Sociology of Racism*— eloquently communicate the idiosyncrasies of the modern-day investigation of race relations. They, like much of the current literature, explain that contemporary race scholarship is tasked with a formidable challenge of measuring and conceptualizing the *subtle* and *diffuse*

manifestations of racism in increasingly racially tolerant settings (p.857). In that, a number of contemporary scholars have found that racism is “analytically distinct from racial discrimination and racial inequality” (p.857). While discrimination is often cited as “the unequal treatment of races,” inequality is said to concern the unequal outcomes” (p.857). To that end, the theoretical scholarship of race has become especially nuanced, critical, and interdisciplinary, particularly offering “analytical primacy to the taken-for-granted policies, practices, norms of organization, systems, and structures” found in higher level entities, such as social processes, social forces, and institutions, like the blood system, in this case (p.860). With these more nuanced frameworks, much of the contemporary race literature concedes that modern-day instances of racial inequality and/or discrimination *may not* always be the immediate results of racism (Pager & Shepard, 2008 as cited in Clair & Denis, 2015, p.857).

Nevertheless, be it as it may, note that an overwhelming number of race-related studies continue to demonstrate that racism is still undoubtedly implicated and intertwined in nearly all, if not all, race-related processes. In that, to advance this thesis I drew from the vast body of contemporary theories— on colonialism, class conflict, gender, sexuality, Whiteness studies, globalization, and environmental studies, among many others— particularly where they conceptualize that race is “fundamentally rooted in political, economic and/or status resource competition” (p.858). In sum, in reviewing the contemporary race theories, notably in the absence of explicit ideologies of racial domination as the direct cause, I found two reoccurring concepts as imperative to current race relations, specifically *implicit race bias* and *structural racialization*. I now turn to them.

Implicit Race Bias

Scholars who are interested in implicit race bias (hereafter implicit bias) like Clair and Denis (2015), have noted this bias to be among the fundamental explanations for the persistence of various race-related inequities today (p.859). By their definition, implicit bias is an unconsciously triggered belief in the inferiority of negative attitude towards a racial group (p.859). The National Research Council's (NRC) (2004) publication titled *Measuring Racial Discrimination* agrees, characterizing implicit biases as "indirect, automatic, ambiguous and ambivalent," going underground so as not to conflict with the broader contemporary antiracist norms (p.6).

Scholars of this sub-discipline have examined a number of themes like the differential media portrayals on racialized versus non-racialized populations, racial profiling in the criminal justice system, as well as *de facto* segregation in housing, education, occupations, and health, among other countless published instances. Relying primarily on micro-sociopsychological experiments, and Implicit Association Tests (IAT), which are frequently studied through experiments, audit studies, critical discourse analysis, and other innovative techniques, manifold studies have considered the association between race, stereotypes, and judgements, revealing that on average individuals more readily associate positive attributes and stereotypes with Caucasians than with other races, with Blacks, generally fairing the worst (Clair & Denis, 2015, p.862).

In opposition, a number of scholars have appropriately questioned the reliability and validity of IATs. Other researchers have also disputed that "laboratory experiments on non-representative participants may not generalize to real-world contexts where behavioural and attitudinal dynamics may differ" (pp.858-59). In response, some scholars have approached

implicit bias within critical discourse frameworks, and such studies have overwhelmingly revealed those implicit measures to be statistically reliable (Flatt, 2015).

In that, building upon the reliability and the legitimacy of implicit bias, in line with Clair and Denis's (2015) suggestions, this study particularly explores the fundamentals of implicit bias with a more profound conceptual engagement from a macrosociological standpoint, wherein institutions have the ability to shape and perpetuate implicit racial attitudes or paradigms (p.857). According to the NRC (2004), organizations tend to mirror "many of the same biases as the people who operate them" (p.64). Whereas most studies have examined how implicit bias can impact expectations and actions, and that unconscious negative beliefs and feelings about racial groups may be revealed in everyday interpersonal interactions at work, school, and on the streets, I explore the same institutionally, examining policies and procedures of blood donation. This means that for this study of the blood system, the institution is examined "as a place that has the ability to "ostensibly neutralize scripts and procedures," as well as the potential to intensify autocognitive processes of existing bias (Clair & Denis, 2015, p.860).

The literature on implicit bias broadly stipulates that preconceived racial knowledge fosters implicit racially bias perceptions, behaviours, and norms (Goff et al., 2008, p.292). Meaning that explicit knowledge is a fundamental precursor to implicit racial associations; people have embedded knowledge of stereotypes about racial groups, and those stereotypes may be triggered unconsciously in specific times and places (p.293). Once more, in this thesis, I explore the plausibility of this manifestation in the blood operation.

Accordingly, a number of studies have documented the various societal stereotypes (e.g. gender, age, sexuality, etc.). In respect to the Black racial classification, the literature is again replete, finding that classical constructions of Blacks are far from obsolete in our current climate

(Jackson, 2006; Washington, 2006; Goff et al., 2008; Feagin, 2010; Yancy, 2016). Scholars like Feagin (2010), who write on the contemporary White racial frame in America, affirm Goff et al.,'s (2008) stating that “[e]lements of the centuries-old white racial frame, [are] often refurbished to be the commonplace in... everyday thinking and actions” today (p.95).

For the Black racial classification, the skin as the principal and visible site of difference came to be the fundamental correlation to the tintured character of Blacks (Epstein, 2007, p.50). As decreed in *Diseases and Physical Peculiarities of the Negro*, the skin colour of Blacks was said to reflect peculiarities “that went all the way inward” to his bile, blood, brain, nerves, and chyle; all his humours, his entire state of being was said to be “tintured with a shade of pervading darkness” (as cited in Epstein, 2007, p.36). In the same vein, Lupton (2013) explains how colonist confirmed by medical discourses, constructed Blacks “as inherently dirty, and diseased, as savage rather than ‘civilized,’[and] as both morally and physically degenerate” (p. 182). Comaroff (1993) adds that the Black body was portrayed to be “porous, odorous and damp and therefore... as potentially contaminating to those who came into contact with it” (as cited in Lupton, 2013, p.182). Early European maritime writings described them as “primitive people who seemed more closely related to apes” (Dapper, 1688, as cited in Goff et al., 2008, p.292). Iconographic stereotypes of African descendants supported representations of innate laziness, aggressiveness, hypersexuality, and in need of benevolent control (p.293). Goff et al., (2008) also tell us that people of African descent were theorized to reside somewhere between the deformed and the simian (p.293). Wailoo (2008) explains that historically Blacks were deemed “vectors of disease.” Marks (1963) describes the essence of Blackness as a “type of infection that proceeded from “some natural infection of the first inhabitants...and so all the whole

[progeny] of them descended, are still polluted with the same blot of infection” (as cited in Yancy, 2016, p.7). The list could go on.

According to Greg Thrasher (2015)—as outlined in *The Culture of Negrophobia in America Circa 21st Century*— such descriptions are Negrophobic. Again, Negrophobia is defined as a series of intersecting discourses or tropes that reinforce problematic notions of Black peoples and their physicality (Hill, 2014; Thrasher, 2015). As “a derivative pathology” of inequality, “it carries a distinct stench of racism” (Thrasher, 2015, para. 2). This phobia, the fear and aversion of Black peoples, fuels systems of Black specific racial inequities (Hill, 2014; Thrasher, 2015). In line with the current race literature, contemporary Negrophobia lacks the venomous vulgarity and “virulent demeanour of hard core [classical] bigotry” (Thrasher, 2015, para.2).

In sum, implicit knowledge as it relates to the social formation of Black bodies is imperative to this thesis, as it engages the nature of the blood system’s response “to such social and discursive activities in which Black bodies were” and are still constructed within risky, diseased, and contaminated philosophies (Finley, 2009, p.23). In that, I look to Jackson (2006) where he stipulates the importance of iteratively engaging the broader historicity of the Black body politic, for they are the direct revelations of racially xenophobic bias tendencies that are implicitly redistributed, recycled, and mediated throughout our institutions and cultural norms to date (p.9).

Accordingly, for this thesis, I contextualize Blacks within the paradigms of the age of exploration, slavery, colonialism, and Civil Rights frameworks. With that, it is important to note that the immediate emphasis of this study is not to recount their histories in detail. Instead, with these maafas in mind, the intention here is to explore, extrapolate, and integrate the already

established Black racial representations, discourses, and meanings that appear to be concretized and fortified in the Canadian worldview, and in consequence its structures and institutions, like the blood system (Jackson, 2006, p.9).

Structural Racialization

In respect to the role of institutions in plights of racial inequality, it has been well established that Canada, like much of the industrial world, has a long history as a racially biased society (Vickers & Isaac, 2012, pp.80-83). This history has done more than change individual cognitive responses, beyond that it has also deeply affected institutional processes. The fact is, organizations tend to reflect many of the same biases as the people who operate within them (NRC, 2004, p.64). Accordingly, organizational rules evolve out of past histories—inclusive of past histories of racism—that are not as easily reconstructed, because such rules may appear rather neutral on the surface (Satzewich and Liodakis, 2007, p.166). Nonetheless, if these processes function in a way that leads to a differential racial treatment or produces differential racial outcomes, it could be deduced that the results are racist.

Racially embedded institutional processes are broadly referenced as structural racialization, and its variants systemic racism, institutional racism, and democratic racism (Henry & Tator, 2010). For this thesis, I draw upon Satzewich and Liodakis (2007) to define institutional racism. According to their work, institutional racism is defined as the particular and general instances of racial discrimination, inequality, exploitation, and domination in the organization or institutional contexts (p.166). Structural theorists of race have studied the macrohistorical processes in colonial oppression, institutional spaces, societal norms, White racial frames, and racial profiling, among many other topics.

By Satzewich and Liodakis's (2007) definition, institutional racism takes three forms (p.165). The first and least likely to take place in present-day Canada occurs when "racist ideas and assumption about the social capacities and incapacities of groups of people can explicitly inform the development of social policies, programs, or national practices" (p.165). Satzewich and Liodakis (2007) provide the pre-1967 Canadian immigration system and Chinese Immigration Act of 1923 as examples. To that, I also add the Negro blood segregation as will be addressed in the results section. These are "good examples of this kind of institutional racism... since government policies were explicitly informed by negative, racist stereotypes about the harm" of racialized populations were presumed to cause to Canadian society (p.166).

Elaborating with context, history dictates that settlers settled on lands taken from Indigenous populations, and in a series of *de facto* and *de jure* sociopolitical schemes, Canada was intended to be exclusively White (Vickers & Isaac, 2012, p.98). Physical characteristics such as skin pigmentation predominated the barring, as well as associated cultural practices deemed primitive and uncivilized, were also disqualifying factors "from ever being included in the new (White) nation" (p.72). A number of documented statements corroborate how this type of institutional racism was legislated. As articulated by Prime Minister Mackenzie King (1908), "Canada should remain a [W]hite man's country," he "believed [this] to be not only desirable for economic and social reasons but highly necessary on political and national grounds" (as cited in Belanger, 2006, para.3). In a subsequent statement, the Prime Minister again affirmed that "[w]e must seek to keep this part of the [c]ontinent free from unrest and from too much intermixture of foreign strains of blood" (para.3).

Today, this notion is completely obscured beneath the pretexts of multiculturalism, diversity, and racial pluralism, wherein racialized populations are seen as "special interest

groups” without taking into account how racial inequities emerged from broader historical, sociopolitical, and economic contexts (van Ryn & Fu, 2003, as cited in Patychuck, 2011, p.8). Thus, in the Canadian analysis of race and ethnicity, it is absolutely imperative to recall historical policies and procedures, to then understand how they have come to impact or define our current national consciousness, value system, and societal structures.

Recognising that “there are few, if any, examples of this first form of institutional racism” in contemporary Canada, Satzewich and Liodakis (2007) nevertheless, tell us that this type of institutional racism is still the foundational blocks that have entrenched the current system-wide “token efforts that mask a continued adherence to white supremacy” (p.156). Henry and Tator (2011) elaborate this point in stating that Canadian society is viewed as egalitarian, “and most Canadians have little difficulty in rejecting the more overt, in your face expressions of racism” (p.35). Even so, scholars like Vickers and Isaac (2012), have determined Canada to be a White “populist, majoritarian interpretation of democracy” (p.88).

The second form of institutional racism identified by Satzewich and Liodakis (2007) occurs “when ideas about the racial inferiority of groups of people inform the initial development of specific policies or programs but no longer sustain those policies and programs (p.166). In their words, “certain policies have racist origins, and even though racism may no longer sustain them, the policies and practices continue to exist” in some form or another (p.166). The Indian Act is the definitive example of this type of institutional racism in Canada. A lesser-known example related to Black populations includes the mid- 1960s Caribbean seasonal agriculture worker program, enacted to fill seasonal farm jobs in Ontario. Satzewich and Liodakis (2007) again explain that “government officials believed that [B]lack workers were racially suited for

backbreaking labour under the hot sun and so justified the program in part on the basis of racist beliefs about the innate capacities of [B]lack people” (p.166).

The last type of institutional racism is admittedly the most pertinent to contemporary society, and accordingly, it has generated the most heated debates. According to Satzewich and Liodakis (2007), the centrality of this type of institutional racism lies in the notion that “policies or programs that may seem ethnically or racially neutral, either intentionally or unintentionally place racialized populations at a disadvantage” (p.166). Much of the debate around this type of institutional racism surround questions of ambiguity about the intent or true motives behind the policies and programs in question (p.166). In light of the implicit nature of current race climates, the tangibility of racism is difficult to substantiate conclusively, so much so, that this period has been referred to as a time of racism without racists. In response, a number of scholars have questioned if it is “fair, or even accurate to label an institution, organization, or companies as racist if such intent is lacking” (p.147).

To this question, the sociological literature retorts with manifold theories, studies, and experiments that demonstrate that “ostensibly neutral criteria are often applied selectively” (p.64). For Blacks, Yancy (2016) agrees with the latter said, and adds that “predominantly white monochromatic spaces,” like any number of contemporary government or public institutions, “while oppressive vis-à-vis Black people...can and often operate in ways that don’t bring attention to their oppressive ways” (p.8). Even more precisely, the literature on structural racialization poignantly contests such questions of *intent*, explaining that in these nuanced times of race relations, the focus on intent is not only tone-deaf, but it also keeps us moving backwards.

As the broader variant of institutional racism, structural racialization, as defined by John Powell (2013) in *Understanding Structural Racialization*, “requires us to move far beyond the idea of racism as a psychological condition, an attitude, a prejudice—some event that occurs in the mind of an actor that predisposes the actor to take an action that is racist” (p.147). Said differently, in this line of reasoning, any structural analysis of race and/or racism must “take the focus off intent, and even off conscious attitudes and beliefs, and instead turn our focus to interventions that acknowledge that systems and structures are either supporting positive outcomes or hindering them” (p.147). This goes without ignoring the individual, to the contrary, such a structural approach urges consideration of the individual as a “constituted being that is shaped by structures, with conflicting feelings and beliefs around race and other matters, acknowledging that most of these conflict are occurring at an unconscious level” (p.147).

Verbatim, Powell’s (2013) articulations are as follows:

Structures not only distribute opportunity but also help create self-identity and community identity. There is a powerful interaction between social and economic structures and culture. There is a powerful interaction between structures and our unconscious beliefs about others and ourselves. Structures provide meaning, and meaning and our values re-create our structures. (Powell, 2013, pp.147-148).

In sum, structural racialization frameworks facilitate a clearer view on “how our nation’s core values—and the public policies and institutional practices that are built upon them—perpetuate social stratifications and outcomes, that all too often reflect hierarchal racial group sorting” (The Aspen Institute, 2004, p.12). Adopting a structural lens to the current study of race in the blood system allows us to apprehend “the racial legacy of our past,” providing insight on “how race and racism persists in our national policies, institutional practices, and cultural

representations;” ultimately demonstrating how they are transmitted (amplified or mitigated), shedding light on the responses to racialized structures (p12).

Risk

A number of academic disciplines have written about risk (Zinn, 2004; Farrell, 2012; Lupton, 2013). This literature is generally divided between *technico-scientific* approaches and the *sociological* approaches (Zinn, 2004; Fiddler, 2011; Lupton, 2013).

The technico-scientific approach— the essence of positivism, emerges from engineering, statistics, epidemiology, and economic disciplines, bringing together the notion of risk via calculations of probability (Lupton, 2013, p.27). For them, risks can be controlled using pre-existing knowledge found in nature and are identified through various forms of calculations (p.27). In their analysis of risk, they use various scientific instruments “to monitor, measure, and calculate” risks; namely constructing predictive models of how potential risks might affect individuals or populations (p.27). This line of analytic questioning explores the accuracy of science and the severity of risks in terms of probabilistic effects (p.27). With that said, the probabilistic approach does acknowledge the inevitability of the *subjective* in all human capacities; accepting the inherent inability of definite value-free risk assessments (p.27). Nonetheless, the calculations and inferences deduced from the technoscientific approaches are most often upheld as objective facts of absolute truth (p.28).

The sociological perspectives of risk refute the positivistic spirit of the technoscientific approaches in their analysis of the nature of risk (p.36). They find that the technoscientific paradigms are oblivious to questions of risk as constructed social facts (p.27). As social facts, risks are “understood, lived, embodied, and negotiated” and are subject to contextual contingency (p.36). Much in the same manner, Renn (1992) explains that risks are proxies

through which “humans view their worlds through perceptual lenses filtered by social and cultural meanings transmitted via the primary” agents of socialization (p.67). From this perspective, risks are central to the sociopolitical dynamics of industrial societies, they organize, monitor and regulate individuals, social groups and institutions (Lupton, 2013, p.37). Meaning that within these societies, risks are apparatuses of knowledge that are endowed with power and authority (p.21). They dictate how we think about institutions, governments, organizations, others, and even ourselves (p.21). Lupton (2013) explains that the “phenomena[s] that we single out and identify as ‘risks’ have an important ontological status in our understandings of selfhood and the social and material worlds” (p.21). Thus, from a sociological standpoint, industrial societies require this “selection process as part of their continued operation,” because risk selection and its management are pivotal to “ordering, function and individual and cultural identity” (p.22).

The Sociology of Risk: Risk Society, Governmentality, and Cultural Theory

The sociological literature on risk is further divided into three major groups; *risk society*, *governmentality*, and *cultural/symbolic* perspectives. The *risk society* is the most prevalent approach. This approach is dominated by sociologists Ulrich Beck and Anthony Giddens, who are mostly interested in the macro-social processes of risk that are characteristic of late modernity in industrial societies (Zinn, 2004; Lupton, 2013). “Beck and Giddens theorize a risk society that foreground government, industry and science as the main producer of risk” (Aiken, 2000, p.57). They speak of *reflexive modernization*, which is a concept rooted in the critique of the outcomes of modernity, notably individualization, technical rationalization, instrumental

knowledge, and the systemic breakdown of traditional norms and values (Lupton, 2013, pp.78-85).

In its simplest notion, the idea of reflexive modernization is the movement of the third stage of development “towards a new modernity” (Beck as cited in Aiken, 2000, p.3). “[T]raditional society was first supplanted by industrial society; this marked the emergence of class, wealth accumulation, rapid scientific advancements and the arrival of industrial and capitalist society” (p.4). Today, the risk society theorists suggest that we are in a third phase, reflexive modernity (p.5). This new industrial society is very different from the old one. As explained by Aiken (2000), the fundamental nature of this reflexive modernity is no longer faced with “harnessing or controlling nature for the benefit of humankind, but ‘essentially with problems resulting from [technological] development itself” (p.4). As such, Beck explains that modernity becomes reflexive, ‘a theme and a problem of itself’ (as cited in Aiken, 2000, p.5). In context, late modernity has brought a change in the characteristics of risks, they have become amplified, reflexive and have greater ramifications across spaces and times (Lupton, 2013, p.108). For the risk society theorists, this period is left to prevent, minimise or solve the human-constructed problems (risk produced) which ultimately arise from the developments of industrial societies (Aiken, 2000, p.5).

For them, the concept of risk represents a new worldview towards uncertainties. “Risk has largely replaced older ideas about the cause of misfortune” (p.64); unanticipated outcomes are no longer solely equated with superstition (Fiddler, 2011, p.34). They are in fact the consequence of human action and innovations, rather than the result of *God’s will* or supernatural realms (Fiddler, 2011, p.34; Lupton, 2013, p.7). To put into context, risks like the

contamination of blood products are generated by humans, and this represents a failure of science and technology (Fiddler, 2011, p.34).

Note that the original risk society is rooted in an analysis of environmental hazards. Nonetheless, the international contamination of blood systems and the “ongoing issues facing policymakers over the need to address potential and actual risks” has proven to be a classic example of the risk society (p.34). In other words, these contamination scandals exemplify the very breakdown described in the risk society’s critique of late modernity (p.34). For example, the global ramifications of the tainting scandals, and the consequential implementation of internationally mandated risk management protocols. Respectively, both are the results of bilateral blood discourses crossing a number of Western blood economies, which necessarily meant/means that global events in one area of the world affect other parts of the world, via regulatory and risk management frameworks (Feldman & Bayer, 1999; Farrell, 2012). Traditionally, blood products would have been confined to specific locales, (e.g. communities and cities). However, characteristic of late modernity the broader discourses of the blood system, inclusive of risk management policies, as well as blood products, are key components that have traversed spaces and times across national borders and affected a large number of people worldwide (Fiddler, 2011, p.34). With the risk society, we can begin to understand how Black populations have been the recipient of the same exclusionary and differential treatment across the Western blood economies, irrespective of actual contamination risk.

The second group is described as *governmentality*. These theorists build on the insights of the French philosopher Michel Foucault and explore risk in the context of surveillance, discipline, and the regulation of populations (Lupton, 2013, p.50). More specifically, this approach examines how institutions and organizations organize power (Fiddler, 2011). For them,

risk is a governance strategy through which populations are managed and monitored in the way that adheres to the interests of the structures in power (p.45). From an epistemological position, governmentality theorists ascribe to a *strong constructionist* framework, whereby nothing is a risk in itself (Lupton, 2013, p.50). In other words, “changes in the identification and management of risks” are conducive to the changes in sociopolitical and cultural rationalities (Fiddler, 2011, p.46).

