

Blood Donation and Community: Exploring the Influence of Social Capital*

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ABSTRACT

Previous social research on blood donation has found that altruistic personality traits are associated with a higher likelihood of donation. However, such research does not adequately explain why campaigns appealing to altruism have had limited success in significantly increasing blood donation rates. Using the concept of social capital, this study conceptualizes blood donation as a social phenomenon that is embedded in the context of community. It reports on the activities of Canada's national blood donation agency in two cities with substantially above-average rates of blood donation. Data were gathered through in-depth interviews with staff and selected donors and non-donors in each city and from ethnographic observation of blood collection and donor recruitment activities. These activities eschewed conventional appeals to altruism, instead emphasizing how individuals could meaningfully enhance their profiles in their community and workplace through blood donation. This study offers valuable insights into the influence of social capital on blood donation.

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INTRODUCTION

Each year, Canadian Blood Services (CBS), the agency that manages Canada's blood system, supplies transfusions of whole blood and blood products for a wide range of critical medical conditions, including massive blood loss from trauma injuries and blood replacement needed in cancer treatment, surgery, and organ transplants (Canadian Blood Services, 2011). CBS operates 40 permanent collection sites and over 20,000 donor clinics annually, and oversees the safety of the blood supply and recruits blood donors (Saberton, Páez, Newbold, and Heddle, 2009). Despite extensive promotion to encourage blood donation, however, the donating population has remained consistently low at approximately 3% to 4% of the total Canadian population (Godin et al., 2005). These low rates of blood donation will likely result in future blood shortages as the demand for blood increases due to an aging population, the emergence of new medical and surgical procedures requiring blood transfusions, and further deferrals of individuals who pose a contamination risk to the blood supply (Saberton et al., 2009). While this study focuses on the Canadian situation, blood donation programs across industrialized countries face similar challenges in recruiting blood donors and maintaining their blood supplies (see Davey, 2004; McKeever, Sweeny, & Staines, 2006; Murphy et al., 2004; Zou et al. 2008). These challenges make urgent the exploration of factors affecting blood donation in order to identify effective strategies for increasing the donor base and fulfilling future blood needs.

This study examines the blood collection and recruitment activities of CBS in two cities with above-average rates of blood donation compared to other cities in the same Canadian province. We examine these activities in the context of donors' and non-donors' community affiliations and theorize blood donation as being primarily influenced by the processes of social capital formation. Our argument is that individuals engage in blood donation less for intrinsic altruistic reasons than because their social networks and communities value and reward this activity.

Two broad objectives guide this study. First, we seek to identify the social capital processes that influence individuals' decisions to donate blood and how these differ from the processes that lead others not to donate. We argue

that blood donation is the contingent outcome of diverse relationships that can be mobilized by donor appeals. Second, we examine CBS's local strategies for recruiting donors and diversifying their donation base. While CBS conventionally relies on personal appeals to altruism to encourage individuals to donate (e.g. "Blood, it's in you to give!"; "Give the gift of life!"), we report on unique strategies used by CBS staff in our sample cities and document how these strategies effectively tie donation to meaningful aspects of donors' workplace and community.

In the following section, we provide an overview of the Canadian blood system in order to contextualize our study historically and structurally. We also discuss the tainted blood scandal, an important context for the restructuring of the Canadian blood system into its current state.

The Canadian Blood System

Canada's blood system traces its roots back to a partnership between the Canadian Red Cross (CRC) and Connaught Laboratories, a company that in the 1940s developed a process for manufacturing freeze-dried human serum for use on WWII battlefields (Picard, 1998). The CRC became involved by supplying Connaught with blood collected from volunteer donors. At the end of the war, the CRC began expanding its donor program to supply blood to hospitals across the country. In 1973, it received a formal mandate and funding from the federal and provincial governments to operate Canada's blood system (Krever, 1997, pp. 43-46).

By the 1980s, the CRC was operating 17 blood centres and a large number of mobile clinics supporting blood drives in rural areas, community centres, churches, schools, legion halls, and factories. The CRC managed blood donation under two services (Krever, 1997, p. 210): Transfusion Services oversaw all activities pertaining to donor screening and the collection, testing, storage, and distribution of blood and blood products; Donor Recruitment Services managed donor recruitment, including advertising blood drives, greeting and registering donors, and monitoring donors post-donation. Under this organizational structure, the CRC collected sufficient blood from diverse donor bases across Canada to readily met the blood needs of Canadians (Krever, 1997).