In the application of the governmentality approach to blood systems, Lupton (1999) provides relevant insight in stating that expert knowledge claims are the “guidelines and advice by which populations are surveyed, compared against norms, trained to conform [to] these norms, and rendered productive” (p.87 as cited in Fiddler, 2011, p.45). These *risk techniques* then become central to governance, “allowing the governments to manage risks at the population level” (p.45). Fiddler (2011) argues that it is through such processes of control and regulation that groups like marginalized populations (e.g. Blacks) are identified as high risk, “thereby requiring broad interventions based on specific knowledge and expertise” (p.45). My discussion builds upon governmentality’s definition of institutional power and control. However, I diverge from the approach’s unwavering commitment to subjectivity and relativism, and their refusal to accept some risks (e.g. HIV/AIDS) as objective (Lupton, 2013, p.50).

The third sociological perspective was introduced by anthropologist Mary Douglas (1966) and her associates as the *symbolic/cultural approach* (hereafter symbolic). Others have labelled Douglas as a functional structuralist who agrees with a critical realist position (Lupton, 2013, p.36). While structuralism principally seeks to understand the ways the core cultural structures of hierarchies and categorizations serve to define risk knowledge and practices (p.38); the functionalist component of the theory is concerned with how social structures serve to

preserve a status quo (p.38). As a critical realist, Douglas (1966) directs her attention to the ways in which real risks are politicized. Her work is notable, in that she marries strong cultural affinities with a critical realist perspective and sees some risks as primarily objective. She states, “the reality of dangers is not the issue... [rather] how they are politicized” (Douglas, 1992, p.29 as cited in Lupton, 2013, p.55).

This body of research has advanced ideas regarding the governing of modern society through cultural interpretations, particularly those regarding the identification and management of risk (Fiddler, 2011, p.49). Much like the other risk perspectives, the cultural risk framework also has aims to challenge the ideas that risk practices are simply objective, individual and utilitarian. Again, this theory “does not question the validity of technical procedures for [risk] identification (Douglas, 1992, p.30, as cited in Tansey and O’Riordan 1999, p.72). What it does however, is it criticises the apparent (de)politicization of risk issues, which according to Tansey and O’Riordan (1999), who provide a detailed review of this theory in their article *Cultural Theory and Risk: A Review*, are “the subtle process of taking for granted the link between hazard identification and the normative choices that follow” (p.72).

Simply stated, the symbolic approach to risk explains “why some issues become politicized, and embroiled in disputes over the allocation of blame and the distribution of power; while other risks appear to be tolerated within norms of social values and trust” (p.72). According to Tansey and O’Riordan (1999), this theory “is a way of interpreting how and why individuals form judgements about danger, pollution, and threat” (p.71). Their explanation maintains that the theory aims to show “that such judgements are not formed independently of social context[,]” instead, always, “they are part of an evolving social debate about... blame, responsibility, and liability” (p.71). To understand “why some risks become politicized and

emphasized whilst others remain latent,” this particular approach to risk “develop[s] a framework that explains how risks are both constructed and selected” (p.71).

Fiddler (2011), who much like this thesis, integrated the theory in her dissertation on blood donation, extends Douglas (1966) reiterating “that the content of beliefs about purity, danger, or taboo in any given culture is essentially arbitrary, yet become culturally fixed as *pollution rules*, thereby serving to organize and reinforce social relations according to hierarchies of power (pp.49-50). These pollution rules are said to function in two ways: (1) “they work instrumentally, to uphold social rules and the moral order,” and (2) they “work as symbols, or analogies for expressing a general view of the social order” (Douglas, 1966, p.14, as cited in Fiddler, 2011, p.50).

The theory, by Fiddler’s (2001) definition, finds that “[p]ollution beliefs operate as rhetorical devices within the ongoing cultural debate over the shape and direction of the social order” (p.50). With that, imperative to the theory is that “pollution beliefs do more than simply enforce conformity” (p.50). As again explained by Fiddler (2011), pollution (or risk) beliefs are in fact deemed the protectors of “implicit assumptions behind shared social experiences, and in so doing, serve to reproduce the social world” (p.50). Recall that this theory upholds that there is always a “direct connections between pollution beliefs and cultural systems of shared values” (p.50). In that, the symbolic integration of risk, as per Douglas (1966), “advances the idea that different cultures denote certain activities as taboo, not because of objective harm that may arise from carrying out these activities, but as a way of maintaining and reinforcing the moral, political, religious, or social orders”— I argue racial order—that binds members of a said culture (as cited in Fiddler, 2011, p.50).

Thus, in “this perspective, every society has its own ethical system, which consists of pollution and purity rules to identify risk (Douglas, 1985, as cited in Fiddler, 2011, p.50). These rules are said to be relatively arbitrary, emerging from specific political, cultural, social, and historical contexts and reflecting deeper anxieties, fears, and moral codes. Iterating Douglas (1990), as outlined in Fiddler (2011), such rules of risk identification ultimately “serve to contain disorder, to support and bolster social ties, [and] to create unity and experience in particular cultural settings” (p.50). For that reason, different individuals and different communities might judge a risk more or less seriously because they value the consequences differently— they value differentially what is being harmed, who is doing harm, and who is responsible in any other way (p.50). It is with that, that we, according to Fiddler (2011), can come to explore the ways in which “the identification, and management of risk is inherently moral and reveals much about our psychological, cultural, social and institutional affiliations, values and norms” (p.50).

In sum, scholars who have published in this area, such as Tansey and O’Riordan (1999), Fiddler (2011), and Lupton (2013), reason that social debates about risks cannot be reduced to concerns about safety, they instead explain how they are inseparable from issues relating to power and legitimacy. The body of these literatures, provide some normative guidelines that emphasise the importance of the processes by which decisions regarding risks are made. The suggestion here, is that the views of any particular individual on matters are shaped by the nature of social groups of which they are a part of (e.g. various institutions), like the blood system in Fiddler’s (2011), and my case.

As the main theoretical orientation of this thesis, in a race context, the symbolic theory of risk will be discussed in greater detail in the ensuing sections. Nonetheless, summarising this introductory review of this approach to risk, the imperative take away is “the idea that we assign

‘symbolic meaning’ to events in the social and natural world to create order and coherence” (p.73). This, according to Tansey and O’Riordan (1999), “does not imply that humans are biologically predisposed to communality [,] but rather that they rely on patterns of habituation and recursiveness” to identify and/or label risks (p.73).

Symbolic Risk Theory: Health-Related Risks

Scholars like Tansey and O’Riordan (1999) have elaborated on the significance of the symbolic theory for risk perception, particularly for health-related risks, studying the genetic modification of food debate (p.71). They determine “that viewpoints about expertise, about scientific integrity, about professional reliability and integrity, and about the credibility of health-related messages [are]...influenced by the interactional context in which judgements are made” (p.71).

In the same manner, and most in line with the current project, as previously mentioned, Fiddler’s (2011) research furthermore validates the significance of the symbolic risk theory in health contexts, with a particular attention to the blood system, she states: “attention to the cultural, social, historical, and political influences on the rules of pollution and purity in the recognition and definition of risks is particularly salient for studying the practices used to manage risks in the blood system” (p.52). Notably, in the blood operation, the most familiar example includes the MSM debate. A number of these debates have demonstrated that “risk issues become highly controversial and hence politicized, using up a disproportionate share of time and resources,” indicating that these issues may be symbolic of a wider trend (Tansey & O’Riordan, 1999, p.87). That is, risks are the reflections of “deeper anxieties and moral codes”

and consequentially, we cannot, and should not, “rely exclusively on scientific expertise and knowledge” (Fiddler, 2011, p.51).

The integration of the cultural theory of risk within the blood operation, as outlined by Fiddler (2011) is of great significance to the current project, as it not only sets precedence, asserting that such an approach is (1) theoretically plausible; but it also (2) sheds light on “the contamination of blood supply systems across” blood banks, considering how “different countries [and agencies] have responded to similar risks in ways that are culturally, socially, and politically distinct[;]” questioning risk reduction practices and constructions in blood systems beyond just the scientific methods (p.51). For that reason, with the symbolic lens, in the interpretation of politicized risk issues in the blood operation, the literature reinforces that it is always necessary “to address who is being blamed and why that might be the case” (Tansey & O’Riordan, 1999, p.87).

Symbolic Risk Theory: Racialized Bodies, and Blame

In the last section, it was noted that the broad focus of the symbolic risk theory has been placed on explaining how and why certain dangers are identified as risks while others are not, and the way in which these serve to maintain and support boundaries and categorizations. Still with this in mind, note that Douglas’s (1966) work is also particularly valuable in discussions of the physical body and blame.

As outlined by Lupton (2013) in her book *Risk*, particularly in her chapter titled, “Purity, Danger, and the Body,” her integration points out that, habitually, “risk[s] tend to be projected onto certain social groups,” certain bodies, particularly “those that are [already] defined as the dangerous ‘risky’ Other, requiring control and intervention” (p.173). These populations are

typically the stereotypical social minorities: women, homosexuals, the disabled, and of particular interest to this study, non-white populations (or racialized bodies) (p.181).

Taking the physical body as an image of society, Lupton (2013) extends Douglas's (1966) arguments, and "insight[s] that the human, fleshly body is a conceptual microcosm for the body politic[.]" and as such its *natural symbols* (e.g. skin colour) reproduce social categories (p.56). Much in the same manner, Carl Zimring (2015), — in *Clean and White: A History of Environmental Racism in the United States*— also understands that dirt is any matter that is out of place. He explains that dirt, are those things which are "deemed dirty, spoiled, or noxious" and with them, they carry polluting effects (p.1).

According to Lupton (2013) who extends that Douglas's risk theory is critical "in contemporary Western societies, particularly the use of risk as a concept for blaming and marginalizing an Other who is positioned as posing a threat (and thus a risk) to the integrity of [the] [S]elf" (p.56). Explained within a discourse of binary polarization, Lupton (2013), echoes Douglas, and clarifies that the emphasis is placed on the subjective nature of society as important to institutions and social groups to administer and monitor boundaries between the Self and the Other (p.173).

To further conceptualize, Lupton's (2013) integration defines the Other as "that which is conceptualized as radically different than the Self," and moreover, the Self exists in dominance to the Other (p.173). The Other represents ambiguity and therefore poses the possibility of a risk. Lupton (2013) states, "Otherness is dangerous because it confounds order and control" (p.173). In Douglas's analysis, this is the idea "that which is seen to be anomalous, difficult to classify, creates feelings of unease and repulsions," and therefore are subject to measures of control (as cited in Lupton, 2013, p.174). Said differently, in the interplays of bodies and blame, objective

risks become the entity of marginalization for the Other who is already prepositioned as a risk to the integrity of the Self (p.56). This, according to Douglas (1966,1969), is because “[t]he body is a complex structure, [and that] the functions of its different parts and their relation afford a source of symbols for other complex structures [,]” like race relations in this case (p.115, as cited in Lupton, 2013, p.57).

Integrating the ideas of blame and bodies to the blood system, Nelkin (1999) echoes Lupton (2013) in stating that “certain historical meanings associated with blood [like racial purity], have helped define... the problem of HIV contamination, shape[d] systems of blood donation, and influence[d] the focus of responsibility and blame” (p.276). In simpler terms, what this means to say is that the socio-history associated with certain bodies and therefore blood, influences blood donation policies in respect to both inclusions and exclusions. Note that in this theory, these articulations, are said to reflect and affect past and present race relations (p.275). In the context of the Black racial classification, the marriage of Nelkin (1999) and Lupton’s (2013) aforesaid, presents an analysis that the socio-history associated with Black bodies (inclusive of their blood), would necessarily influence transfusion policies and procedures in respect to inclusion and exclusion. To this, Lupton (2013) responds with Douglas’s notion that the body is a “highly potent symbolic object” ingrained within the processes of risk and Otherness, and as such, “anxieties and fears tend to emerge from and cohere around the body” (p.173).

To recap with context, the “physical body as a metaphor of society,” is a reflection of historical, political and social circumstances and/or associations (as cited in Nelkin, 1999, p.275). Consequentially, “the social meanings placed on the body and on body parts often relate to the structure and strains of social relationships” (p.275). In sum, by way of Lupton’s (2013) conceptions of bodies and blame, within a symbolic risk application, it can then be understood

that it is because of certain historical associations and sociopolitical circumstances, that the notion of the normative body came to be understood as superordinate to the Black physical body in places like the blood system, and elsewhere.

Historically, as will be outlined in the results section, the exclusion and differential treatment of Blacks within the blood donation enterprise has been a consistent measure adopted to care for the blood supply, carrying a heavy burden of an ethnoracial stigma (Gilmore & Somerville, 1999, p.135). Building upon the plausibility of integrating Douglas's (1966) conceptions into an analysis of race, I now look to Berthold's (2010) genealogy of (im)purity and hygiene in America, and further compliment it to Finley's (2008) examination of Black bodies as matters in/out of place.

Race and Purity Ideals

“Purity ideals flourish because of their exceptional ability to masquerade as the most healthy and innocent of ideals, even while they conjure up and revitalize our racist heritage”

-Berthold, 2010, p.3

Berthold (2010) advances the connection between contemporary purity ideals and racism, theorising “that today's supposedly innocuous preoccupation with hygiene is rooted in a racist heritage” (p.21). With a genealogical approach, this integration of the cultural risk theory infers that contemporary America, much like Canada in our case, has a “zealous preoccupation with hygiene,” and for that, “we are all lovers of purity” (p.1). In a race context, this genealogical deconstruction of purity ideals, captures the connections between superordinate Whiteness and purity, expounding how they are absolutely alive and well in today's race relations (p.1). In that, the centrality of Berthold's (2010) extension of the symbolic risk theory, encompasses two

important points: (1) that “physical and moral purity ideals form popular discursive practices that help reproduce [W]hite identity, which is formulated to reinforce [W]hite dominance” (p.6); and (2) that these ideas still manage to flourish “because they reinforce our still-racialized socio-economic hierarchy” (p.3).

At the beginning of the analysis, Berthold (2010) names a number of contemporary purity ideals/rituals. Notable mentions include the consumption of purified bottled water, and the practice of applying antibacterial soaps, centred on anxieties about germs and other contaminants. Speaking about contemporary America (Westerners), she states:

[T]he “dirt” with which we seem most concerned is microscopic, and there is a popular obsession over hygienic purity. Americans are excessively, needlessly, even recklessly clean. Our stores carry whole aisles full of brightly-packaged cleaning and hygiene products. We are offered antibacterial writing utensils, toothbrush holders, and shopping-cart wipes. We bathe more often and consume more detergents, disinfectants, and deodorants than any other identifiable group on the planet. (Berthold, 2010, pp.6-7).

Berthold (2010) finds irony in the noted purity rituals, advancing that our commitments to “[p]urity ideals, ostensibly so healthy and clean” actually “betray themselves by making us sick,” finding that many of these products actually “make us less healthy, in some cases by weakening our immune systems, in others by adding toxins to the environment” (p.2). To that, Berthold (2010) contends that the fact that “[o]ur hygienic preoccupation is not making us healthier, and yet, we are forever trying to make ourselves cleaner... should tell us there may be something else at work (p.7). Zeroing in on the “something else at work,” the theory cites that hyper-cleanliness is based upon a national psyche that values a moral purity and cleanliness.

The notion of moral purity is the fundamentality of what leads Berthold (2010) to arrive at racism from bottled water/antibacterial soap. Recognizing that such a juxtaposition may appear completely unrelated, she retorts that “the purveyors of purity draw upon the same themes of physical and moral purity that have helped produce [W]hite identity and dominance in the US[,]” and elsewhere in the West (p.1). Said differently, in this theory, the fixation with moral purity, manifested in said purity rituals, reinforces the notion of superordinate Whiteness. To soundly apprehend this latter said, alongside what Berthold (2010) determines to be the motivations behind purity ideals, means to necessarily take a retrospect into our past. She states the following:

Cleanliness was associated explicitly with civility, high class, and whiteness.

Whiteness, as it has come down to us, is conceived in part as a sort of physical hygiene—the lack of a mark of pollution. (Berthold, 2010, p.3).

Citing Fanon (1967) she also outlines the historical symbolism of Blackness.

Satan is black, one talks of the shadow, when one is dirty one is black—whether one is thinking of physical dirtiness or moral dirtiness...blackness, darkness, shadow, shades, night, and the labyrinths of the earths, abysmal depths, blacken someone’s reputation; and on the other side, the bright look of innocence, the white dove of peace, magical, heavenly light. (pp.188–89 as cited in Berthold, 2010, p.3).

These citations, for Berthold (2010), constitute that purity ideas are not only physical, but they are simultaneously moral, one in the same. For her, “there is no distinction...between literal and symbolic dirt—it is *all symbolic*” (p.10). To develop this argument, she finds an example in the construction of Whiteness, stating: “White people are neither literally nor symbolically white...

[they] are not the colour of snow or bleached linen, nor are [they] uniquely virtuous and pure” yet, this conception and “the lack of a mark physically has symbolized the lack of a mark morally, and this, in turn, has helped bolster a dominant identity” (p.10).

In America (again like in Canada), Berthold (2010) determines that White populations, the group with social and economic dominance, have conceived themselves as the standard, and therefore pure, both physically and morally” (p.10). This history of hierarchical relation has produced representations of Whiteness as mind/spirit and civilization, and non-Whiteness as primitive, closer to nature, deemed impure, savage, and threats to the boundaries of civilization warranting purification and/or civilization (p.12). Where non-White bodies, in particularly Black bodies, are concerned—as outlined in the review of the literature—they exist in direct opposition and subordination to the hegemony of the White status quo of purity. The literature is superfluous with examples of the racialized embodiment of (im)purity and how they have successfully been superimposed on physical bodies (Washington, 2006).

The parallels between the symbolism of Black and White, as quoted above, are clear. According to Berthold (2010), this embodiment demonstrates how easily slippage takes place between the exclusion of *dirt* (physical) and the exclusion of *dirty people* (symbolic). Governed by Douglas’s (1966) definition of dirt, Berthold (2010) also defines dirt, contamination, or pollution as “labels likely to be associated with behaviors that fall outside of, and thereby threaten, our most carefully guarded categories of social classification, including races”—among others like class, gender, and sexuality (p.10).

Moreover, the methods in which purity ideals manage to flourish inconspicuously in contemporary purity rituals, is paramount to the current project’s examination of blood policies and procedures. In line with the contemporary race literature, Berthold (2010) agrees that the

connections between Whiteness and physical and moral cleanliness are inevitably less direct in our time and that broadly speaking, race-based oppositions are rarely spelt out blatantly (p.13). This inconspicuousness, according to Berthold (2010), can be reasoned to the nature of purity ideals, and how they are already reinforced into our racialized socio-economic hierarchy—subsisting in the implicit (p.5). Illustrating an example of the ingrained and authoritative nature of moral ideals, in the same context of this thesis, Berthold (2010) also makes mention of the discourses of racial science. Alongside the biopolitics of race, she too explains that though “ideas of race and racial purity were debunked by biologists... ideals of extreme hygienic purity still nevertheless continue to linger with us, and even flourish, despite scientific evidence of their futility and harm” (p.22).

Fundamentally, in this theory, the contemporary purity rhetoric gets its power from the superordinate standard of Whiteness, and this Whiteness is necessarily racialized, stating that it “carries with it, from its inception, an alienating, alienated ethical and political orientation, while at the same time declaring itself neutral and innocent” (p.21). That is, in the seemingly mundane process of purchasing bottled water or disinfectants, or blood donation in this case, Berthold’s (2010) extension of the symbolic risk theory finds that the rhetoric of purity is inherently engaged and ingrained—reflexively “acting out and reproducing the anxieties of this racialized genealogy”—while we, the lovers of purity, are “unreflective about the actual effects of [our] practices” (p.21).

In the unreflective state, our everyday valorization in “ordinary things like hygiene, food, and water”—or blood in this case—are necessarily laced with manifestations of racial histories (p.22). More importantly, the theory finds that our commitment to them reveals the extent to which, we have not gotten beyond certain racist habits of thinking. Thus, for Berthold (2010),

any invocations of purity ideals, however unassuming it may appear, is in fact “genealogically tied to repressive concepts such as racial purity [,]” because they are the likeness and the mobilization of a genealogy of racialized associations, and it is within those racialized associations that “racism... is couched in the simultaneous oppositions of purity and pollution, cleanliness and dirt, civilization and savagery, [and] White and dark” (p.22).

The summation of Berthold’s (2010) analysis finds that “[b]oth physical purity and moral purity ideals, in the past and today, employ a model of cleansing to promote a sense of the good that depends upon exclusion” (p.21). This integration of the symbolic risk analytics demonstrates that, “most often when we explore the genealogy of discursive practices, we find their beginnings in political and economic power structures, and not in the pure origins they claim” (p.21). Citing Douglas, Berthold (2010) quotes that at their fundamentality, purity ideas, “they are rarely just about physical dirt— it is about wielding power over impure” others (pp.2-3).

The imperative take away from Berthold’s (2010) extension of the symbolic risk theory, is that our racist history precedes us; and as such, we have an ingrained and predisposed preoccupation with purity ideals (p.20). With that, particularly were racial classifications are named, as is the case for Black populations in the blood operation, inevitably, according to this theory, this presence of race then cannot exist without a trace of racism. With that said, for the safety of blood products, the blood system justly invests and is preoccupied with the *physical hygiene* of blood products. Nevertheless, the plausibility of Berthold’s (2010) theoretical arguments into this thesis necessitates an exploration of the blood operation that transcends just a physical examination of the purity of blood, but one that also acknowledges the presence of the moral (im)purity of blood in the hygiene (risk) discourses of the blood operation that are directly related to the discourses of race, racism, and Black populations.

Risk, Blacks, and Matter In/Out of Place

Likewise to Berthold (2010), Finley's (2008) work also extends Douglas's (1966) *dirt* as "a universal theory that [can] make intelligible this ubiquitous concern for cleanliness and order," within a theoretical analysis of race (p.36). To be more precise, Finley's (2008) efforts particularly lie in an examination of Black bodies, providing a "theoretical coherence" to questions of how/why Black bodies are treated violently (both physically and/or symbolically) in society by the dominant culture and its institutions (p.16).

As mentioned previously, this analysis is originally situated in the particularities of the NOI and religiosity, during the Civil Rights era in America. Beyond the United States, Finley's (2008) conceptions can also be pertinent to a number of Western Black Diasporas, like Canada in this case. In line with this thesis, Finley's (2008) integration of the symbolic risk theory engages the *Black exceptionalism* standpoint within the *Black body politic*, deducing that although historical moments have admittedly offered new challenges with changing sociopolitical and institutional realities, the Black body still remains and endures as a focus in many structures in society, like the blood system in this case (p.1). In that, Finley's (2008) position is categorical, and infers that the exceptional attention to Blackness "is made necessary only by the exigencies of race and racism" (p.1).

Integrating Douglas's (1966) *matter out of place*, Finley (2008) offers a theory of context, introducing the conception of the Black body *in place* and the Black Body *out of place*. In that, he determines that the Black body can either be in place, which means to be negated and considered no threat to the social order; or out of place, constructed as grotesque posing a threat to the given order (p.16).

Black bodies out-of-place are apprehended and classified as dangerous in that they are perceived to have crossed symbolic (i.e., attitudinal, intellectual) and social (i.e., physical bodies crossing geographical) boundaries, categories of being and behavior, fixed classifications that maintained the social order. (Finley, 2008, p.54).

Black bodies fixed in-place pose no threat to anyone in the dominant group, neither do they do damage to the established social order or cosmology. It is a property of fixing status and categorization to make the world intelligible that also renders the world logical, under control, safeguarded. (Finley, 2008, p.55).

According to Finley (2008), the recalcitrant Black body is the body out of place. This version of the Black body is bluntly antithetic to normative standards; it is the most obvious, and stereotypically dangerous body (p.16). By Finley's (2008) accounts, the perception of risk afforded to Black bodies comes to be "when attitudes, behaviours, and practices" are either perceived as oppositional and/or transgress social and symbolic classifications (p.56). This, according to Finley (2008), "often implies geographical considerations, such as being in the "wrong" neighbourhood or having inter-racial sex or miscegenation [,]" and so on (p.143).

In contrast, as again defined by Finley (2008), the Black body in-place is constructed to protect the symbolic and social order from pollution and/or danger (pp.55-56). This is the body with identities and meanings that are viewed as fixed and non-confrontational, in other words, Black bodies that *know* their place and stay in it (p.40). Innocuous, while still subject to ardent surveillance, this Black body is the ideal type for twenty-first-century structures. Accordingly, insofar as this Black body stays defined within the "limited spheres of activity [e.g. Black blood

policies and procedures] which renders them acceptable” and inoffensive, it is defined as in-place (p.40).

It is important to note that, the in-place is contingent upon the obligation that Black peoples “must buy into and internalize discourses and ideas of Black inferiority, obsequious and overly deferential attitudes toward” dominant frames, “and any intellectual state or condition that makes them complacent with their in-placeness” (p.40). Therefore, the Black body in-place, much like the Black body out-of-place subsists in the same preordained structure that is equally “hierarchical and naturalizing—that is, the discourses and practices were intended to give the impression that White supremacy and Black inferiority were natural and universal” (p.41). Thus, what deciphers the in from the out of place, is characteristically a matter of administration and/or operationalization. What this means to say is, that by virtue of the dominant gaze, in all contexts, the Black body subsists “in a culture where Blackness is still over-determined by myths and presuppositions that fix [said] body as a site of danger,” irrespective of how it may be presented (p.55).

In sum, Finley’s (2008) theoretical integration of the symbolic risk theory finds that “[c]ultural and social prohibitions and taboos,” the Black race, in this case, “function to trace the outlines of the exterior boundaries of the ideal social order” (p.38). Verbatim, Finley’s (2008) argument state that “[a]ny transversals or violations of the cosmological schemes of this order or any of the classes are seen to threaten the order and the cosmology[,] and as such are seen as *dangerous*” (p.38). Thus, by Finley’s (2008) interpretation, when the dominant system “has been perceived to have been violated[, meaning] something is viewed as being out of whack and a danger to the system, rituals...are enacted to restore order, homeostasis, and in-placeness” (p.57).

CHAPTER THREE: METHODS

In this chapter I describe the research methods, providing a detailed description of the sample selection and data collection procedures.

Methodology

In this study, I implemented two of Crotty's (1998) basic questions for initiating and developing a research design (as cited in Owen, 2014, p.5). The questions asked, what methods would be utilized? And, what methodology would be administered? These questions addressed the strategic plan of design for the chosen method (p.5). The questions were imperative to the construction of the research design of this thesis, because they provided what Owen (2014) describes as "a comprehensive approach... toward making appropriate decisions regarding [the] overall research design" (p.5).

According to Crotty (1998), methods are "the techniques or procedures used to gather and analyze data related to some research question or hypothesis" (as cited in Owen, 2014, p.5). Methods vary, they can include "participant observation, statistical analysis, questionnaires, life histories, interviews, and document analysis" (p.5). This study of blood policies used document analysis within a qualitative design to collect suitable data in support of addressing both the theoretical framework and research question of the thesis (p.5). Atkinson and Coffey (1997) define documents as constructed, shared and organized *social fact* (as cited by Bowen, 2009, p.27). This position maintains that the analysis of documents is a systemic and analytic procedure of evaluating materials whereby data is "examined and interpreted... to elicit meaning, gain understanding and develop empirical knowledge" (p.27). As inherent social

entities, documents allow for the analyses of organizational ideologies and/or histories, which inform both practice and policy (Owen, 2014). In sum, a qualitative analysis of document materials allows for rich descriptions of the research issues which focus on the interactions and contexts whereby policy decisions and negotiations took place.

In accordance with Bowen's (2009) directives on the appropriate administration of the analysis of documents, with the methodology, my aim was to contextualize data materials in space-time capacities. This was a process whereby the maximum level of consciousness and/or insight of a respective time could be uncovered within each document. This analytic procedure involved "finding, selecting and synthesising [the] data" contained within document materials to understand the trajectory of the said blood narratives (p.28). Thus, this denotes that respectively, the analyzed documents were approached or addressed as situated and dated social products, equipped with histories, mandates, assumptions, and limitations. In consequence, the data materials were subject to Evans's (2012) following questions;

1. Who authored the document?
2. Who was the intended audience?
3. What was the storyline?
4. Why was the document written?
5. What type of document was it or what purpose did it serve?
6. What are the basic assumptions made by the author?
7. Is this document reliable?
8. What can be learned about the society that produced this document?
9. What was going on in the society when the document was created?
10. What is my understanding or the meaning of this document?

The application of the abovementioned questions onto the data inventory, utilized in combination with the broader academic literature, at once provided convergence, credibility,

corroboration and confluence within the study's narratives (Bowen, 2009, p. 27). As such, this study employed a *stand-alone method* whereby the research relied solely on the analysis of documents which included: background papers, books and brochures, maps, newspapers, press releases, application forms, and organizational reports and websites. Such information was sought out from the CHS, CRCS, CBS, HQ, ARC, SCAGO, and the AABB. These organizations were chosen because, in the process of the orientation reading, they were identified as organizations who have addressed or mapped the mentioned Black narratives. Much in the same manner as Dryden (2016), I identified documents that address deferrals of Black populations in Canada. In addition, any materials that touched on how Black populations were conceptualized as risky or different within the context of blood donation, were considered relevant.

The public accessibility of the websites of the mentioned blood related organizations facilitated access to the various document materials. In addition, I deliberately applied American data sources, because the fundamentality of Canadian blood policies demonstrate an association to American directives. As such, the incorporation of American documents became imperative to the mapping of the Canadian narratives.

The analysis of documents appropriately grasps the process of blood donation as a complicated social performance subject to explicit and implicit measures of control. Quantitatively speaking, these various agents of control cannot be adequately understood or analyzed through the normative calculations and classifications of positivistic methodologies. As such, it is my contention that in respect to the topic at hand, the application of quantitative methodologies would have merely served as an explicit affirmation of an already established fact— that Black populations demonstrate low rates of participations within the Canadian blood system— entirely missing the ongoing imbedded conceptual frameworks of science, knowledge,

policy, exclusion, difference, race and ethnicity. For this reason, the thesis called for the application of a qualitative methodology framed within an analysis of various textual documents.

Snowballing, Sequential, and Purposive Sampling

With respect to the Canadian blood system and the narratives of Black populations, the academic literature is marginal at best. Thus, as a relatively ground-breaking area of study, the dissemination of various documents to recreate the trajectory of exclusion was undertaken. To accommodate for this *newness*, a historiography was undertaken to orient the research at a fundamental level. Following the orientation of the literature, the initial sampling of data derived from *snowball sampling*, whereby additional knowledge of the policy was acquired by virtue of chain referrals within the literature (Neuman & Robson, 2012, p.133). This implied using the references of a particular work or citation to identify additional findings (p.133). As an untapped area of study, I found it necessary to formulate a narrative history, whereby the Black narratives were recounted following the chronological order of particular events or circumstances.

The process of snowball sampling begins with one case or set of information, based on the information about the interrelationships from that particular case, more information is identified, and this process is subsequently repeated (p.133). Through preliminary readings and database searches of Health Canada, FDA, AABB; keywords generated search strings. The following keywords were applied; “Canadian Blood Services,” “tainting scandal,” “HIV and HIV-O,” “indefinite deferral,” “Africa,” and “Haitian.” These keywords generated an adequate number of sources. Particularly, Krever (1997) was identified as a seminal document. From here on, I engaged *sequential sampling* as the main form of sampling. Sequential sampling sought to uncover all of the relevant information possible with respect to Black blood narratives as it

pertained to the Canadian and American blood systems. This processes included exhausting all possible leads until no new themes emerged from the data sampling, known as *theoretical saturation* (Neuman & Robson, 2012) 2012, p. 134).

Sequential sampling included the process of following the leads provided in Krever (1997). Through this 1200 page document, I discovered primary documents. Primary documents were materials that supported the conceptual frameworks of the study, while also providing additional context to Krever (1997) and the research questions (Owen, 2014, p. 14). In their totality, the documents were essential to the past and present trajectory of Black populations in the blood system.

Data Inventory

Canadian Blood Services. (1999-2018). *Annual Report*. Ottawa: Canadian Blood Services.

Canadian Hemophilia Society position on HIV-O deferral in Africa, Issue Document: Deferral of Donors Who Lived In or Visited Africa Since 1977 (September, 29, 2012).

Centers for Disease Control and Prevention, Identification of HIV-1 Group O Infection – 1996. JAMA 276:521-2 (1996).

FDA Document: Guidance for Industry Recommendations for Management of Donors at Increased Risk for Human Immunodeficiency Virus Type 1 (HIV-1) Group O Infection (August 2009).

FDA Memorandum to All Registered Blood and Plasma Establishments, “Interim Recommendations for Deferral of Donors at Increased Risk for HIV-1 Group O Infection” (December 11, 1996).

Hema Quebec. (1999-2018). *Annual Report*. Montreal: Hema Quebec.

Letter addressed to Director of the Centre for Blood and Tissues Evaluation written by Ms.

Tunji-Ajayi the Sickle Cell Disease Association of Canada, re: Canada's position on HIV-O policy, December 17, 2012.

Letter addressed to Director of the Centre for Blood and Tissues Evaluation written by Ms.

Tunji-Ajayi the Sickle Cell Disease Association of Canada, re: Canada's position on HIV-O policy, March 14th, 2013.

Letter addressed to Ms. Tunji-Ajayi of Sickle Cell Disease Association of Canada written by Dr.

Gantz of Health Canada, re: Canada's position on the HIV-O policy, June 11, 2013.

Letter addressed to Ms. Tunji-Ajayi Sickle Cell Disease Association of Canada written by Leah

Hollins of Canadian Blood Services, December 16, 2015.

Letter addressed to Ms. Tunji-Ajayi Sickle Cell Disease Association of Canada written by Mindy

Goldman of Canadian Blood Services, December 10, 2015.

Permanent Donor Deferral Policy: Background Rationale to have questions relaxed/removed,

The Sickle Cell Association of Ontario.

Data Analysis

The study applied a discourse- historical approach (DHA), a subcategory within CDA.

CDA is a contemporary approach to the study of language and discourses in social institutions (Wodak & Meyer, 2009; Wodak & Reisigl, 2001, 2015; Van Dijk, 1993, 2001). Its main focus is on how social relations such as identity, dominance, knowledge, and power are constructed through discourse, such as written and spoken text (Wodak & Meyer, 2009; Wodak & Reisigl,

2001, 2015; Van Dijk, 1993, 2001). According to Fairclough and Wodak (1997), as cited in Wodak (Wodak & Meyer, 2009), the main tenets of CDA are as follows:

1. CDA addresses social problems.
2. Power relations are discursive.
3. Discourse constitutes society and culture.
4. Discourse does ideological work.
5. Discourse is historical.
6. The link between text and society is mediated.
7. Discourse analysis is interpretative and explanatory.
8. Discourse is a form of social action

As a subcategory of critical discourse, DHA maintains a strong emphasis on context and history, while also recognising the above stated as its tenets (Wodak & Reisigl, 2001, p.383). According to Wodak & Reisigl (2001) “[o]ne of most salient distinguishing features of the discourse-historical approach...is its endeavor to work interdisciplinary... on the basis of a variety of different empirical data, as well as background information (p.383). That is, social practices and ideologies—like race and science— are produced, promulgated, promoted and legitimized by means of discourse, and as such they are manifested discursively (Wodak & Reisigl, 2015, p.576). With that said, the data analysis was primarily informed by the discourse-historical approach within the study of race (Wodak & Reisigl, 2001).

As an analytical procedure, DHA establishes that historical context must be integrated into the interpretation, and the analysis must be developed in accordance with the research question, with a constant iterative movement (back and forth) between theory and empirical data (Wodak & Meyer, 2009, p.27). In my examination of the discourses of racial science, I followed DHA’s strategy of analysis which stipulates that; (1) a *topic* of a specific discourse must be established; (2) *discursive strategies* must be investigated; (3) the *linguistic means*, and (4) the

context-dependent *linguistic realizations* of the discriminatory stereotypes must also be investigated (Wodak & Meyer, 2009, p.30).

To appropriately suit the research topic, I complimented DHA with the semantic, and more latent or allusive structures of Van Dijk's (1993, 2001, 2015) *sociocognitive approach* (SCA). Note, that I placed zero emphasis on his sociocongitivity to the discourses of racism. With this custom amalgamation, I critically examined the narratives involving the Black ethnoracial identity within Canadian blood literature, from the perspectives of history and power, as outlined within CDA. Thus, I proceeded to find evidence for the ways race is “enacted, expressed, signaled, coded, referred, presupposed, confirmed, described, defended, legitimated or persuasively conveyed” within the blood system as science. (Van Dijk, 1993, p.119).

In saying this, DHA will inform the more linguistic orientations of the data, as well as the initial line of questioning directed at the data. While, Van Dijk's (1993) approach will contribute to the semantic or latent structural aspects of the analysis. As subsets of critical discourse analysis, SCA and DHA have obvious overlaps in their procedural steps of analysis. For this reason, I did not strictly hold each of them within the respective *linguistic* and *semantic* orientations that I outlined earlier. For example, although I acknowledge that I principally informed the linguistic structures of the analysis within DHA's procedure, I was flexible, and also applied some of SCA's linguistic markers to the data analysis (e.g. lexical style, word style, and schemata) (Van Dijk, 1993).

I conducted a manual data analysis of documents to identify empirical evidence to support my reading and interpretation. To facilitate the manual process, I began with multiple photocopies of the documents. In this first step, titled *authentication and organization*, I familiarized myself with the data inventory. The first set of documents were separated

chronologically by date, the second by authors, and the third by categories of documents. To ensure the legitimacy of the data inventory, I questioned the data with Evans's (2012) ten previously mentioned questions. In terms of authenticity and legitimacy of the data inventory, I did not encounter difficulties because the data derived directly from official policy and websites published by governmental agencies or blood related organizations.

In second, once the data inventory had been authenticated and organized, the *data analysis* began. At this stage, I took another probe into the data. This time within the discourse-historical approach. DHA suggests a triangulation procedure to ensure validity (Wodak & Meyer, 2008, p.32). This triangulatory approach is based on a concept of context which takes into account four levels:

1. The immediate language- or text-internal co-text.
2. The intertextual and interdiscursive relationship between utterances, texts, genres and discourses.
3. The extralinguistic (social) level, which is called the 'context of situation' and explained by middle-range theories.
4. The broader sociopolitical and historical contexts. (p.32).

To see how the theoretical concepts fit the evidence and reveal features of the data, I approached the data inventory with these four levels in mind. Ultimately, my aim was to uncover the varying ways by which Black peoples were linguistically or rhetorically employed through the blood system. In view of that, I additionally subjected the data inventory to Wodak & Reisigl's (2001) five questions of evidence:

1. How are persons named and referred to linguistically?
2. Which traits, characteristics, qualities, and features are attributed to them?

3. By means of which arguments and argumentation schemes do specific persons or social groups try to justify and legitimate the exclusion, discrimination, suppression, and exploitation of others?
4. From which perspective or point of view are these nominations, attributions, and arguments expressed?
5. Are the respective discriminating utterances articulated overtly or are they mitigated? (p.385).

With these questions I was specifically interested in the discursive strategies which are involved in the binaries of the presentation of the “positive [S]elf in opposition to the negative [O]ther” (p.385). In this context, the strategy implies the “practices adopted to achieve a certain social, political, psychological, or linguistic aim” (p.385).

By “identify[ing] empirical observation[s] pertaining to validity claims of specific arguments,” I intended to achieve empiricism. Thus, in the abductive tradition of the discourse-historical approach, I concentrated the data analysis within the following discursive strategies:

1. “*Referential strategy or strategy of nomination*, where the linguistic devices of interest are membership categorization (Sacks, 1992), metaphors and metonymies and synecdoches” (as cited in Wodak & Meyer, 2008, p.30).
2. “*Strategies of predication* which appear in stereotypical, evaluative attributions of positive or negative traits and implicit or explicit predicates” (p.30).
3. “*Strategies of argumentation* which are reflected in certain topoi used to justify political inclusion or exclusion” (p.30)

4. “*Strategies of perspectivization, framing or discourse* representation use means of reporting, description, narration or quotation of events and utterances” (p.30)
5. “*Strategies of intensification and mitigation* try to intensify or mitigate the illocutionary force of utterances” (Ng and Bradac, 1993 as cited in Wodak & Meyer, 2008, p.30).

Discursive practices are defined as socially “constructive, perpetuating, transformational, and destructive social macrofunctions of discourses” (Wodak & Reisigl, 2001, p.385). They are the “genesis and production” of collective subjects like ethnoracial identities; they perpetuate, reproduce, and justify a social status quo (p.385). Furthermore, discursive practices are also instrumental in the transformation of a status quo, with respect to its formation, and /or destruction (p.385).

In keeping with the same *data analysis* step, I took the third probe into the data. This time, I applied SCA’s semantic properties of discourse to analyze the data. Semantic or latent structures are associated with meaning and/or (inter)action (Van Dijk, 1993, p.103). Van Dijk (1993) explains that beyond the linguistic or surface structures, there are additional ways to uncover signals that point to the author’s perspective and underlying opinions (p.103). To uncover the semantic properties of the data, I analysed the data for the following semantic or latent structures:

1. The *perspective* includes the point of view from which the event, individual or group is seen; the sociopolitical position of the author.
2. The *level of description and degree of completeness* is where event, individual or groups may be described at various levels of generality or specificity. (e.g.

vagueness about racism, while details are precise about the “deviances” of the Other, or vice versa).

3. The *implications* explore the implicit meanings. This is where meanings are conveyed without being explicitly stated.
4. The *apparent denials and apparent concessions* include disclaimers.
5. The *global topics* explore representation. What topics are expressed, signalled or otherwise given prominence, or vice versa which topics are not?

After the analysis of the data, the third step involved *reading and interpretation*. In the application of Wodak & Reisigl’s (2001) and Van Dijk’s (1993) steps for data analysis, I anticipated the emergence of new concepts resulting from the generalization of findings. Again, the documents were read and interpreted with the intent to extract qualitative insights informed by the mentioned aspects of DHA, SCA and the symbolic perspective of risk in line with my research question. More specifically, the major assumptions and assertions uncovered within the documents were examined and tested against critical discourse analysis’s truth claims.

As new findings arose, adjustments of concepts to suit the emerging evidence took place. Each of the document claims were assessed separately. However, the decisions about the communicative intent of the document were based on the cumulative understanding of both semantic and linguistic markers (Wall, Stahl & Salam, 2015, p.268). The incorporation of SCA semantic markers allowed the analysis to transcend the focus on the micro-textual components of the documents, towards a collaborative semantic and textual analysis. Dant (1991) explains that although the individual sentences should be analyzed, “decisions about the document or body of literature should be made at an aggregate level” (as cited in Wall, Stahl & Salam, 2015 p.268). Furthermore, in line with Cukier’s (2009) guidelines on the analysis of data, the data analysis

occurred within the individual documents, as well as across different sources (as cited in Wall, Stahl & Salam, 2015, p.268).

Finally, the fourth step was the *explanation of findings*, which ensues in the discussion chapter. There, I explain the aggregate findings by highlighting the dominant perspectives, directing the reader to uncovered views, potential gaps, or “ignored or marginalized perspectives,” and propose recommendations based on the findings (p.268).