This situation changed drastically in the early 1980s, when blood supplies in Canada and around the world were contaminated with the Human Immunodeficiency Virus (HIV). The CRC's initial response to this threat was timid: the CRC failed to implement measures to exclude individuals belonging to groups known to be at higher risk for HIV from donating blood. Instead, it asked donors to voluntarily refrain from donating blood if they believed their blood might present a risk to the blood supply (Krever, 1997, p. 286). Because many donors did not know they had been infected with HIV, however, they unintentionally donated contaminated blood. It was not until 1989 that the CRC began actively screening for HIV-related risk factors (e.g. asking donors if they had had sex with another man) and implementing tests of donated blood for the virus (Weinberg et al., 2002). By the early 1990s, an estimated 2,000 Canadians had become infected with HIV through contaminated blood transfusions (Picard, 1998). These events primarily affected individuals suffering from hemophilia because of their reliance on blood products: nearly half the population of Canadian hemophiliacs acquired HIV/AIDS from tainted transfusions before the CRC began screening and testing blood. This crisis diminished the public's confidence in the Canadian blood system and resulted in a dramatic decrease in rates of blood donation (Gilmore and Sommerville, 1999).

To investigate this crisis, the Canadian Federal Government appointed Justice Horace Krever to head the Commission of Inquiry on the Blood System in Canada (the Krever Inquiry). Between 1992 and 1996, the Krever Inquiry heard from 427 witnesses and produced 50,000 pages of testimony. Justice Krever (1997) concluded that "the Red Cross did not carry out risk-reduction measures assiduously" and deemed the measures taken "ineffective and half-hearted" (293-294). He argued that if regulatory officials had acted according to their mandate, many hemophiliacs would have avoided HIV infection. On 26 November 1997, Krever tabled a report in the House of Commons that contained 50 recommendations for overhauling the collection, processing, and management of blood in Canada. Krever (1997) insisted that the principle of safety should transcend all other principles and urged the implementation of the precautionary principle as a first line of defense against possible threats to the blood supply (1049).

In 1998, the federal, provincial, and territorial governments of Canada replaced the CRC with two new organizations to oversee the blood system: Canadian Blood Services (CBS) and Héma-Québec (HQ). CBS was established

in 1998 following a Memorandum of Understanding (MOU), whereas HQ was created to oversee collecting, processing, and distributing transfusion-ready blood and blood products in the province of Québec. Both agencies are nevertheless regulated by Health Canada and follow the same standards. Heeding Justice Krever's recommendation, these agencies have sought to restore public confidence in the Canadian blood system and to increase donation rates, which remained low in the wake of this health crisis.

As was the case with the CRC, CBS and HQ only collect blood from volunteer donors. The belief is that such donors are inherently safer than paid donors, who might have "a financial motive for giving blood even if they were not healthy enough to do so" (Krever, 1997, p. 211).

This policy of voluntary blood donation has roots in the work of sociologist Richard Titmuss (1972), who argued that "a competitive, materialistic, acquisitive society based on hierarchies of power and privilege ignores at its peril the life-giving impulse towards altruism" (7). In a landmark study, Titmuss compared the commercial blood system in the US with the voluntary system in England. He demonstrated that a blood system based on voluntarism was less likely to lead donors to misrepresent their health status at the time of donation. He also saw voluntary blood donation as an example of "the relationship of giving between human beings in its purest form, because people will give without expectations that they will necessarily be given to in return" (ibid, 8). For Titmuss, voluntary donation systems encouraged people to care for one another, thereby strengthening community bonds and, ultimately, contributing to a safer and more efficient blood supply.

Blood donation and social capital

In this section, we propose a model of blood donation in which the processes of social capital play a central role in the decision to donate or not to donate blood. This model contrasts with the currently dominant psychosocial explanations for blood donation, which postulate intrinsic altruism as the primary reason for individuals' blood donation (see Oswald, 1977; Lightman, 1981; Piliavin and Callero, 1991). Much research on donation and altruism aims to identify indicators for predicting patterns of repeat donation among the donor population. The most influential research in this regard comes from Piliavin (1987, 1990) and Piliavin and Callero (1991) who document an "altruistic identity" among repeat blood donors.

If altruism constituted such a strong explanation, however, blood donation rates would not vary according to social factors such as ethnicity, gender, education, income, occupation, religion, and age (see Shaz et al., 2009; Crawford et al., 2008). Altruism also fails to explain why the majority of the population does not donate blood or why donor recruitment campaigns based on appeals to intrinsic altruism are generally ineffective in significantly increasing blood donation rates. Indeed, Healy (2000, 2006) criticizes the concept of altruism, arguing that it reifies blood donors as a special class of morally superior people. He doubts the conceptual value of altruism in explaining donation because the personality traits of repeat donors are also commonly found in the non-donor population (Healy, 2000).