CHAPTER FOUR: RESULTS AND ANALYSIS

Mapping Blackness in the Canadian Blood System

In Part I of this chapter I present the five central narratives uncovered in the process of data collection. Each narrative forcibly and disproportionately affect(ed) Black populations, recounting the positioning and/or role of the Black racial identity in the blood system during given periods. In Part II, I present the four overarching trends that ran parallel to the five uncovered narratives.

PART I

Bad Blood Black Blood: The Negro Blood Segregation

Below is the oft-cited poem published in protest to the ARC's Negro segregation, printed in the 1942 Cleveland Call and Post at the beginning of the resistance:

The cross of Red that burned so bright
 In fire, store, and flood
 Is now the crooked Nazi sign
 That spurns a Negro blood!

In line with this poem, I uncovered that the first Canadian blood transfusions were reserved for White American and British soldiers (Vickers & Isaac, 2012, p. 82; Dryden, 2015, p.121). Hence, all collected blood in Canada was racially catalogued with the purpose of ensuring that White soldiers did not receive inferior blood said to be inherent to Blacks (Vickers & Isaac, 2012, p.82; Dryden, 2015, p.121).

The racial tagging of blood in Canada was a combination of nationalistic anti-Black sentiments, partnered with the ARC's racial directives (as per Jim Crow laws), whereby fears of miscegenation, mongrelisation, and Black pathologies (namely syphilis at the time) were the rationales for said exclusions (Lederer 2008, p.115; Dryden 2015, p.121). In her book, Lederer (2008) requotes the sentiments of the era, providing a statement made to the Louisiana House of Representatives in 1960: "I would see my family die and go to eternity before I would see them have a drop of nigger blood in them" (p.107).

Such sentiments "represented more than a cultural preference. It reflected assumptions about blood purity and disease" (p.115). Red Cross Chairman Norman H. Davis describes the root of such attitudes in his address to First Lady Eleanor Roosevelt, he stated:

It must be recognized that there are many people in this country who object to having Negro blood used for transfusion of white persons. This is a matter of tradition and sentiment rather than of science, as there is no known difference in the physical properties of white and Negro blood. (as cited in Lederer 2008, p.117).

Thus, the data demonstrated that influenced by the scientific and normative sociopolitical narratives *du jours*, the ascription of the Negro as a cultural contagion, and a "vector of disease" was predictably weaved and enmeshed within blood policies (Lederer, 2008, pp.107-137; Dryden, 2015, p.121). Consequentially, blood narratives of racism, racial segregation, and miscegenation framed the first policies of blood donation in Canada (Vickers & Isaac, 2012, p.82; Dryden, 2015, p.121). With that, it becomes evident that the ostracised positioning of Blacks erected in association with the inception of Western transfusion science (Lederer, 2008, pp.107-137; Dryden, 2015, p.121).

The literature determines that it was not until the mid-1960s convulsion of the American Civil Rights movement that the practice of racial tagging of Black blood was reluctantly eliminated across the United States (Lederer, 2018, p.107), and consequentially in Canada as well. Still, post-Civil Rights, the literature demonstrates that such assumptions about disease and racial differences have not dissipated (p.116). As advanced by Dryden (2015), “these blood narratives of racial segregation... framed early practices of blood donation in Canada and constitute the social determinants of blood, belonging, and inclusion that continues to inform the blood system today” (p.121).

In Canada, the topic of the Negro segregation is invisible, it has not been given any level of prominence throughout the Canadian data sets, and the omission of this Black blood story is overt. There are no publically accessible sources of information from the current blood operators, CRCS, or Health Canada to officially confirm or deny if this policy in fact took place.

A review of the CRCS’s *Historical Highlights*, which documents the 120 years of the CRCS, cataloguing artefacts and events, did not cover or mention the Negro segregation policy. In contrast, in respect to the representation of minority populations, prominence was given to the role of White women in blood donation and war efforts.

Therefore, to substantiate this policy, this study relied upon Canadian scholars—(Vickers & Isaac, 2012, p.82; Dryden, 2015, p.121) — (secondary sources) who have respectively confirmed this policy to have occurred in Canada.

Voluntary Exclusion: The Haitian Blood Ban

“Haitians Fight Blood War against AIDS Discrimination”

-Black Enterprise, July 1990

In the 1980s, when the first cases of HIV and AIDS were initially identified, researchers implicated four major high-risk groups for the spread of these new blood-borne diseases: *homosexuals, heroin users, hemophiliacs, and Haitians*—collectively referred with the moniker *the 4Hs*. Note, that Zaire (present-day Democratic Republic of Congo) was also excluded, and the sexual partners of the 4H populations were also barred (Krever, 1997).

Of the named populations, the Haitian risk assessment—the sole ethnic, and consequentially racial exclusion—differed from the other three behavioural based exclusions by virtue of race and ethnicity. As explained by Leiss, Tyshenko and Krewski (2007), in their CBS donor deferral risk assessment, a behavioural risk assessment is an exclusion established on the participation in a high-risk activity which prohibits a said population or person from meeting the blood donation requirements (p.25). In their findings, Leiss et al., (2007) state that geographic exclusions—which indeed intersect with racial identity in the case of Haitians—cannot be evaluated as a behavioural assessment (pp.24-25), and therefore, I understand, necessitates a different schema of analysis.

In March of 1983, the United States Public Health Service advised all agencies collecting blood in the United States that anyone considered at risk for developing AIDS— meaning the 4Hs— should be categorically excluded from donation (Krever, 1997, p.231). One week later, in the first of three press releases, the CRCS asked donors belonging to those populations to refrain *voluntarily* from donating blood in Canada (p.231).

The Canadian approach to donor exclusion was much more passive than that of the United States (Krever, 1997). With concerns of discrimination and offence towards the singled out groups, an executive committee of the CRCS found that the voluntary withdrawal of those labelled to be at risk, versus an active exclusion, was the adequate course to communicate the restrictions in Canada (p.231). This self-exclusion was rationalized to embody the CRCS's ideologies as a system established on the expression of altruism and trust (p.286). They felt that a voluntary disclaimer would empower excluded donors—who otherwise intended to selflessly provide blood without remuneration—with the ability to discern their own ineligibility before presenting at blood clinics (p.286). The first press release read as follows:

Canadian Red Cross Society advises members of groups identified as high risk of carrying Acquired Immunodeficiency Syndrome (AIDS) not to give blood. These groups are: Patients diagnosed with AIDS, sexual partners of AIDS patients, persons with AIDS symptoms, sexually-active homosexual or bisexual men with multiple partners, recent Haitian immigrants, current or past drug abusers, and sexual partners of individuals at high risk for AIDS. Although to date there is no conclusive evidence that AIDS is transmitted through the blood or blood products, and no cases of AIDS in Canada can be linked to blood transfusion, the Canadian Red Cross Society is doing everything possible under current conditions of knowledge to protect recipients of blood and blood products from any possible threat to their health. The Red Cross is not considering questioning potential donors at blood clinics concerning their sexual preference or their racial origins. The society is, however, asking members of the groups at high risk of developing AIDS to voluntarily exclude themselves from giving blood. All blood donors in

Canada are voluntary donors and, as such, represent a group with a highly-developed sense of responsibility to their community. The Red Cross is confident, therefore, that donors finding themselves within the identified risk groups will exercise that sense of responsibility and will refrain from giving blood until such time as the cause and transmission of AIDS can be clarified. (Krever, 1997, p.231).

From the communication above, note that the parameters that constitute a *recent immigrant*, were described with a level of generality, no dates of entry were provided.

The Haitian community was not prepared for the Red Cross's exclusionary actions, adding insult to injury, they were never consulted before the exclusion was issued (p.233). In fact, it has been well established that the Canadian press release was prepared hastily in response to the announcement by the U.S. Department of Health and Human Services (p.233).

Moreover, it is apparent that with the voluntary stipulation, the CRCS's strategy was employed so as not to outwardly exclude the total Haitian population. Although, in theory, this policy was not officially race-based, in practice, because of local and national demographics, the Haitian ban had the effect of screening based on the Black racial classification (Nijjar, 2010, 2013).

Note that the U.S. Department of Commerce (1993) reports that in 1980, the Black population in the United States reached 26.5 million, 11.7% of the total population (p.2). While the Migration Policy Institute (2014) document titled *The Haitian Diaspora in the United States* finds that "in 1980, about 90,000 Haitian immigrants resided in the United States" making up less than half a percent (0.33%) of the total Black population (p.1). These statistics substantiate

that in the United States, this policy impacted a relatively insignificant number of their total Black population.

Conversely, in Canada, census data demonstrates that in the 1980s, the policy would have impacted almost entirely the total Haitian population, and consequentially a disproportionate number of the total Black population in Canada. This correlation is supported by the Statistics Canada (2001) report titled *Profiles of Ethnic Communities in Canada - The Haitian Community in Canada*. The document states that “[t]he majority of the Haitian population in Canada is foreign-born” arriving in the last 40 years (p.9). Note their migration trends:

Of foreign-born Haitians living in Canada in 2001, 33% had arrived in the previous decade, while 30% immigrated in the 1980s, and another 33% arrived in Canada between 1971 and 1981. In contrast, only 5% of Canadians of Haitian origin came to Canada before 1971. (Statistics Canada, 2001, p.9).

The data supports that the “Canadian blood authorities based their decision on that of their American counterparts” generalizing the two international diasporas without taking into account the substantial population and racial density of the Canadian-Haitian presence, notably in the province of Quebec (Charbonneau & Tran, 2015, p.68). In that, the above-mentioned statistics demonstrate that in 1983, when the Haitian blood policy was implemented, nearly all Haitians were recent entrants to Canada; this in practice disqualified the total Haitian population.

Naturally, members of the Haitian community resented the implicit stigma and discrimination which described them as high-risk, and they further condemned the CRCS’s position as racist (p.233). In April of 1990, more than 50,000 demonstrators gathered in New York City to protest this exclusion (Galarneau, 2010, p.210). A number of demonstrations also took place in Canada, complaints were lodged with the Quebec Human Rights Commission and

the League of Red Cross Societies, manifestations took place at the Haitian embassy in Ottawa, the consulates in Toronto and Montreal, and picketing took place at the Ottawa blood headquarters (Krever, 1997, p.233).



Figure 1. Demonstrators of Haitian and sub-Saharan African origin protesting the ban on blood donation.

Source. <https://www.newyorker.com/news/news-desk/trump-reopens-an-old-wound-for-haitians>



Figure 2. Screenshot image (1:46) of YouTube video titled “Haitian AIDS March,” footage dated April 20 1990.

Source: <https://www.youtube.com/watch?v=ot3MrHTVaHU>

The CRCS was especially sensitive to the accusation that it was acting in a racist manner, an accusation that struck at the heart of its identity as a humanitarian and non-discriminatory organization (p.233). In July of 1983, in a subsequent second press release, a series of statements

were issued by the Red Cross which reiterated who the high-risk groups were. The comments pertaining to Haitians were as follows:

Haitians should be, and are, allowed to donate blood in Canada provided they meet the existing selection criteria required of all blood donors. However, because of uncertainties currently surrounding this issue... recent immigrants from Haiti are being advised not to become blood donors at this time. (July 19, 1983, CRCS as cited in Krever, 1997, p.250).

Above, note the argumentation schemes used to justify the exclusion of Haitians. This communication, much like the previously mentioned is paradoxical. Both statements include *apparent concessions* and *disclaimers*, which are attempts to mitigate the illocutionary force of the overt Haitian utterance.

Three days later, after the July 19th communication, the Red Cross issued another press release which again reiterated Haitians as a named group among the 4Hs (as cited in Krever, 1997, p.250). The Krever commission contends that it was these statements that reignited the CRCS dispute with the Haitian community. Before the last two press releases, attempts to address the Haitian concerns and resolve complaints about human rights appeared to be underway (p.233). A joint communication was even drafted, reporting the resolution of the dispute between the Haitian community and the Red Cross (p.251). Though, after the second press release, the communiqué was never signed by the Haitian community (p.251).

These events would go on to impact the Haitian experience in Canada significantly, most specifically in the province of Quebec, where as demonstrated, Haitians are proportionally more important than in the United States, and the rest of Canada (Tran & Charbonneau, 2015, p.69). The data finds that the lasting consequences were to alienate Haitians and the total Black

population from donating blood, even after the voluntary self-exclusion was lifted in the early 1990s (p.69). The measures adopted to protect the Canadian blood supply carried a substantial burden of ethnoracial stigma. Furthermore, the data demonstrate that said exclusion unleashed a litany of discrimination against the Haitian community, its members, and the broader Black populations (Tran, Charbonneau, & Valderrama-Benitez, 2013). Note the examples.

By way of solidarity, it has been reported that Black individuals in Canada “still [refuse] to give blood because of the legacy and debate surrounding the scandal” (Tran et al., 2013, p.518). Another example, includes the recent Canadian Broadcasting Corporation article published April 2, 2018, titled *Don de sang: 35 and plus tard, les répercussions d'un communiqué*, informant Marlene Rateau recounts:

“La stigmatisation était grave aussi pour les autres, mais ils pouvaient se diluer dans la population. Mais nous? 1983, pour les Noirs, c'était: "Il a probablement le sida, je ne m'assoierai pas à côté de lui dans l'autobus, car je ne veux pas attraper ce mal." C'était épouvantable!

“Aujourd'hui encore, je ne leur pardonne pas.”

In the same news article, Concordia Research Chair in HIV/AIDS and Sexual Health, Dr. Viviane Namasté states:

“[L]es traces de cette blessure existent toujours...Les gens m'ont dit qu'ils en avaient parlé à leurs enfants et leurs petits-enfants. C'est sûr qu'il y a eu un transfert générationnel de cette histoire.”

Note that Rateau and Namaste's remarks have been empirically substantiated in the following publications (Tran et al., 2013; Tran & Charbonneau, 2015).

The Sub-Saharan African Deferrals

TYPES OF DEFERRAL

Indefinite Deferral – Prospective donor is unable to donate blood for someone else for an unspecified period of time due to current regulatory requirements. **EXAMPLE:** A prospective donor who states that they lived in England for 1 year in 1989 would be deferred indefinitely. This donor would not be able to donate blood until the current requirement changes. These donors may be eligible to donate autologous blood.

Permanent Deferral – Prospective donor will never be eligible to donate blood for someone else. **EXAMPLE:** A prospective donor states that he/she has Hepatitis C. Additionally, some permanent deferrals may result from the testing performed on a previous donation. These donors may be eligible to donate autologous blood.

Temporary Deferral – Prospective donor is unable to donate blood for a limited period of time. **EXAMPLE:** A prospective donor who discloses that he/she received a tattoo is temporarily deferred for 12 months after he/she received the tattoo.

Figure 3. Blood Donation Deferral Definitions

Source: AABB Donor History Questionnaire User Brochure

In March of 1997, Health Canada enacted the indefinite deferral of individuals who had either lived, visited or had *sexual contact* with persons from eight sub-Saharan nations—Cameroon, Central African Republic, Chad, Congo, Equatorial Guinea, Gabon, Niger, and Nigeria—subsequently excluding these populations from blood donation in Canada. Via its regulatory delegates HQ and CBS, Health Canada initially upheld this exclusionary policy to safeguard the Canadian blood supplies from a contamination risk of the HIV-1 Group Outlier, said to be exclusively linked to sub-Saharan African populations. The indefinite deferral of Africans read as follows:

Geographic Deferrals:

People who have lived in certain regions of Africa, who may have been exposed to a new strain of the virus that causes AIDS (HIV-I Group O), are not eligible to donate blood. People who have received a blood transfusion while visiting there

or who have had sex with someone that has lived there, are also not permitted to donate blood. This is not based on race or ethnicity but possible exposure to HIV-I Group O. Countries included are: Cameroon, Central African Republic, Chad, Congo, Equatorial Guinea, Gabon, Niger and Nigeria. (CBS, Geographic Indefinite Deferral).

The indefinite deferral clause helped deflect the criticism that the policy was discriminatory against African and/or Black populations. An indefinite appointment shifted the “onus of responsibility to the science of the unavailable” HIV-O detecting technology (Flatt, 2015, p.119). “If the ban was made permanent in its initial wording,” as was the case with the Haitian and Negro policies, “the argument that this was blatant discrimination against a group of people would be supported— as that group of people could not conceivably change” where they were born, had lived, visited, and who they had sexual contact with (p.119).

Additionally, it is important to notice the racial disclaimer that was always appended to this policy. Disclaimers are strategies of arguments and argumentation used to justify and legitimize the exclusion and/or differential treatment. With this denial, there is an admission of a racial association of the discourse. It then becomes clear that the official HIV-O donation “policy and its application in practice were designed with intentional putative efforts to neutralize” racism by avoiding the usage of the Black racial classification in the policy and in the DHQs (p.199). I stipulate that this coding was done to suppress the ways in which the phrasing and representation of the HIV-O question may have unintentionally reinforced racist assumptions, thus creating a space for a more overt manifestation of Negrophobia (p.199).

To provide more context, the group O infection is said to have originated from Cameroon with reported instances in other Central and Western sub-Saharan African geographic regions,

notably Gabon and Equatorial Guinea. The first confirmed report of HIV-1 group O in North America was in a US patient in 1994 (Centers for Disease Control and Prevention (CFDCP), 1996, p.561). It involved an individual who had immigrated to the Los Angeles County from an unknown region of sub-Saharan Africa (p.561). The individual was initially evaluated for a number of “lymphadenopathies,” and was eventually tested for both the HIV-1 and HIV-2 antibodies; the results were negative (p.562).

In October 1995, said patient was again evaluated for “persistent lymphadenopathy” (p.561). Different testing technologies for both HIV-1 and HIV-2 were administered, and the results were variant; weakly reactive to the HIV-1 antibody, and negative for the HIV-2 antibody (p.563). Hereafter, the multiple samples collected from the patient—all subject to the FDA’s approved HIV-1 and 2 detecting technologies— demonstrated inconsistencies in recognition of the O serology; specific collected samples continued to be reactive while others were negative (p.565). As a result, in December of 1996, the FDA’s Blood Products Advisory Committee (BPAC) recommended that manufacturers modify their testing kits to include the group O serology (FDA, 2009, p.4).

In consequence, pending the licensing of the new medico-technologies with specific capabilities to detect the then-new group, the FDA introduced direct HIV-O risk questions into American blood donor history questionnaires (p.4). Canada followed the American directive by adopting an almost identically worded policy (CHS, 2012). A single confirmatory response to an HIV-1 group O question led to the indefinite deferral of patients who were either born in, lived in, or visited the named sub-Saharan African countries (FDA, 2009, p.3; CHS, 2012).

In 2003, group O detection technologies were implemented across all American blood systems (FDA, 2009, p.3; CHS, 2012). The FDA followed the recommendation to discontinue

the use of donor questions which referenced the African ethnicity as an HIV-1 group O risk population (FDA, 2009, p.3).

In 2004, CHS (2012) confirmed that Canadian blood product testing technologies were licenced to detect the group O infection, yet Health Canada did not motion to discontinue the indefinite deferral donor question which referenced the African ethnicity as an HIV-1 group O risk. It is important to note that since the identification of the group O infection between the years 1994 to 1996, there have been no additional group O cases in the U.S. (FDA, 2009), and no cases have ever been reported in Canada (CHS, 2012).

In June 2015, the indefinite deferral of the eight sub-Saharan nations were amended. Seven of the eight nations were no longer deferred under the HIV-O contamination risk. Cameroon remained deferred, alongside Togo which was added to the exclusions as temporary deferrals under the rationale of “possible exposure to newly emerging strains of HIV.” The amended *HIV Geographical Risks* read:

If you have lived in Africa since 1977, specifically Togo or Cameroon, you must wait one year from the date of departure from the affected country, to donate blood. Anyone who has had sex with someone who lived there is also not permitted to donate blood for one year after last sexual contact. (CBS, HIV Geographical Risk, Togo and Cameroon Temporary Deferral).

Notice that emerging strains of HIV was only associated to African countries.

Twenty one years after the implementation of this policy, the April 2018 CBS communiqué confirms that HIV-O or emergent strains of HIV questions as they pertain to sub-Saharan African countries, were removed from circulation. The communiqué titled *Recent Changes for Donors* read as follows:

We no longer ask if you or your sexual partner has visited Togo or Cameroon in the past year. This change is thanks to international HIV surveillance and the latest scientific evidence showing these areas are no longer at high risk of variant strains of HIV. (CBS, Recent Changes for Donors).

Beyond this brief communication, there were no other media releases by blood operators, media outlets, or stakeholders reporting on the above-mentioned policy amendment and repeal.

Additionally, note that much like the Haitian ban, the African policy also disproportionately impacted the total Black population in Canada, in a manner that it could not impact the majority African American Black populations of the United States. Demographically, in Canada, African populations are majority foreign-born:

The majority of African immigrants living in Canada today are relatively recent arrivals. Of immigrants with African ethnic origins living in Canada in 2001, 58% had arrived in the previous decade, while another 31% had arrived in Canada between 1981 and 1990. In contrast, only about 6% had arrived in 1960s, while less than 1% had come to Canada before 1961. (Statistics Canada, 2001, pp.9-10).

To further dissect some of the discourses of the HIV-O policy, the FDA blood donation eligibility guidelines provided by the AABB were reviewed, as well as CBS DHQs and websites. The AABB is an international association providing accreditation and representing institutions involved in the field of transfusion medicine and cellular therapies; they have partnerships with the FDA, Health Canada, CBS and HQ, in order to provide guidelines for blood donation. The documents under analysis are the 2008 AABB Donor History Questionnaire and the Donor History Questionnaire User Brochure. These brochures were developed to assist blood personnel interviewer “in determining if a prospective donor was eligible to donate” (Flatt, 2015, p.113).

The documents provide “guidelines as to the types of deferrals that may result from affirmative responses to certain questions in the DHQ” (p.112). Important to note that the DHQs were always administered on the date of donation, and the DHQs were designed for self-administration by donors, with follow-up review question administered by blood clinic personnel.