Our model rests on the premise that processes of social capital formation exert a primary influence on blood donation. Social capital forms in social networks when individuals with close social ties engage in behaviour that reaffirms and supports valued social relationships and the communities in which these relationships are formed (Granovetter, 1973; Putnam, 1995). This model thus situates the actions of blood donors and non-donors in the context of their social relationships (or “social networks”). Social networks constitute a primary source of social capital because network members provide a wide range of social support activities for one another (Lin, 2001; Wellman and Frank, 2001). These networks also foster patterns of trust and reciprocity among members—in that sense, social capital has both an individual and a collective aspect (Putnam, 2000: 19-20).

Grounding our analysis in processes of social capital formation, we argue that people are more likely to donate blood when they are embedded in trusted social networks that value blood donation. The decision to donate blood is therefore motivated less by intrinsic altruism and more by donors’ desire to act according to network norms and to maintain or enhance their status within these networks. Of course, networks can operate in ways that discourage individuals from donating blood if they do not support the value of donating blood. We propose, however, that blood agencies can seize advantage of these social capital formation processes to increase donation rates and to diversify their donor bases.

Our approach is inspired by Healy’s (2000) work, which compares the donor recruitment practices of state-run systems and those of Red Cross blood systems in the European Union. Healy found that state-run systems tend to

attract donor bases that represent the overall social composition of their countries, whereas Red Cross systems primarily attract donors with strong religious and community-service values. For Healy, these differences suggest how blood donation agencies influence the social processes of donation by representing the value of donation to their donor bases. He argues that the act of donating blood is not inherently altruistic; rather, donors come to think of their donation as an altruistic act because most blood agencies extensively promote this attribute in donor recruitment campaigns. The act of donating blood is thus “structured, promoted, and made logistically possible by organizations and institutions with a strong interest in producing it” (Healy, 2004, p. 387).

In a similar vein, Alessandrini (2007) significantly found that Australian blood donors tended to volunteer frequently and articulated a strong awareness of their influence as community members. Alessandrini posits blood donation as an aspect of identity construction whereby donors enhance their identity as full-fledged citizens “through participation in volunteering activities that provide rewards in and of themselves and also serve to further embed them in society through community involvement” (315). Alessandrini’s study thus suggests that blood donation may be prompted more by a desire to reaffirm one’s affiliation to community than by the presence of a uniquely altruistic personality.

In light of Healy’s and Alessandrini’s research, we propose that a social capital perspective on blood donation helps explain not only why some individuals choose to donate but also why most individuals choose not to donate blood, even in the face of urgent appeals by blood donation agencies. Such an explanation is important because any increases in donation rates will necessarily come from individuals who are eligible to donate but are currently reluctant or unwilling to do so. Existing research reports belief in medical ineligibility, apathy, inconvenience, general fear, and specific fear of HIV as reasons for non-donation (Oswalt 1977, 1977; Leibrecht et al., 1976; LoBello, 1990; Piliavin, 1990). However, other evidence casts doubt on the validity of these reasons, which people give when asked about why they do not donate blood. For example, one poll indicates that 87% of Canadians believe that not enough blood is donated, 77% find the blood system safer now than five years ago, and 90% believe the process of donating blood to be safe (Ipsos-Reid, 2001). If so many Canadians think blood donation is crucial, undersubscribed, and safe, then why do only 3% of them donate blood? To treat non-donors’

reasons for non-donation as expressions of some objective reality ignores the longstanding sociological literature dealing with vocabularies of motives (Mills, 1963; Stryker, 1980) and the way in which socially acceptable “accounts” (Scott and Lyman, 1968) are provided as reflections of acceptable social norms, rather than as inherent causal contingencies. These reasons should therefore be considered a “mask” (Strauss, 1959) for more deeply held views that donors are reluctant to express for fear of disapproval in their social network.

In summary, although intrinsic altruism may play a role in the motivation to donate blood, we argue that social context likely exerts a stronger influence in this disposition. We therefore explore the formative role of the processes of social capital formation in blood donation, focusing on how social context operates to make the decision to donate blood more likely and how these processes differ from the ones involved in the decision not to donate blood. We also examine how CBS uses these processes in its efforts to recruit donors. Following Healy’s suggestion that collection regimes produce different donor populations, we seek to better understand how donor recruitment practices at the CBS constitute “incentives” to donation (Healy, 2000, 1634).