In Figures 4 and 5, the flowcharts “were designed by the AABB to offer a visual representation of the process of donation screening as well as a description of the question the donor historian [should] ask of the donor, and the subsequent outcome based on the donor response” (p.115). Standard flow-charting symbols were used to guide the personnel through the donor questionnaire process. In accordance with the flowcharts, publicly accessible DHQs from CBS were also analyzed; version F020831, dates 2006-05-15; 2009-04-01; 2010-10-30; 2011-05-01; and 2011-09-01. Note that the standardized blood donor questionnaire was created in consequence to Krever (1997). From 1998 to 2015, the DHQs were administered in paper form.

Sex vs Sexual Contact

The epigraph in Figure 4 demonstrates the sequences applied by the donor historians for one of the HIV-O related questions, specifically inquiring about sexual contact with Africans, or individuals who had visited, or lived in Africa. A survey of all *sex* and *sexual contact* related questions was undertaken. The results demonstrate that of a total of 10 sex-related questions on the DHQs under analysis, all located in the high-risk personal question section, to be administered face to face by clinic personnel; 9 out of the 10 questions referenced the terminology *sex*. Conversely, the African related question, marking the last, and again the 10th

sex-related question of the DHQ, was the only question which cited *sexual contact*. Note the DHQ questions below.

Question 17: At any time since 1977 have you taken money or drugs for sex? (CBS, DHQ F020831).

Question 19: Male donors: Have you had sex with a man, even one time since 1977? (CBS, DHQ F020831).

Question 22. Have you had sex with anyone who has AIDS or has tested positive for HIV or AIDS? (CBS, DHQ F020831).

Question 23: Female donors: In the last 12 months, have you had sex with a man who had sex, even one time since 1977 with another man? (CBS, DHQ F020831).

Question 24: Have you had sex in the last 12 months with anyone who has ever taken illegal drugs or illegal steroids with a needle? (CBS, DHQ F020831).

Question 25: At any time in the last 12 months, have you paid money or drugs for sex? (CBS, DHQ F020831).

Question 26: At any time in the last 12 months, have you had sex with anyone who has taken money or drugs for sex? (CBS, DHQ F020831).

Question 27: Have you had sex in the last 6 months with anyone who has taken clotting factor concentrates? (CBS, DHQ F020831).

Question 30: In the past 6 months, have you had sex with someone whose sexual background you don't know? (CBS, DHQ F020831).

Question 31:

a) Were you born in or have you lived in Africa since 1977? (CBS, DHQ F020831).

b) Since 1977, did you receive a blood transfusion or blood product in Africa? (CBS, DHQ F020831).

c) Have you had *sexual contact* with anyone who was born in or lived in Africa since 1977? (CBS, DHQ F020831).

Note that in the DHQs, no definitions were provided to delineate the potential difference for the usage towards African populations in juxtaposition to the rest of the population. This was an interesting difference in how sexual behaviour may be treated or conceived within the context

of Africans in contrast to the rest of the population (Flatt, 2015, p.117). In that, the DHQs under analysis failed to provide any definition as to the meaning of *sex* or *sexual contact* regarding Africans, and those who may have come into sexual contact with said African populations. I reiterate, that there were no instances of elaboration, explanations or definitions given in the DHQs under analysis, or CBS literature. The AABB document did however, provide an operational definition. Note the explanation.

Sexual contact – The meaning of the words “sexual contact with” and “sex” are identical, and apply to any of the following activities, whether or not a condom or other protection was used: (1) Vaginal sex (contact between penis and vagina); (2) Oral sex (mouth or tongue on someone’s vagina, penis, or anus; (3) Anal sex (contact between penis and anus). (AABB, n.d., p.5).

The *sexual contact* language exceptional to African related questions was consistent with the differential treatment afforded to Africans (otherwise Black populations) throughout the data results.

Question: 20. Since your last donation, have you had sexual contact with anyone who was born in or lived in Africa?

Donor Eligibility: If the donor had a sex partner who was born in or lived in certain countries in Africa (see list below) after 1977, the donor is indefinitely deferred. Donors who have had sexual contact may have been exposed to rare strains of HIV that are not detected by current test methods.

Note: Not all donors define "sex" or "sexual contact" in the same way. The donor must have read the educational materials provided.

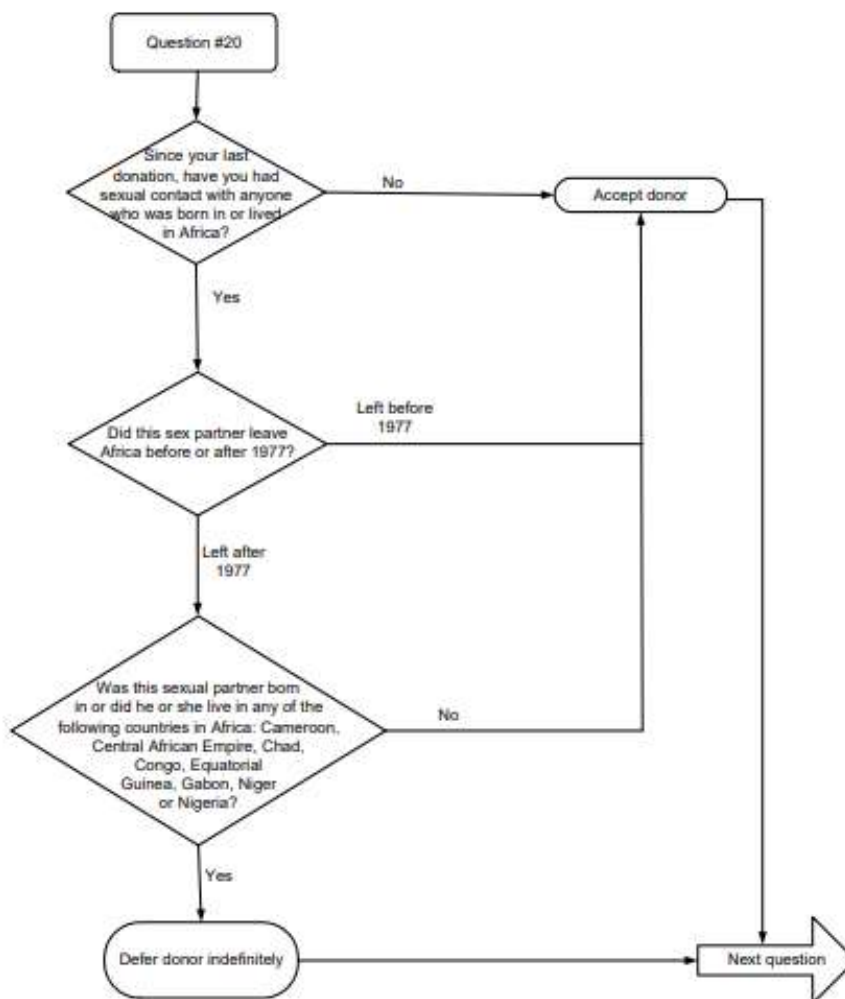


Figure 4. AABB Donor History Questionnaire User Brochure HIV-O sexual contact question.

Africa

Additionally, in the DHQs under analysis, the African question was the last question of the forms, located in the high-risk section of the document, to be dictated by donor personnel

face to face. While there is no explicit indication that these risks are ranked in any purposeful order, the issue of last placement generally concedes the least level of importance or relevance.

Also, note that the African questions were preceded by questions about HIV. The spatial association of HIV and African questions is important (Flatt, 2015, p.195). Integrating Flatt's (2015) schemata to African populations, I also found that "[t]he direct placement of questions about HIV symptoms, HIV testing, and positive HIV test results are indicative of a wider understanding and long history of [Africans] and HIV/AIDS" (pp.195-196). Without any mention of the HIV-O disease or the eight deferred countries, the African question then presents *all Africans*, those who have come into sexual contact with Africans, and those who have been subject to medical interventions (transfusions) as unsafe. I speculate that the last placement, the sexual contact language, as well as the high risk spatial connection of the African question, is itself revealing of not only the minimized "nature of the 'sensitivity' of this question but, more insidiously, reflects its association with the stigmatized behavior" of African sexual practices "that have long been viewed by [the West] as a kind of justification for sexually transmitted infections, including HIV and AIDS [,]" among many other communicable diseases (Flatt, 2015, p.192).

This issue of placement was consistent in CBS news release communications as well, the same pattern of last placement was evident in the previously mentioned April 13, 2018 *Changes to Donor Criteria* announcement. Globally throughout the data, when African related announcements were represented, they were consistently listed in the last placement.

Another uncovered trend in the DHQs is that African related questions were always presented as capture questions. Furthermore, the African questions were never self-administered,

they were always located in the high-risk section of the DHQs (see Figure 5). According to the AABB, such questions are defined as follows.

Capture Question – A question that covers a broad topic. When an affirmative answer is given, additional follow-up question to elicit additional information are asked by the donor historian. EXAMPLE: Have you ever been to Africa? If the donor answers yes, additional question must be asked. (AABB, n.d. p.5).

Self-administer Questionnaire – A questionnaire that the donor completes on his/her own, followed by donor health historian review. (AABB, n.d. p.5).



Figure 5. CBS DHQ edited sample.

Source: Paul Nijjar, Black People: Please Give Blood (Unless You're African).

The next flowchart (Figure 6) represents the sequence for the question “were you born in or have you lived in Africa since 1977,” questioning travel, residence, or place of birth to Africa.

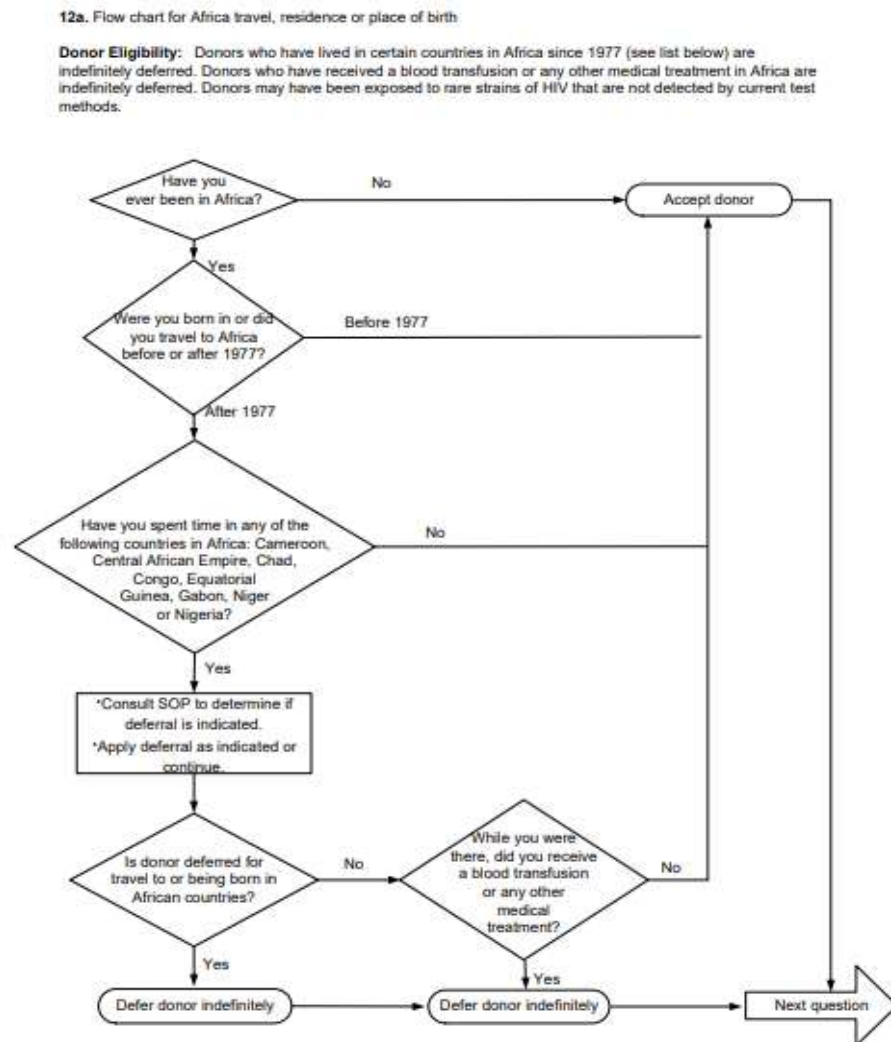


Figure 6. AABB Donor History Questionnaire User Brochure HIV-O birthplace and travel question.

Note the level of generality (capture question) in which the African question was presented. Substituting *Africa* for Cameroon, Central African Republic, Chad, Congo, Equatorial Guinea, Gabon, Niger, and Nigeria is itself a comment about the possible racism or cultural insensitivity of the blood operation (Nijjar, 2010, 2013). Recall that this strain of the disease has

reported instances in the United States, as well as France and Brazil. Nevertheless, the data supports that the deferral was framed exclusively in an African context, and no other geographic regions were deferred. The messaging was clear: all of Africa is problematic, and it is acceptable to capture the entire continent as high-risk (Nijjar, 2010, 2013).

The CBS Annual Report 2014-2015 confirms the introduction of electronic records of donation (eDHQ) that year. From the eDHQ images, note the *strategies of predication* and *implications* employed. The data demonstrates that the images presented have an intended correlation between image and question. In that, the images associated with the African questions conveyed stereotypical attributions with negative traits associated with sub-Saharan African (and otherwise Black) populations. In Figures 7, 8 and 9 note the image captures of the three African related questions.



Figure 7. CBS eDHQ Question "Since 1977, were you born in or have you lived in Africa?"

Source: Source: OmiSoore Dryden. “A Constant Battle: Bad Blood, #Black Lives Matter, and the Politics of Queer Disidentifications.” Political Science Speaker Series. January 26 2017, University of Alberta.

From Figure 7, note the level of vagueness in the presentation of this map (Dryden, 2016). The notable shape of the African continent is presented without context. This representation of Africa plays into the myth of continuity; a myth that suggests that Africa is homogenous and undifferentiated. Note the continent was not titled, neither were the then 8 excluded countries. Also, notice the *referential strategies*, the national borders were delineated by green colour shades, in a military or camouflage design, colours associated to war, conflict, and tribalism; all rampant negative stereotypes associated to African populations.

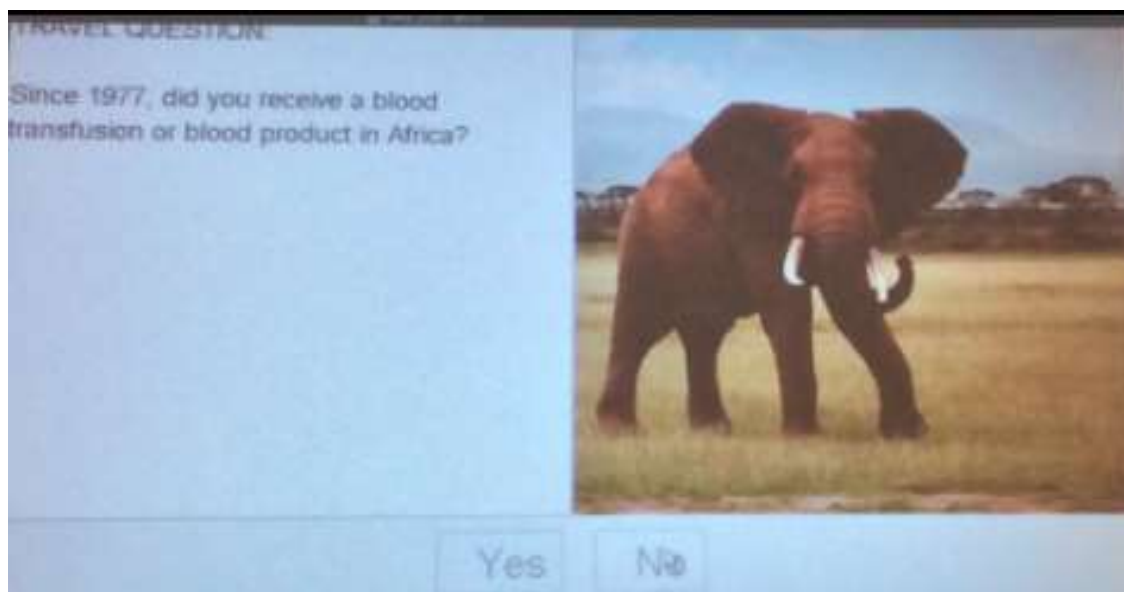


Figure 8. CBS eDHQ Question. Travel Question: “Since 1977, did you receive a blood transfusion or blood product in Africa?”

Source: OmiSoore Dryden. “A Constant Battle: Bad Blood, #Black Lives Matter, and the Politics of Queer Disidentifications.” Political Science Speaker Series. January 26 2017, University of Alberta.

Figures 8 and 9 are consistent with representations of dehumanization, once more favouring stereotypes about the continent. In that, the images play into myths of geography that suggest that the continent is savannah. The correlation between the questions intended for African populations, and flora and fauna are not clear.



Figure 9. CBS eDHQ Question Lifestyle Question: “Have you had sexual contact with anyone who was born in or lived in Africa since 1977?”

Source: Source: OmiSoore Dryden. “A Constant Battle: Bad Blood, #Black Lives Matter, and the Politics of Queer Disidentifications.” Political Science Speaker Series. January 26 2017, University of Alberta.

The eDHQs depicted in the last three figures are revelatory racial tropes, with well documented racist undertones that perpetuate problematic notions of Africans (and otherwise Blacks) that are rooted in implications of sub-humanity and animalism. Particularly the images of flora and fauna are riddled with racial metaphors and metonymies that are consistent with iconographies which degrade and objectify said populations, their features, and geographies into symbols of sub-humanity, desolate lands, and/or warfare.

The Congo Discrepancy: the Democratic Republic or the Republic?

A review of the eight deferred countries was also undertaken, and a blatant error was uncovered. Congo, as was cited throughout the HIV-O policy has never been a country. The *Democratic Republic of Congo*, as well as the *Republic of Congo*, are autonomous countries. Note the flags and the FDA's (2009) comments regarding the discrepancy.



Figure 10. Flags of the Democratic Republic of Congo and of the Republic of Congo during the years of the African indefinite deferral.

The country formerly named as Zaire, recently renamed the Democratic Republic of Congo, as not identified any cases of HIV-1 group O infections thus far, but the name of the country might be confused with the country Congo where HIV-1 group O has been identified. As a result, we recommend revisions to the list of countries of origin or residence where HIV-1 group O is endemic that is used to identify potential donors who are at increased risk of group O infection. (FDA, 2009, pp.2-3).

With this excerpt, the FDA (2009) acknowledges that the African policy was instated, and was likely administered incorrectly, with a considerable error that more than likely deferred

a number of potential donors, as well as the sexual partners of those individuals. The data supports that for a period of 18 years, in Canada, this policy inaccurately deferred populations from the DRC, even beyond the FDA's publication of this document in 2009, and the repeal of the policy in the United States shortly thereafter. By way of this error, nine African countries were deferred, instead of the eight cited throughout the data. There was no indication, or asterisk associated to *Congo* to delineate the potential confusion. In fact, there were no Canadian data sources that even made mention of the Congo discrepancy, demonstrating that said error was permitted to persist in silence without documented surveillance.

Ethnic Indefinite Deferrals: African Questions (HIV-O) versus European Questions (vCJD)

To further contextualize and probe into the ethnoracial discourses at hand, in the same manner as the African related questions, I concurrently surveyed and contrasted the administration of the vCJD question, the other ethnic indefinite deferral— that impacted disproportionately Caucasian populations, namely from the United Kingdom and France.

Much in the same manner as the MSM and the HIV-O policies, the vCJD was also a longstanding indefinite deferral. According to a HQ (2007) vCJD pamphlet, vCJD is a degenerative brain disease that is fatal in 100% of cases. It is caused in humans by exposure to *bovine spongiform encephalopathy* (or mad cow disease), which like HIV, also appeared in the early 1980s. The HQ document states that the disease is transmitted to humans through the ingestion of certain contaminated beef products. Note that “the epidemiological future of vCJD is still unknown,” and although the risk is extremely low, blood products may still transmit vCJD in humans (HQ, 2007). The pamphlet confirms that a few cases of transmission have been reported following blood transfusions.

For the vCJD policy, the following was uncovered, take note of the contrasts afforded to the questions, particularly where the levels of specificity, accuracy, and completeness are afforded to the vCJD policy. The vCJD was question 8 of the DHQs under analysis. Note the issue of placement. Even as a longstanding indefinite deferral, the vCJD question was always located in the *cubicle* (low-risk) section, self-administered portion of the DHQ, to be completed in the absence of the donor historian. The questions were as follows:

Question 8:

- a) Since 1980, did you receive a blood transfusion or blood product in the United Kingdom, France or elsewhere in Europe? (CBS, DHQ F020831).
- b) Have you spent a total of 3 months or more in the United Kingdom (England, Northern Ireland, Scotland, Wales, the Isle of Man, or the Channel Islands) from January 1, 1980, through December 31, 1996? (CBS, DHQ F020831).
- c) Have you spent a total of 3 months or more in France from January 1, 1980, through December 31, 1996? (CBS, DHQ F020831).
- d) Have you spent a total of 5 years or more in Europe since January 1, 1980? (CBS, DHQ F020831).

CBS (1998-2013) website elaboration on the vCJD policy was as follow:

Possible Exposure to CJD or vCJD:

People are not eligible to donate blood or plasma if they have spent a cumulative total of three months or more in the United Kingdom (U.K.) between January 1980, and December 31, 1996, or if they have spent a cumulative total of three months or more in France between January 1980, and December 31, 1996, or if

they have spent a cumulative total of five years or more in Western Europe outside the U.K. or France since 1980. In addition, people will no longer be eligible to donate blood or plasma if they have had a blood transfusion in the U.K., France or Western Europe since 1980. This is owing to the risk of transmission of variant Creutzfeldt Jakob Disease (vCJD) through blood. (CBS, Indefinite Deferrals).

Immediately notice the word count of the vCJD questions (93 words) in contrast to the HIV-O questions (45 words) in the DHQs under analysis. More than double the description was afforded to the vCJD question, providing a superior level of accuracy and specificity for this question. In that, notice how the language of the vCJD was extremely precise, stipulating time periods in days, months, and years. Further to that, not only were the deferred countries named (France and UK), but the regions (England, Northern Ireland, Scotland, Wales, the Isle of Man, or the Channel Islands) were also further stipulated. This was in direct contrast to the HIV-O questions, presented in a continental context, with a wide sweeping *since 1977* period stamp appended to the African questions. Additionally, this level of specificity and accuracy was also in direct contrast to the *Congo* discrepancy as previously explained.

Another difference was in the titles of the deferrals as presented on CBS (2010-2013). While the HIV-O was named a “Geographic Deferral,” the vCJD policy was titled as “Possible Exposure to CJD or vCJD.” The term geographic deferral confined the deferral to Africa. While titling “Possible Exposure to CJD or vCJD,” poignantly prefaced the question around the disease, and not the geography, or its populations; this de-ethnicized the policy, removing the semblance of geography for the otherwise ethnic and geographic European deferral. In fact, at no time during the analysis was the vCJD policy referenced in a continental context as European.

Also, the data demonstrate that disclaimers of race and ethnicity were not associated with vCJD questions. A review of the vCJD flowchart was also conducted. Note the epigraph:

Donor Eligibility: Donors who have spent time that adds up to three (3) months or more in the United Kingdom from 1980 through 1996 are indefinitely deferred. Donors may be at theoretical risk of developing vCJD from eating beef from the UK. There may be a theoretical risk of transmitting vCJD through blood transfusion.

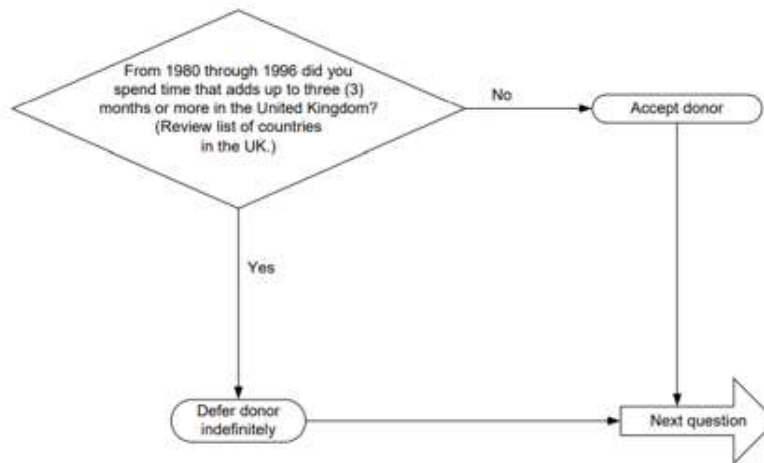


Figure 11. AABB Donor History Questionnaire User Brochure vCJD deferral question.

Immediately note the size difference of the African related flowcharts represented in Figures 4 and 6 in contrast to Figure 11 above. While the African related question was administered as two separate questions, the vCJD deferral is noticeably less invasive administered in one question, with a one-step format. Note that the diamond references a question or a decision point. Combined, Figures 4 and 6 had eight decision points in comparison to the one represented in the vCJD figure above. The charts confirm that African populations, as well as those who had visited and lived, or those who had sexual contact with African populations, were subject to a more rigorous process than the vCJD populations. Additionally, a review of the CBS (2018) online eligibility quiz (see Figure 12) demonstrates that questions

related to European deferrals were represented with the flag of the Union Jack. This symbol accurately corresponded to the United Kingdom and was also accurately emblematic of the target population.



Figure 12. CBS (2018) Eligibility Quiz, vCJD question, “I have spent 3 months or more consecutively in the United Kingdom.”

The added attention afforded to the vCJD question was a pattern throughout the data sets. A review of the CBS Annual reports (1998-2017) and CBS meeting minutes demonstrated a consistent review of this policy. Additionally, when presented on the CBS (2013-2017) website, this policy, as well as the MSM policies were given prominence with their own specific headings. In contrast, there was no annual review documented for the African related questions, and the meeting minutes did not reflect the HIV-O topics on the agenda, with the exception of one mention in the 2012-2013 Annual Report.

This demonstrated a concerted effort to “manage the risk of screening donors in ways that make it harder for Africans (and the people who have sex with them) to give blood and make it easier for other (primarily white and favoured minorities in North America) to give blood”

(Nijjar, 2010). This points to a trend wherein the politically neutral meanings associated to European migrants, made for preferential treatments in blood screening. When it came to potential European donors, it became apparent that there was a politically neutral meaning associated to their blood in the policies and procedures, demonstrating the weakness of that category as an Othered social identity in Canada (Valentine, 2005, p.120). These politically neutral meanings associated to vCJD, from a racial perspective, made for preferential and differential treatments. This interplay corroborates the “metaphysics of White value” which has been proven to operate through class, disability, and sexual orientation markers, only compounding “existential and sociopolitical problems for Black bodies” (Yancy, 2016, p.xv).

The Discourse of Silence

The HIV-O existed in a discourse of silence. In the spirit of CDA, scholars like Dryden (n.d.) reasons the “apparent lack of knowledge regarding” such policies as predictable, “since as a nation, Canada has difficulty understanding the place, space, and locations of [B]lackness within its midst” (p.8).

Note that in respect to the three longstanding deferrals, the MSM deferral was the most prolific. The data results demonstrated a colossal and consistent devotion to the MSM policies. Since its implementation in 1983, the MSM policy has been debated worldwide throughout countless publications (Feldman & Bayer, 1999; Fiddler, 2010; Flatt, 2015; Dryden, 2015). To a much lesser extent, as corroborated by Valentine (2005), “the theoretical risk of transmission of vCJD through blood transfusion has not generated the same controversy as the exclusion of gay men” (p.120). Nonetheless, by way of academic citations and representation in organizational literature, it was determined that the European deferral has a relatively robust body of literature in Canada. In last, the African deferral has gained the most negligible academic and/or social

conversation. With the exception of Dryden's (2010, 2015, 2016) publications/activism; the "CHS Position on HIV- O deferral in Africa" document; the SCAGO; and two blog posts from Nijjar (2010, 2013), there has been an agonizingly silent discourse around the African deferral, institutionally within the blood system, as well as internationally (see Table 3).

Looking at the disproportionate attention afforded to policies, I racialize the three longstanding blood policies, exploring both the MSM and vCJD deferrals as policies that disproportionately effects White populations, in contrast to the HIV-O deferral, which disproportionately impacts Black populations. In that, statistically, I first acknowledge the muteness around the African policy demographically and socio-politically. Admittedly, the 1990s sub-Saharan African positioning within Canada likely played a significant role in this discourse of silence. Statistics Canada (2001) confirms that these migrants were predominantly asylum seekers, providing them with fewer opportunities, resources, and/or awareness to effectively dissent their exclusion in the manner in which it was observed with the MSM and vCJD deferrals.

Beyond this demographic justification, scholars like Dryden (n.d.) comment on the state of Blackness in Canada, and alongside Hannabach (2015), the aggregate of the data results finds that the disproportional response that is directed at the African policy, are revelations of the pathologized and subordinated political identity of Blacks, where "Haitian, African and all Black bodies" are *always already* associated with contamination (p.30). In proximity to the vCJD policy, the African policy pointed to the privileges afforded to Whiteness even in the face of inequality. This interplay provided insight into the relationships of the (in)visibility of Black blood policies in juxtaposition to the other two longstanding indefinite deferrals.

In summing the African section of these results, it is important to note that the combination of the Haitian and African policies created a racial disproportionality unique to the Canadian demographic landscape. In its totality, both policies, spanning a combined 35 years, not only deferred but deterred a number of Black populations from donor participation in Canada. Again, I iterate that these screening procedures were not officially race-based. Nevertheless, the data analysis demonstrated that because of local and national demographics, said policies had the effect of screening based on race (Nijjar, 2010, 2013).

Much in the same manner as Flatt's (2015) study, I observed that public defense by the blood operators maintained that the Black blood policies are not discriminatory were plainly stated alongside the policies (p.240). Disclaiming notes appended to policies explained that the basis for the exclusions were based on scientific evidence of risk for transmitted infection and was not based on any judgment concerning the donor's race (p.240). In such claims, I saw racial differentiation (or discrimination) being flatly denied by blood operators, which repeated the mantras that it was not race and ethnicity "that are...banned as a category of persons, but that the risky element," the ethnicity and the geographic location was "grounds for deferral" (p.240). This was false universalism in action, coded in the disclaiming "language of tolerance," a language that makes "it socially acceptable to present this policy both in written form and in the practice of [blood] donation" (p.240). Such a masking of the Black racial classification with the clinically benign terminologies of *African* and *Haitian*, circumvented what was viewed as direct evidence of discrimination against racial minorities (p.240). Building upon Flatt (2015), such tactics obscure "the history of the policy and the ongoing discussions behind the scenes and in the mainstream media[,] that reflect the more realistic interpretation that these policies referred directly to Black populations (p.240).

Ultimately, placing measures of control on ethnically Black populations “under the premise of ‘protection’ of the potential recipients [,]” reified the fears that the Black racial classification, and its populations are contaminated and contaminating, and “are almost exclusively to blame for HIV infections” (p.240). Again, with Flatt (2015), it becomes clear that “[i]t is this element of the reification of these fears that lends support for the classification of these policies and their subsequent application in practice as [Negrophobic]” (p.240).

To date, no definite statistics have quantified the number of Black peoples who were deferred or impacted as a result of either the Haitian and African policies. However, in the immediate, what can be deduced is that the total Black population will continue to be impacted by a number of blood policies reserved explicitly for the Black racial classification, referred to as phenotype blood.

Phenotyped Blood: Rare Blood Black Blood

Since 2010, the blood operators, most notably HQ, has made explicit demands for *Black blood*— also referred to as rare blood and/or phenotyped blood— via news releases and organizational communiqués. The HQ Annual Report 2016-2017 section titled *Challenge of Diversity* remarks the following:

Another important issue is donor diversity. The number of donor searches for non-Caucasian patients is increasing year by year, reflecting the growing diversity of the Québec population. To address this gap, we are continuing our recruitment efforts in the Black community in collaboration with its leaders. (HQ, Annual Report 2016-2017, Challenge of Diversity, p.5).

From the quote, notice the singularity or the racial homogeneity ascribed to the Black community. Moreover, notice the utterance of diversity and non-Caucasians, yet the target population (or archetype) is in fact solely the Black community. This is a *semantic strategy* of implication, again this is where meanings are conveyed without being explicitly stated. This strategy was prolific within the HQ data sets, no other racialized communities were named under the diversity umbrella for blood donation. Below, note the various appeals to the Black communities for Black blood.

HQ: The Black “Appeals to Solidarity”



Figure 13. Héma Quebec Calls for Black blood donation.

Source CBC news article posted February 01, 2016 11:18 AM ET.

HQ Press release Montreal February 15, 2018:

Black History Month- Héma Quebec Reiterates its call for new blood donors from Black Communities.

HQ Press release Montréal, February 17, 2017:

[26th annual black history month–Héma-Québec calls on women in Black communities to give blood.](#)

HQ Press release Montréal, February 1, 2016:

[Blood donation – The contribution of the Black communities has increased significantly, but the need is still great.](#)

HQ Press release Montréal, January 31, 2014:

[23rd edition of Black History Month – Héma-Québec reiterates its appeal to Black communities.](#)

HQ Press release Montréal, January 31, 2013:

[22nd edition of Black History Month - Encouraging results: the contribution of Black communities to the blood supply remains a major challenge.](#)

HQ Press release Montréal, January 31, 2012:

[21st edition of Black History Month: The collective blood supply needs the contribution of the Black communities.](#)

HQ Press release Montréal, February 1, 2011:

[Héma-Québec reminds the public about the importance of the contribution of the Black communities to Québec's blood supply.](#)

HQ Press release Montréal, February 1, 2010:

[Black communities: essential support for the collective blood supply.](#)

News Articles: CBS and HQ Appeals for Black blood

In 2016, CTV News reported:

Quebec blood agency urges black community to donate blood (CTV News
Published Monday, February 8, 2016 7:39AM EST).

<https://www.ctvnews.ca/health/quebec-blood-agency-urges-black-community-to-donate-blood-1.2768748>

That same year, CBS News reported:

Héma-Québec calls for more blood donations from black community (CBC News
Posted: Feb 01, 2016 11:18 AM ET)

<http://www.cbc.ca/news/canada/montreal/h%C3%A9ma-qu%C3%A9bec-black-donors-1.3428599>

Service Quebec (2017) published:

26th annual Black History Month - Héma-Québec calls on women in Black communities to give blood (Portail Québec - Services Québec, Feb. 17, 2017)
<http://www.filinformation.gouv.qc.ca/Pages/Article.aspx?aiguillage=ajd&type=1&lang=fr&idArticle=2502177630>

In 2011, a National Post article was titled

Canadian Blood Services calls for more blood from visible minorities (National Post Posted June 13, 2011 12:28 PM EDT).

<http://nationalpost.com/news/canada/canadian-blood-services-calls-for-more-blood-from-visible-minorities>

In 2012, CBC News article was titled:

“Blacks urged to donate blood, stem cells.”

This article elaborated:

During Black History Month, Canadian Blood Services is appealing for young, black male donors in particular to donate blood and be registered (CBC News · Posted: Feb 04, 2012 10:44 AM ET).

(<http://www.cbc.ca/news/health/blacks-urged-to-donate-blood-stem-cells-1.1282507>)

A Monday, Jan. 30, 2012 CBS News Release was titled:

Black History Month Celebrates Life through New Blood and Stem Cell Donors
<https://blood.ca/en/journalists/black-history-month-celebrates-life-through-new-blood-and-stem-cell-donors>

The datasets demonstrate that the insufficiency of Black blood within the blood systems is an essential concern for Canadian blood operators. According to the awareness campaign directed at cultural communities, as written in the 2009-2010 HQ Annual Report, “the longer-term goal is to be able to rely on a Black donor registry to find compatible blood” (p.14).

Unlike the Haitian and African policies, the phenotype blood demands are direct appeals to Black populations, based entirely on their racial classification. The data demonstrate that the appeals were centered on the idea that there were not enough Black donors, and this was because

Black populations were unaware of the significance of blood donation, even more specifically the significance to its racial community. However, the data results demonstrate that the Black public outreach programs were decidedly paradoxical.

Countering this undercurrent of *blaming the victim*—a message that resounded throughout the appeals— the HIV-O deferrals told one story, while the Black appeals to blood donation, said another. Note that the African indefinite deferral ran concurrently to the Black appeals. The data demonstrate that in 2010, when the racial appeals began to appear, with the HIV-O policy, blood operators rendered ineligible a disproportionate number of potential Black donors by virtue of the HIV-O policies. Even still, potentially eligible Black donors, would be subject to overly-broad, but racially poignant African questions in the screening process. Add to that the historical memory resulting from the 1980s Haitian ban, the idea that the Black community was and is unconscious to blood donation was demonstratively false. The data demonstrate that a number of organizations actively petitioned blood operators for the repeal of the African policy, directly pointing out the paradox. In the December 17, 2012 letter addressed to Dr. Peter Ganz – Director, Centre for Blood and Tissues Evaluation, SCAGO Interim President and CEO writes about the African deferral, and states:

This issue is extremely important for the sickle cell community as many potential health donors are unnecessarily being turned away. This policy has made blood donation drives for phenotype blood almost impossible.

The “Permanent Donor Deferral Policy Background Rationale to have the questions relaxed/removed” document, co-sponsored by SCAGO, The Sickle Cell Association of Ontario (SCAO), and Sickle Cell Anemia of Quebec, challenged the African indefinite deferral in stating:

[A]n obstacle that we have to constantly deal with... we found out that majority of the people from the groups we are educating and encouraging to donate blood “were born in or have lived in certain Central and West African countries since 1977.” Despite the fact that many of these willing donors were otherwise healthy, the organization has had to change its focus. (p.3).

Section: SCAO – Our Stand of the same document stated:

There are people dedicated to helping individuals living with sickle cell, by donating blood, but are turned away for reasons we feel are very arbitrary. So we request that you consider re-evaluating your criteria and propose some solutions which will increase the blood supply, while maintaining the safety of the Canadian blood banks. (p.5).

Other examples indicating the awareness for the disproportionalities were uncovered in correspondence letters— December 17, 2012; June 11, 2013; December 10, 2015; December 16, 2015— between SCAGO and Health Canada, where African indefinite policy amendments were discussed. The data demonstrate that blood operators understood the criticisms, yet steadfastly did not alter their screening. This corroborated that a number of Black peoples directly or indirectly learned that they were not welcome donating blood and blood products in Canada.

Additionally, Black blood appeals also presented the paradox of race as biology. As stated by HQ in their appeals to solidarity, a “human blood donation can save the life of another human being, regardless of skin color,” yet, together, in their appeals to Black blood, CBS and HQ insists upon the specificity of the Black racial origin for the compatibility of Black to Black blood donation.

Hence, for Black populations, the data supports that the donation system operates vis-a-vis a *for us by us* (FUBU) donor-recipient operation by urging Black people to become regular

blood donors to help particularly those in *their* racial community. This appeal is premised and rationalized on the transfusion demands of alleged racialized diseases (e.g. sickle cell anemia and thalassemia) which suppose that the specificities of the Black race contains the ability to treat said racialized disorders. In that, throughout the data sets Black blood was referenced and categorized as rare blood or phenotyped blood.

Note that in 2010, the HQ DHQ paper format under analysis confirm that the category of racial justification for its potential donors, with *Black* being one of the new options. Other racial classifications provided included: Arab, Asian, Aboriginal, White, East Indian (Asian), Latin American, and Other. Tran et al., (2013) confirm that this adaptation has meant that it is now possible on the basis of this racial information to know that a particular blood donation can potentially be used to treat certain disorders (p.524). In their study, *Blood Donation Practices, Motivations and Beliefs in Montreal's Black Communities: The Modern Gift Under A New Light*, they identify a 21-day process, confirming the extent to which Black blood is catalogued and differentiated within the Canadian donor operation. They state:

When the [Black racial] information is available, this rare blood is set aside from the regular collective bank for 21 days during which time it can be transferred to hospitals to treat [Black] patients with certain [Black] disorders such as sickle cell anemia. If it remains unclaimed after 3 weeks, the blood re-enters the collective bank for general use within the population. (Tran et al., 2013, p.524).

Inductive reasoning dictates that the 21-day process can further be confirmed by way of racial specification. The specificity of the Black blood demand, certainly warrants specific characteristics in its collection, banking, and transfusion. Simply stated: if it is not going to be processed differently or separately, why bother asking for it?

Note that with the exception of this study, there are no other sources of information that confirm or deny that this process is taking place. Given the constant demands for Black blood, it was eerie that the specifics of this tagging procedure were not justified. While the appeal for Black blood and the differential traits associated to their blood were presented by the media and blood operators with a level of prominence, conversely, the process wherein Black blood was processed, sorted, and/or *segregated* was not.

For further clarification and/or confirmation, I looked at the ARC for data sources. In the course of the data analysis, American sources have demonstrated more transparency in their management of Black blood. This approach conceivably offered additional insights into the current Canadian operation of segregating and tagging Black blood. The ARC's Annual Report 2013 stipulates the following:

The Red Cross Blue Tag program seeks to recruit blood donors specifically to help patients with sickle cell disease. Under this program, donors who identify themselves as African-American or black can have a blue tag attached to their blood collection bag. This indicates that the donated unit will undergo advanced screening and may be matched to a patient with sickle cell disease. For the Red Cross, the Blue Tag program has grown from its start in Philadelphia and is now used across the country, and it has become the foundation for future outreach and recruitment efforts in the African-American community. (ARC, 2013, p.15).

The Blue Tag Tie implemented around 2010, is the national consequence of the Cooperative Sickle Cell Donor Program (CSCDP), a program that began locally in Philadelphia in September 1997 (Sesok-Pizzini, Friedman, Smith-Whitley, Nance, 2006, p.120). The tagging system classifies and segregates African American and Black blood by attaching a blue tag to the

collection bag. According to the ARC (2016), the blood is then deferred from the general donor pool for a period of 21 days, while it waits for a sickle-cell (African American or Black) recipient. After 21 days, if the blood is not matched, the ARC (2016) stated that the blood would be released to the general donor pool.

There are clear parallels between the Blue Tag Tie and the Canadian findings. In the Canadian blood operation, there is an apparent hypervisibility for the demand of Black blood, which acts in tandem with the invisibility afforded to the processes of screening, sorting, and distributing Black blood once it is collected. In line with Charbonneau and Tran (2013), the timelines of the policy implementations, and the propensity to follow American blood directives, it would not be erroneous to confirm that this process is taking place in Canada as well.



Figure 14. American Red Cross Blue Tag Tie attached to blood collection bags of Black donors.

Source: http://www.senatorhughes.com/enews/2014_7_7_BloodDrive.htm.

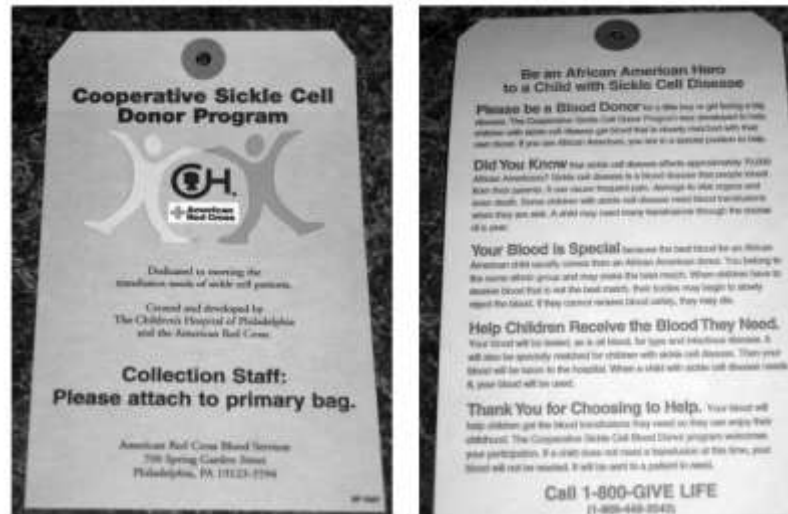


Figure 15. Blue Blood Tag, explains that African American blood is special.

Source: American Red Cross, *Immunohematology Journal of Blood Group Serology and Education* Volume 22, Number 3, 2006

Black Women and Blood Donation Program (BWBD)

“Replacing Iron Lost After a Blood Donation in Black Women.”

-Héma Quebec Annual Report 2016

The HQ 2015-2016 Annual Report is the first citing of this policy. The report explains the policy as following:

Black women have a hemoglobin level that is physiologically lower than that of Caucasian women. As a result, one-third of those who register for a blood drive are prohibited from giving blood because their level is lower than 125 g/l. By lowering the criterion to 115 g/l for Black women, the program enables a greater number of them to give blood. (HQ Annual Report, 2015-2016, p.26).

The HQ (2018) BWBD webpage explains this policy as follows.

Several Black women who would like to give blood are prevented from doing so because their hemoglobin count is naturally lower than Héma-Québec's eligibility criterion (125 g/l). Lowering the criterion to 115 g/l and replacing the iron lost during a blood donation could make a majority of Black women regularly eligible to give blood without affecting their health. This is the goal of the program.

Integrating these new donors would help us better meet the blood requirements of those in need within the Black community.

Again, note the level of generalization afforded to the target population. Across all data sets, the BWBD program did not delineate an operational definition for the Black racial classification (e.g. mixed race, biracial, or ethnicity), nor did it provide a definition for women for that matter. Furthermore, the explanation surrounding the BWBD iron deficiency were presented vaguely with a limited level of explanation in comparison to other presentations of hemoglobin found in organizational literature.

Also, there was a noticeable shift with the coded race language of the HQ (2018) website, and the more overt racial language of the annual report. While the website, which is otherwise more accessible, cites *eligibility criterion* as the comparator for Black women, the annual report, less visible and generally directed at partners and stakeholders, overtly opposes Caucasian women to Black women. Once more, the negative trait, or the predisposed ailment was again associated to the Black racial group, while the evaluative or standard attribution for normal hemoglobin was associated to Caucasians.

This process of separation, creates a binary polarization of Black women (innately unhealthy) in juxtaposition to Caucasian women (innately healthy). Hence the differential treatment, the lowering criterion is exceptional to the Black race. Recall that other women who

may present for donation with lower hemoglobin¹ will not be subject to the same differential treatment reserved for Black women only.

Lastly, in line with the phenotyped blood requests, also recall that the appeals to increase the participation of Black women in the blood system are in place for the sole purpose to bolster Black to Black blood donation, to meet the blood requirements of those in need within the Black community, not immediately for the benefit of the general population.

Who can participate?

You can take part in the program if you meet the following criteria:

- You are a Black woman;
- You meet Héma-Québec's eligibility criteria for giving blood.



Figure 16. Black Woman and Blood Donation Program HQ website 2018

Malaria

I recognize that Black populations are also disproportionately impacted by the malaria deferral. Given that the malaria policy defers populations across a number of geographic regions

inclusive of North America, South America, Africa, as well as Asia, this policy does not meet the conditions of an explicitly Black blood narrative.

PART II

This section of the results presents the four meta- narratives that I uncovered across the previously described accounts—the Negro Segregation, Haitian Voluntary Exclusion, African Indefinite Deferral, Phenotyped Blood, and Black Women and Blood Donation. These meta-themes represent: Black immigration and Black Blood policies, Following Suit: American Directives, Activism to Repeal, and Racialized Diseases.

Black Immigration Waves and Policy Implementation Dates

A successive association was identified between the migration trends of Black populations into Canada, and the implementation of blood policies that disproportionately target Black populations. Said differently, influx of new Black populations consistently appeared to be followed by associated Black blood policy. See Table 1, and recall the Black immigration trends as outlined in the section Black History section of the review of literature.

The most indicative point of this trend, was that in recent years, as census data reports that Black immigration is now sourced from a number of nations, meaning that Black populations arrive from all over the world, presenting with complex migration stories. In line with this more global immigration trend, blood policies have also conspicuously moved away from ethnic and geographical policies, returning to all-encompassing Black racial policies, much like the initial Negro Ban (e.g. Phenotyped blood and Black Women and Blood Donation). This trend suggests that Black blood policies mirror the immigration cohorts. See Table 1.

Table 1

<u>“BLACK” POLICY IMPLEMENTATION DATES AND BLACK IMMIGRATION</u>		
<u>WAVES TO CANADA</u>		
IMMIGRATION WAVES		BLOOD POLICIES DATES
First Black Immigration (1930's)	→	Negro Segregation (1940-1970)
Caribbean Immigration (1970's and 1980's)	→	Haitian Voluntary Exclusion (1983 – 1990)
Sub-Sahara African Immigration (mid 1990's - Present)	→	African Indefinite Deferral (1997 – 2015)
Globalized Immigration of Black Populations (2000's - Present)	→	Phenotype Blood (2000 – Present) ----- Black Women and Blood Donation (2010-Present)

Canada Follows American Directives

The data confirm a pattern where Canadian blood policies followed American directives. With the exception of the BWBD program which at this time appears to be specific to HQ. This master narrative was manifested in the form of successive policy implementation dates, matching

terminologies, word sequence, and even policy inaccuracies, replicated almost identically throughout the Canadian data sets.

Table 2

<u>CANADIAN “BLACK” BLOOD POLICIES THAT FOLLOWED AMERICAN DIRECTIVES</u>		
AMERICAN DIRECTIVES		CANADIAN POLICIES
American Red Cross Society Jim Crow Policy	→	Negro Segregation
American Red Cross Society American 4H Ban	→	Haitian Voluntary Exclusion Canadian 4H Ban
Food and Drug Administration African HIV-O Indefinite Deferral	→	African HIV-O Indefinite Deferral
American Red Cross Society Blue Bag Tie Sickle Cell Anemia	→	Phenotype Blood (21 Day Process)
Black Women and Blood Donation	→	TBD

Table 2 demonstrates a pattern wherein Canadian health discourses are reliant upon the outsourcing of data from American governing bodies like the FDA and AABB. Canada is reliant upon their recommendations and their accreditations. It is integral to denote that this process of knowledge sharing is not exceptional to the named policies which disproportionately impact(ed)

Black populations. This practice was observed across a number of other blood donation policies (e.g. MSM, Chagas diseases, malaria and etc.). Nevertheless, in analyzing this “following suit” trend, particularly where Blacks in Canada are concerned, the data sources demonstrated that by swiftly adopting American policies, without taking into account the very complex demographics of Black populations in Canada, said policies have had adverse donor ramifications for Canadian Black populations in a manner that is not observed in the United States— at times deferring a disproportionate number of the total Black population from blood donation in Canada.

This process of following suit is a pertinent one, it speaks to the homogenization of Blackness. In that, it is imperative to grasp that a shared complexion does not equal a shared ethnicity, nor does it equate to automatic shared patterns of health, especially when mediated by international borders, where histories, patterns of migration, socio-economic statuses, climate, and access to resources vary regionally, let alone internationally, as are the case for said populations in Canada and the United States.

Interestingly, the data demonstrate that while Canada followed suit, this trend was unidirectional. The data confirm that in the US, the CDCP removed Haitians from the list of at-risk groups in April 1985. While in Canada, the 1988 questionnaire used by the CRCS, maintained an exclusion note for those who, since 1977, had lived in a region where AIDS cases were more frequent, although it did not explicitly mention Haiti. Officially, this note no longer appeared on the questionnaire in 1994. Recall that this pattern was also evident with the HIV-O policy. For example, the FDA discontinued the African question in 2009, while the amended version of the policy remained in Canada until 2018.

Social Movements: Silence, Dissent, Amendments, and Policy Repeals

The data support a successive association where dissention or advocacy movements towards Black blood policy were soon thereafter followed by policy amendments and/or repeals.

Table 3

<u>“BLACK” BLOOD POLICY IMPLEMENTATION DATES AND LOBBYING DATES</u>		
BLOOD POLICY		ACTIVISM/REPEAL
Negro Segregation (1940-1960)	→	Civil Rights Movement (United States) Policy Repealed: 1960's
Haitian Voluntary Exclusion (1983 – 1990)	→	Haitian Revolt (United States & Canada) Policy Repealed: 1990
African Deferral (1997 – 2018)	→	Organizational/Academic Lobbying (SCAGO, CHS, Dr. Dryden, Paul Nijjar) 2010 - Present Policy Amended (only Togo Cameroon deferred): 2015 Policy Repealed: 2018
Phenotype Blood – Sickle Cell Anemia (2000 – Present)	→	N/A
Black Women and Blood Donation (2010-Present)	→	N/A

The African policy was the most indicative in establishing this trend. For a period of approximately 12 years, from 1998 to 2010, the data demonstrate that this policy went without public or academic surveillance in Canada. Note the table and timeline.

The Timeline

1998

- York University students and faculty condemn Canadian Blood Services as homophobic and racist. Subsequently, October 26 and 29th clinics were cancelled.

2010

- Dryden (2010) publishes the academic article titled, *Canadians Denied: A Queer Diasporic Analysis of the Canadian Blood Donor*.
- Paul Nijjar publishes a blog titled *Black People: Please Give Blood (Unless You're African)*.

2012

- CHS publishes the *HIV-O Deferral in Africa, Issue Document: Deferral of Donors Who Lived in Africa and Visited Africa since 1977*.
- Letter addressed to Director of the Centre for Blood and Tissues Evaluation written by Ms. Tunji-Ajayi the Sickle Cell Disease Association of Canada, re: Canada's position on HIV-O policy, December 17, 2012.

2013

- Letter addressed to Director of the Centre for Blood and Tissues Evaluation written by Ms. Tunji-Ajayi the Sickle Cell Disease Association of Canada, re: Canada's position on HIV-O policy, March 14, 2013.
- Letter addressed to Ms. Tunji-Ajayi of Sickle Cell Disease Association of Canada written by Dr. Gantz of Health Canada, re: Canada's position on the HIV-O policy, June 11, 2013.

2015 Indefinite Deferral of 8 African countries repealed. Togo and Cameroon subject to temporary deferrals.

- Letter addressed to Ms. Tunji-Ajayi Sickle Cell Disease Association of Canada written by Leah Hollins of Canadian Blood Services, December 16, 2015.
- Letter addressed to Ms. Tunji-Ajayi Sickle Cell Disease Association of Canada written by Mindy Goldman of Canadian Blood Services, December 10, 2015.
- The Varsity, publishes an article titled *End the Ban campaign questions blood donation policy*.
- Dryden (2015) publishes *Disrupting Queer Inclusion: Canadian Homonationalisms and the Politics of Belonging* re: Black MSM.

2016

- The Ethnic Aisle, The Blood Issue Spring 2016, publishes the article *Bad Blood: Why does Canada still reject queer and immigrant blood?*
- CBS News June 15, 2016 publishes article: *Blood donation screening needs to change: Sudbury researcher*.
- Dryden (2016) publishes doctoral dissertation titled *Unrepresentable Blood: Canadian Blood Donation, "Gay Blood" and the Queerness of Blackness*.

2017

- CBS news publishes article *Sudbury researcher says blood donation questions 'racist' unfairly target gay men*.
- Dryden awarded 400,000 grant from CBS, research topic, ACB in blood DHQ.

2018 Togo and Cameroon Policy Repealed: African related questions are no longer in circulation.

The explanations for the policy amendment and repeals were cited as “international HIV surveillance and the latest scientific evidence showing these areas are no longer at high risk of variant strains of HIV” as the reasoning (CBS, 2018). All the same, comprehensively, the successive associations outlined above, suggest that policy amendments and repeals may not

entirely of been based upon only scientific evidence. In referencing “the possibility of modifying the questionnaire for donors who have travelled to certain African countries,” the 2011-2012 CBS Annual Report corroborates that scientific technologies were no longer the reason that the policy was still in place. Note the communication.

Given the fact that screening tests have been used for several years to detect HIV-O, the questions about trips to African countries where this virus is present are unnecessary.

Separately, in respect to phenotype blood policies, at this time, in Canada, there is no documented social or academic movements uncovered, that subjects these Black donation policies and procedures to question. Internationally, in the UK, the NHS has received some public backlash. Additionally, for the US, recently, as of 2017-2018, the ARC website has removed the Blue Blood Tag program which was once hypervisible.

Racialization of Disease

The data demonstrate that policies which disproportionately impact Black populations were always associated to diseases or disorders that are said to impact especially their racial population. In reference to disease traits, characteristics, qualities, and features attributed to Black populations were as follows: rare blood, phenotype blood, low hemoglobin¹, HIV/AIDS, HIV-O, newly emerging strains of HIV, and sickle cell traits and disease.

Table 4

<u>BLACK BLOOD POLICIES AND RACIALIZED DISEASES</u>		
BLOOD POLICY		DISEASE
Negro Segregation (1940-1970)	→	Syphilis
Haitian Voluntary Exclusion (1983 – 1990)	→	HIV/AIDS
African Indefinite Deferral (1997 – 2015)	→	HIV-1 Group O and Emergent Strains of HIV
Phenotype Blood – Sickle Cell Anemia (2000 – Present)	→	Sickle Cell Disease Sickle Cell Traits
Black Women and Blood Donation (2010-Present)	→	Low Hemoglobin1 (Iron Deficiency)

In the data sets, sickle-cell anemia and traits were the most prolific conditions cited, followed by HIV-O, emergent strains of HIV, and to a much lesser extent, low hemoglobin1. These diseases and conditions were one of the ways in which genetic differences between the general donor population and Blacks were delineated.

This association of particular diseases with the Black racial groups was a central part of the data, identifying the so-called immutable differences between Blacks and the general population. In that, the notion of racial disease factored heavily into initiatives to facilitate Black

to Black blood donation, Black blood donor demands, the indefinite deferrals of Africans, and the barring of Negro blood in the early days of the transfusion system.



Figure 17. Contact information for “Women in Black Communities wanting to learn and register for the program for Black Women.”

Source: Bulletin for Volunteers, Donors and Partners of Héma Québec Fall 2017 Edition.

The data demonstrated a pattern wherein HQ was especially forward in naming and racializing diseases to Black populations. For them, where Black populations were cited or depicted it was always in association to a racialized disease or rare blood traits. Furthermore, the representation of these images were either exclusively related to the *Cultural Communities* category in association to sickle cell disease or the BWBD program. In contrast, images of White persons were represented indiscriminately throughout their publications.

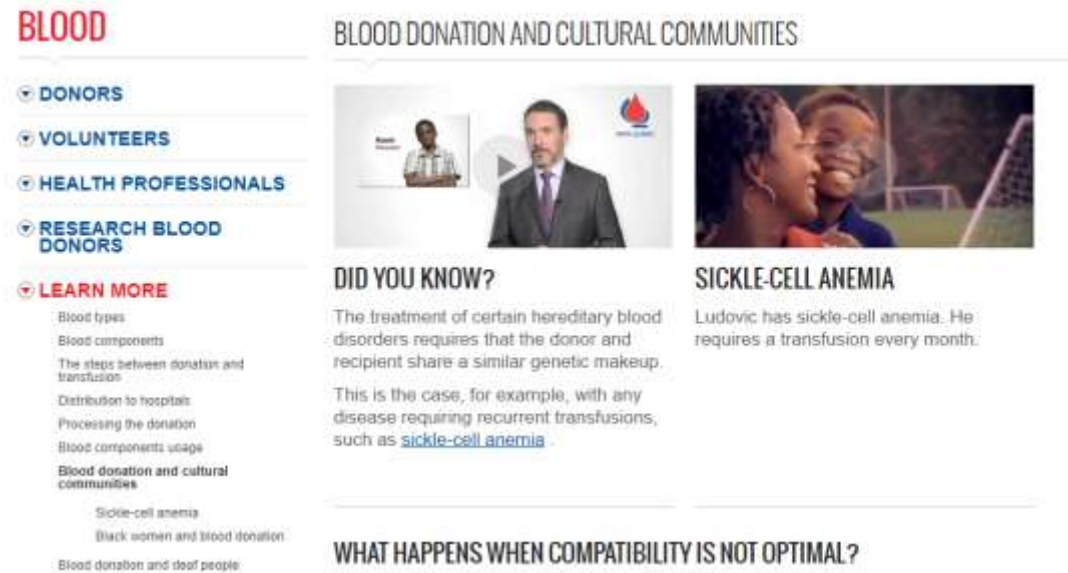


Figure 18. HQ Blood Donation and Cultural Communities webpage

Source: HQ Website 2018, <https://www.youtube.com/watch?v=K3rgMyTcyGM>

Immediately, from Figure 18 notice the patient- healer (expert) dynamics, represented by the imbalanced scaling of racialized and non-racialized persons. Dr. Marc Germaine (Vice President of Medical Affairs), a White adult male dressed in formal attire, as the narrator, explains HQ's position on the significance of blood donation and cultural communities. In the video display, he is presented in juxtaposition to a smaller and subsidiary image of an informally dressed juvenile Black male. The power imbalance is apparent.

This imbalance remained a consistent theme throughout the 1:21 video clip titled *Did You Know?* As Dr. Germaine speaks the transcribed text below, eight subsidiary images of ethnic individuals flash in and out of view in the background, of the eight individuals, one is Asian, three were Other (e.g. South Asian and/or Middle Eastern), and four, half, were Black individuals. Note that the sole White representation (the doctor and narrator) was the only permanent fixture throughout the clip. His articulations were transcribed as follows:

In general, when it comes to blood transfusions, ethnic origin and skin colour make no difference, but there are exceptions, everyone knows the importance of selecting blood type A, B, O when providing a transfusion, there are other blood groups however, and choosing the right ones can prevent a severe transfusion reaction for anyone receiving blood on a regular basis. In this situation, a donor must be found who matches the recipient for these other blood groups. It is important to understand that the closer the genetic makeup of a donor and the recipient, better are the chances of a successful transfusion. For example, if a member of the Black community requires frequent blood transfusion, it is easier to find a compatible donor within that same community. For this reason Quebec's blood supply requires more donors from all the various communities. It is therefore important to make everyone aware that they can save lives by giving blood. Regardless of your ethnic origin or skin color, your gift of blood is vital, your generosity will help a sick person who needs a transfusion. Please give blood, give life. (HQ, Blood Donation and Cultural Communities, Video *Did You Know?*).

The disproportionate representation (or hyper-visualization) of Black individuals in this clip was consistent throughout HQ data sets. This was another instance wherein the universal appeals to cultural communities often implicitly zeroed in on Black communities (Black exceptionalism) by naming them in examples or disproportionately representing them in imageries. Recall that the title, *Blood Donation and Cultural Communities* was not exclusive to Black populations. However, take note that the excerpt again noted the Black community as the archetype, the model for racial genetic incompatibilities. Furthermore, from the excerpt above,

take note of the discourse of binary polarization employed where the A, B, O blood groups are pegged against *other* blood groups. Notice that other blood groups, which pertain to cultural communities, are presented with a level of ambiguity, which are mentioned, but never explained.

The fact that no other racial groups were represented as having specific race based blood demands, affirms the Black racial classification as the targeted population. In fact, the Stem Cell Donor Registry and Public Blood Cord, were the only places that other racial groups were named; and even there, the racial representations depicted perpetuated archaic colour symbols of racial groups (see Figure 19).

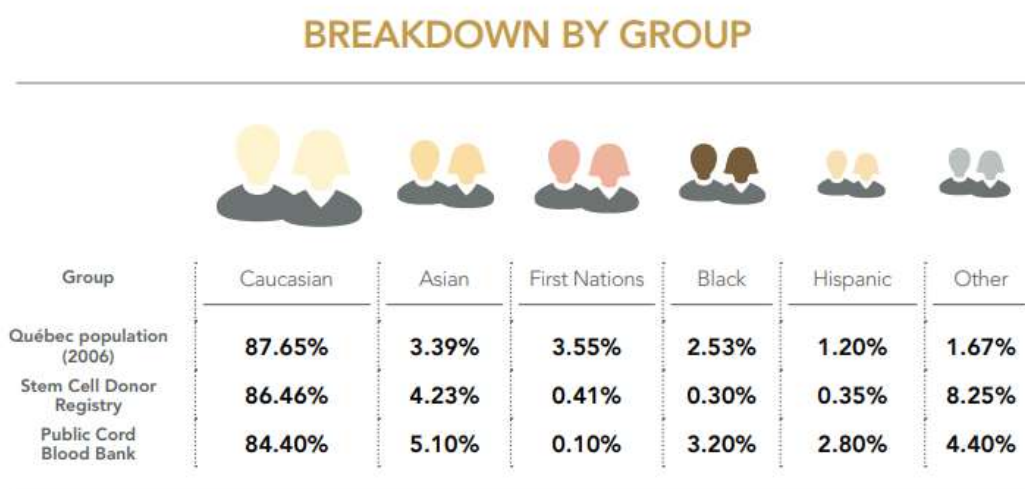


Figure 18. Stem Cell Donor Registry and Public Blood Cord, Héma Quebec: Annual Report 2015-2016

In contrast to HQ, CBS's (2013-2018) publications demonstrate an implicit approach to the administration of the Black racial classification. For example, when it came to CBS and Black blood demands, there was a contradictory discourse. It was noted that all of the CBS appeals to the Black racial classification were reported solely via third parties, namely media

sources. Noticeably absent were racial or ethnic donor requirements and/or blood programs, as well as sickle cell awareness campaigns.

Another interesting point is that in the recently added *rare blood* category, CBS (2018) again opted to not reference race or ethnicity in blood donation, instead they tactically represented the rare blood category with the image of a Black individual. Important to note that this is not an innocuous placement, it is a *strategy of implication* in action (see Figure 20). Again, recall with CBS, the only reference ever made to race and ethnicity was represented in the now repealed HIV-O policy. These interplays of (in)visibility are *strategies of mitigation and intensification*.

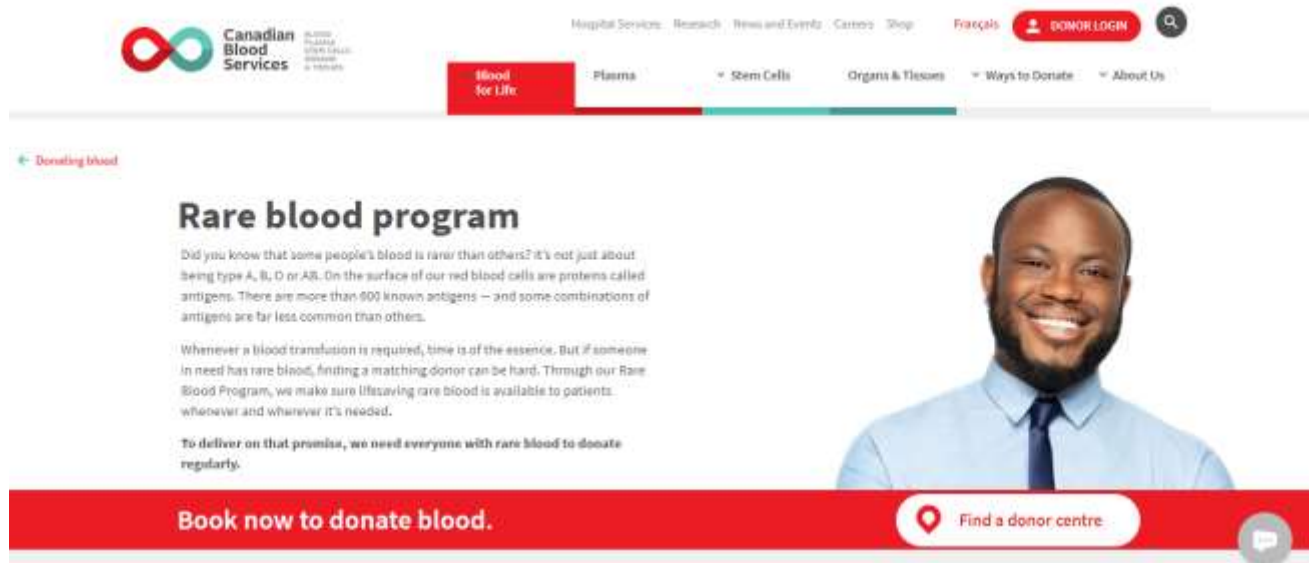


Figure 20. CBS (2018) website, Rare Blood Program depicting image of Black individual.

In concluding this results and analysis chapter, and in an effort to rationalize the aggregate of the data results, I draw from Dryden (n.d.), where she cites Hall (1997), asserting that here in Canada, “the [B]lack body remains a site of spectacle... a body constituted through a variety of images and narratives that attempt to cement Black people within a time of “there or

then” and in spaces and places outside of the norm (p.8). With this inference, I observe along with the results, that the “spectacle of Blackness” in the blood system is framed through a historical discourse of “the slave institutional, colonial, and Eurocentric narratives of Black bodies” that associate Blackness to a “certain sense of decay,” a decay that must be prevented from tainting the blood system (p.8).

CHAPTER FIVE: DISSCUSSION

Spoiled Performances: The Bureaucratization of Negrophobia

“Everything is never said”

-Foucault 1972

Based on the aggregate of the data results, it is my position that the blood system is at best culturally insensitive, at worst it implicitly perpetuates racist assumptions of Black populations (Nijjar, 2010, 2013). Unquestionably, there is an overwhelming discourse of difference afforded to the Black racial classification in the blood operation, supporting a pattern wherein the general population can donate blood more readily, while placing uniquely restrictive barriers on the Black racial classification, rendering them subject to incessant measures of surveillance.

In brief, the results indicated that the blood system continues to (re)produce the long-lasting ideological discourses that racialize and biologize Black populations as different than the norm. The data trends consistently revealed an eerie pattern of either segregation, surveillance, exclusion, and/or differentiation that is specific to this racialized population, again in a manner that was not observed across any other racial groups. Consistently, it was observed that Black blood policies were “framed as a safeguard against infecting the general population, a claim that echoes” and revisits historical representations of Black populations as vectors of disease, providing a bridge to bring exotic disease to the general population (Flatt, 2015, p.239). Note that these results were in concert with the findings of numerous discursive representation studies that support that racist ideological discourses about Black population continue to be recycled throughout Western institutions (Washington, 2006).

Recall that from the inauguration of the banking system, the Black racial classification was constructed and constrained by an institutional commitment to a hierarchal racial worldview. Blood policies mimicked the social system, obfuscating the existence of the Black body as recalcitrant, and in need of benevolent control (Finley, 2009, p.31). This resulted in the Negro Segregation, a direct response to explicitly “imposed racial conditions of existence that distorted and disfigured [B]lack bodies” in the blood operation (p.3). My argument maintains that much like today’s Black blood policies, the Negro policies mimicked the social system, making the existence of a recalcitrant and agential body highly unlikely or at best obscuring and obfuscating its possibilities (p.31).

With this historical memory at the forefront of my attention, I posit that based on the data results (with the exception of the Negro Segregation), of the policies which disproportionately impact(ed) and/or target Black populations represented in the results chapter as the Haitian Voluntary Exclusion; the African Indefinite Deferral; Phenotyped Blood; and Black Women and Blood Donation, I found none to be explicitly racist.

Nevertheless, I recognize this absence of overt racism to be an absolutely intentional by-product of present-day race relations. In no way have negative racial constructions of Blacks miraculously vanished, the literature has proven so, it is replete with such accounts. Lest we forget, this is a moment of racism without racists, where everything is never said. With the fall of colonialism, and an exponential increase in globalization, the flagrant anti-Black hostilities of past decades have gentled across the globe. Consequentially, the overtness of past racial antagonism in the blood system have also drastically fallen out of favour among blood operators in Canada and elsewhere (Goff et al., 2008, p.292. Building upon Berthold (2010), I reason that racially framed policies of blood donation are not innocuous, but they are carefully and

meticulously crafted as to not evoke adverse racial reactions, as once observed with the implementation of past Black centered policies. Hence, for this discussion, with a marriage of Goffman's dramaturgical tools and Douglas's purity ideals, I put forward the plausibility of a *spoiled performance* in the interaction order of the blood system, which I maintain reflects and effects the broader society.

Two-Faced Race Relations

Originally rooted in symbolic interactionism, Goffman's (1956) dramaturgical theory is a micro-sociological perspective wherein the theory examines the meaning of interaction orders within interpersonal contexts and their symbolism. This theory has proven appropriate in a race context, in *The Presentation of Self in Everyday Life*, he provides a plethora of references, among those references, the topic of race, and in particular, the topic of the Black racial classification (then referred to as Negro) is not lost on him.

His analysis includes three such examples. The first engages the interplay of racial epithets, precisely the process wherein individuals refrain from employing *nigger* in the presence of a Negro, but do so at liberty otherwise (p.110). Another example speaks to the southern race etiquette, where at the time, "a Negro may [have called] his [W]hite fellow-worker by his first name, but when other [W]hites approach it is understood that mistering will be reintroduced" (p.48). Lastly, the third example runs parallel to the latter mentioned. In this particular instance, Goffman (1956) provides an analysis of the inter-racial relations of the desegregated workplace, speaking particularly to instances where racist colleagues are forced to entertain relations with the "professional Negro, who is "of [a] so despised a group" (p.104).

Building upon said examples, alongside Houts's (2004) more recent dramaturgical analysis on race, again *Backstage, Frontstage Interactions: Everyday Racial Events and White College Students*, I too establish the applicability of race in a dramaturgical project, and put forward the notion "that everyday interactions in the frontstage and backstage are not tangential to the social structure," but in fact they make up the racialized social structure, within the context of structural and institutional racism (pp.8-9).

In that, I employ the sum of Goffman's (1956) theory macrosocially, and magnified his otherwise interpersonal examples of Negro interactions structurally, to understand the operationalization of the Black racial classification in the blood system, as a manifestation of the societal and/or blood system's backstage. That is, I put forward that institutions and society, much like individuals, use impression management to sustain a performance that fits the requirements of the broader contemporary culture. Furthermore, as outlined in the review of literature, as a population that has traversed through a number of maafas, gripped in a unique history of racial domination, I understand that Goffman's (1956) attention to the interaction of the Negro substantiates the complex trajectories of this particular racial group. His Negro examples indicate that this racial classification, and its peoples, have historically, and as the results demonstrated continue to navigate the many dimensions of interaction orders in manners that no other racial group experience.

The dramaturgical lens is straightforward, it advances "that people use impression management... to sustain a performance that fits the requirements of a particular situation" (Houts, 2004, p.7). "As though we are actors on a stage, [the theory suggests] that there are two structural features of dramaturgy:" the front region and the back region (p.7). In the front region (hereafter frontstage), individuals and groups— *performance teams*— "perform the roles that

leads the audience to form an impression” (p.8). In Goffman’s (1959) words, as cited in Houts (2004), the frontstage is “that part of the individual’s [or team’s] performance which regularly functions in a general and fixed fashion to define the situation for those who observe the performance” (p.8). Furthermore, it is imperative to note “that in the front, performers typically conceal behaviours, attitudes, and emotions that can be expressed in the backstage” (p.8).

In contrast to the front, the backstage is defined as the location “where the impression fostered by the performance is knowingly contradicted” and “where the performer can reliably expect that no member of the audience will intrude” (Goffman, 1959, pp.112-113, as cited in Houts, 2004, p.8). In her extension of the theory, Houts (2004) explains that “[e]rrors and mistakes are often corrected in the backstage before the frontstage performance. The backstage is characterized by a less formal atmosphere, where the actors can openly violate expected roles of behaviors” (p.8). It is imperative to note that “there is a critical barrier between the frontstage and the backstage, for if the two intersect (such as when an outsider intrudes into the backstage), it leads to a spoiled performance” (p.8). The theory dictates that when mismanaged (spoiled) performances occur, “remedies must be made, such as performing a new role fit for the intruder or offering an aligning action or verbal account” (p.8).

With that established, I concede that the authentic essence of the racial order in our society is revealed in the administration and/or operationalization of the Black racial classification within the blood system. Examining the indices found at what I conceived to be the frontstage, in consortium with a historical narrative, I envision the plausibility of the backstage of the blood system. In that, I particularly engage the historical race structures of the blood system to make intelligible the more contemporary structure. By incorporating the comprehensive scope of Black blood policies in Canada, inclusive of the five narratives

introduced in the results chapter, I look to the case of the Negro segregation as the starting point of my analysis. The explicit narratives in this inaugural policy, by Douglas's definition, may lead us to a genuine blueprint or schemata of all the subsequent policies which disproportionately impact Black populations in the blood system. With that in mind, I take into account all the classical purity ideals—inferiority, biologized difference, contamination, and mongrelisation—of the Negro policy and conclude, much like Dryden, that they continue to inform current Black blood policies, albeit implicitly.

With that, beyond the Negro policy, I constitute that the blood system has never stopped being a site of White normativity that occludes normative Black donorship (Yancy, 2016, p.xviii.). I further maintain that the blood system, much like the broader society, is White-controlled, White-normed, and in consequence, it is slanted toward White interests (Feagin, 2010, p.139). With Feagin's (2010) literature on the White racial frame, more specifically, his conceptions of *anti-Black framing*, I add that the centrality of White interests has been a fascination with the subordination of the Black racial classification (p.56). Thus, I suggest that these frames of accepted views of oppression vis-a-vis the Black racial classification have blended with the ordinary bureaucratic frame of the blood system, producing a societal concept that this racial interplay of geneticized difference and racialized diseases, are just a normative routines of organizational operation (p.139).

The embeddedness of the Black racial classification and its constructions is a force to be reckoned with. Its essence is just so fundamental to our construction of race, it actually makes it very difficult and abstract to dissociate the Black racial classification as anything but the Other; so much so that the literature on implicit bias, has demonstrated that even Black populations internalize the negative biases imposed on their very own racial classification. This is an

authoritative rationalizing structure that frames racial ideas, notions, images, and I argue policy into the everyday operation of organizational structures of the blood system (Feagin, 2010, p.138). I reinforce this with Yancy's (2016) comments, which maintain "that predominantly White monochromatic spaces," like the blood system in this case, "while oppressive vis-à-vis Black people... can often operate in ways that don't bring attention to their oppressive ways" (p.8). Compounding these comments, with the conceptions of moral purity, as outlined by Berthold (2011) and Dryden (2016), I concede that the governing administration of the Black racial classification, is fundamentally entrenched in the symbolism of purity ideals, said differently, this is the idea that the fear that racial ideologies and constructions of Blacks are detrimental to the value system of Canadian society.

With that established, I theorise that a successful Negrophobic performance is underway in the backstage of the blood system, and with careful attention, by way of a CDA in this case, it became quite evident in the frontstage. It is my position that this continued success has been contingent on the blood system's ability to convince the audience, us in this case, of a neutral position on the Black race. In that, I observe the deployment of frontstage props to be the highly scientific terminologies that racialize and geneticize *Black blood*, always justified adjacently to mantras and disclaimers of the sameness of blood. Furthermore, I maintain that this type of contradictory discourse is judiciously situated to moderate the authentic vulgarity of racism concealed to the backstage, which I understand to be the fundamentality of Black blood policies in Canada.

To the lay observer, the racial indications associated with Black blood are either accepted with general indifference or collaboratively in a revered scientized *separate but equal* discourse. This, I find to be a product of the backstage preparation, put in place to ensure that should race

come into question, it can be rebutted with claims of scientized risk language. To that, I respond that the general indifference or collaboration in institutionalized racial events are the patterns of contemporary racial discrimination and inequality. Simply stated, these Black blood policies continue to thrive going unnoticed because they remain highly organized and institutionalized, operating in tandem with societies value system (backstage), wherein the disqualification of this particular racial group is the norm rather than the exception (Feagin, 2010, p.139).

With a macrosocial application of dramaturgy, I looked beyond what the blood system wanted us to consume at the frontstage; taking a more meticulous look at the discourses that inform their policies and procedures in a critical race context to understand the role of the Black race. I find that the data results uncovered in the results section are non-other than spoiled performances.

In addition to the results outlined, perhaps the most telling revelation of the racial backstage of the blood system is the fact that there has never been a time in the history of the blood system where Black populations have been able to donate blood without some sort of impunity or special characterization, and I mean never. The timeline narrates this clearly. Be it the overtly racist policies of the Negro segregation, or the ethnic ban of Haitian donors, to the indefinite deferral of sub-Saharan African source countries, to the more recent demands for phenotyped Black blood, the Black racial classification is, and has been treated with suspicion. Again without ever categorically pronouncing the overt, Black blood is not the same. The measures of control adopted for Black populations have been comprehensive and longstanding.

Since explicit racism is just no longer the way in which we administer the Black race, Galeotti (1993) explains that in contemporary climates of discrimination, instances like racism, require exceptional “reasons to present a discriminatory viewpoint” (as cited in Flatt, 2015,

p.49). This means to say that to legitimize a discriminatory utterance, the differential racial treatment has to represent “something that is in some way necessary to guard against a potential threat or harm” (McClure, 1990, as cited in Flatt, 2015, p.49). Building upon these comments, my position maintains that the blood operation embodies a belief system of biological difference between Black populations in juxtaposition to all other racial groups. Such assumptions perpetuate representations of Black populations in a manner that hinders their ability to participate equitably in blood donation and elsewhere. In turn, this facilitates a differential treatment that is afforded explicitly to the Black racial classification. I identify this exceptional racial process as institutionalized (or bureaucratized) Negrophobia.

Much in the same manner as Morin and Garfinkle’s (1978) definition of structural homophobia, Negrophobia, while it is often simply understood as a fear or aversion of Black peoples, again in a structural context, it is a discriminatory process “that allows for overt, legal, and socially-sanctioned discrimination against” the Black racial classification (as cited in Flatt, 2015, p.238). Integrated to the blood system, like Flatt’s (2015) discussion on homophobia, I too find that the conception of institutionalized Negrophobia “resituate[s] the understanding of [racial] beliefs and practices into the realm of social behavior” (p.238). This means to say that, “[b]ehaviors, attitudes, and beliefs that are treated as coming within societal values, more accurately, resulting from, at least in part, from the overarching social structure in which” the institution, the blood system, is situated (p.238). This points to the reality that the racial frames, associated with the Black racial classification, albeit refurbished or altered, remain powerful and pervasive across the blood system. Thus, it is my position that the fundamentality of these new policies echo the very same underlying narratives of the inferiorized, diseased, and risky racial Other that were once openly dictated during a particularly epoch where it was appropriate to do

so. Thus, I conclude that there is little to no difference between the Negro segregation and the more recent Black blood policies. Quite simply, it is the discourse— language, administration, and the genetic justifications— that have gentled, presented in lingos of tolerance. Nevertheless, at their fundamentality, the processes have proven to be discursive, remaining the same— the systematic exclusion and differentiation of the Black racial classification— albeit implicitly.

CHAPTER SIX: CONCLUSION

“Critiques lead to improvement, growth ultimately makes us better equipped to serve every body. It is my sincere hope that, as you look[ed] and... read the stories, you... [have] become more comfortable with being uncomfortable.”

-Franchesca Hebert- Spence

For this project, I set out to examine the place of the Black racial classification in the Canadian blood system. In doing so, much like Flatt (2015), my intention was also to scrutinize risk claims of medical discourses of objectivity in policies and procedures of blood donation. The principal research question asked if donation policies and procedures, that (in)directly target(ed) Black populations, create a space for the maintenance and reproduction of Negrophobia and/or racism within the Canadian blood system. With this question, I resituated the concept of Negrophobia as a social problem, not merely an aspect of individual attitudes, but of one that is reflective of larger social processes (p.237).

Together, the research question and sub-questions were designed to ask whether the policy language and discourse used to administer Black population in blood donation may have been based on purity and racial beliefs about risk, and whether these questions, in practice, operate in ways that may reinforce racist assumptions about Black populations (Flatt, 2015). In that, as detailed in the results section, I uncovered a number of patterns and representations that I found to be consistent with the processes of structural Negrophobia.

Using CDA as the primary vehicle of analysis, an inductive qualitative research design, I was able to pinpoint how institutionalized practices can be detected within this aspect of the Canadian blood system, unveiling underlying institutionalized assumptions that have been written into official policy, and manifest in at number of micro and macro levels (Flatt, 2015). In

that, I was able to iteratively engage the historicity of the concept of the Black body politic, particularly what the scripting of this body reveals about embedded racial tendencies that are redistributed and recycled in mass-mediated cultural and institutional practices. Ultimately, this methodological approach helped to recount the genesis of the Black phenomenon, while mapping contemporary parallels and grappling age-old problems revisited (Jackson, 2006, p.9). Like Jackson (2006), I found that applying this mode of inquiry for examining Black populations was “valuable and transitive,” providing the ability to support reformulations and reconstructions of knowledge, in addition to shedding light on the sociopolitical machinery that function to perpetuate historically concomitant ideologies (p.10).

In conclusion, it should be recognised that there is a real perception problem about Black populations in the discourses of the blood operation. It is my contention that the Canadian blood operation has a very real image problem, where consistently, potential donors that are Black have historically, and continue to face a much more adverse welcome than all other potential donors (Nijjar, 2010, 2013). With the data presented, disclaiming language about not discriminating against race and ethnicity has proven to be implausible. A simple look at the history of donation policies and their disproportionate impact on Black populations in their context, as well as comprehensively, as was outlined in this thesis, corroborates that a serious aversion towards this racial population has been discursively at play. Fundamentally, if the desire is to truly recruit more Black donors, I echo Nijjar (2013), the blood operation should acknowledge how their historical and contemporary screening procedures and policy discourses have affected and continue to affect Black donorship.

Limitations

Admittedly, this research topic is limited by way of existing literature. As noted in the review of the literature, this is essentially an untouched area of scholarship, with only one other scholar, Dryden (2010, 2015, 2016) publishing critically on Black narratives within the blood system in Canada. To further exasperate this limitation, blood operators are not very transparent around current and retired policies that disproportionately impact Black populations. Unlike the MSM policies, information was not readily available. Agonizingly, said policies are either invisible, or hypervisible always presented with limited context, with the historical literature on Black history in the blood system noticeably absent in the publicly accessible Canadian archives of blood literature. Accordingly, in an effort to mitigate the gaps in the Canadian literature, key parallels had to be drawn from the American blood literature compounded with various other scholarly articles that touch on MSM policies.

Future Research

In an effort to capture the Black specific discourse(s) at play in the blood system, by design, efforts were concentrated on the narratives brought out of publically accessible data sources. Subsequent research on the blood system and Black populations would benefit from an ethnography of archives of the Canadian Red Cross Society, Canadian Blood Services, and/or Héma Quebec. Unrestricted access to internal data sources, such as meeting minutes, images, retired questionnaires, and policy language would bring forth an added dimension to studies of Black populations that otherwise were not accessible for the scope of this thesis project.

Furthermore, an analysis of the *internal* discourse in juxtaposition to the *external* discourse would be of value to the analysis of current policies.

Additionally, future research should also look to undertake individual case studies of the Negro Segregation, The Haitian Voluntary Ban, the African Indefinite Deferral, Phenotyped Blood and Sickle Cell, and Black Women and Blood Donation policies. Beyond the association of disproportionate impacts on Black populations, each case has complex intersectional points of analysis that necessitate more concentrated examinations.

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