Methodology

This study constitutes part of a larger research project comparing blood collection and donor recruitment among 5 cities with substantial differences in blood donation rates. In this paper, we focus on the activities of two donor clinics (A and B) operating in two cities surrounded by large, dispersed catchment areas. Both clinics operate out of permanent sites but also run mobile clinics to serve their catchment areas. We selected these clinics for our current investigation because the two cities in which they operate consistently report blood donation rates that are 70% higher than those of the other cities in our sample. Investigating these clinics allowed us to identify how CBS personnel operated to take advantage of, and even create, situations that increase blood donation in their communities and how they overcame barriers that impede blood donation.

Data collection involved field observation of donor recruitment and blood collection activities, as well as in-depth interviews with CBS staff and selected donors and non-donors. We observed a range of donor recruitment activities in businesses and in not-for-profit and public sector organizations. We

observed blood collection activities at the clinics over two periods of 3-days each. We conducted 16 in-depth interviews with CBS employees (nurses, management personnel, community recruitment staff, and volunteers). We also completed interviews with 28 donors and 11 non-donors across both cities. We asked these participants about their motivation to donate blood or about their reasons for not donating blood.

All interviews were audio recorded and transcribed verbatim. The transcripts were line-numbered and coded using the principles of thematic analysis (Spencer, Ritchie & O'Connor, 2003). The transcripts were scrutinized for recurrent and salient themes, which were then clustered into increasingly refined analytical categories on the basis of shared meaning. These categories inform our account of participants' views about blood donation. More profoundly, these categories also capture how blood donation and recruitment activities are related to the processes of social capital formation in our sample. We illustrate these analytic categories with representative quotations from interviews with participants.

Findings

In this section, we describe how blood collection and donor recruitment activities at the clinics contributed to the embedding of blood donation as a valued social activity in the two cities where we conducted our research. We demonstrate how collection and recruitment activities relate blood donation to meaningful aspects of donors' everyday lives as members of these communities. In the final section, we discuss donors' and non-donors' views on blood donation and how they link this activity to both social relations and personal understandings of obligation and reciprocity.

Blood donation and workplace culture

We observed several strategies employed by clinic staff to enhance awareness of blood donation in the workplace. Central to these strategies was the role of the Community Development Coordinator (CDC) at each clinic. The role of the CDC is to act as "ambassador" of blood donation in the communities served by blood clinics. The CDCs in our sample implemented a donor recruitment program that encouraged employees in businesses and not-for-profit and public sector organizations to donate as a group. They regularly visited these organizations to promote awareness of blood donation and to cultivate local cultures of donation. This cultivation involved identifying

individuals in these organizations with a history of blood donation and prompting them to encourage co-workers to donate at least once (and preferably on a regular basis).

The CDCs also created a reward system to foster competitions among organizations: organizations whose employees donated the most blood would be publicly recognized in a newsletter and with a plaque. These organizations would also be acknowledged in the local community newspaper. This competition benefited the winning organizations by giving them welcomed publicity, by instilling pride in their employees, and by contributing to increased staff morale. This comment from a donor at Clinic B illustrates this point:

I think it's a good opportunity because of corporate image. Especially for us, but for any corporation, I don't think anyone can negatively put a spin on it no matter what they do. So I would hope it would spread to other communities. I'm not quite sure how it could spread but I would say any corporation, if they're looking for some solid corporate citizen-type stuff, it's a really great opportunity.

Other donors we interviewed in these organizations spoke of how competing for blood donation created peer pressure on employees to consider donating blood. The following comment from a first-time donor working in an autoshop suggests that this type of peer pressure is more effective in organizations with a high level of social cohesion among employees:

We have a lot of barbeques and we're a pretty close-knit sort of bunch of guys. It's an unusual setting really because there isn't any other place in the shop that's like that. It's just the body shop it's very uh very uh close. You know they want to get things done right 'n they see their buddies giving blood so they think oh okay well maybe I'll do it then.

According to the CDCs, this reward program was very successful in generating a large number of first-time donors, many of whom became repeat donors. Our findings corroborate this assessment: we found that slightly over 50% of donors we interviewed cited the program as an important reason for donating blood.

This donor recruitment program illustrates how the social networks in which individuals are embedded can influence blood donation behaviour. The program successfully tapped into the processes of social capital formation in

the workplace to recruit new donors and to encourage continuous blood donation. More specifically, the valued social relationships in these networks influenced patterns of blood donation by linking donation to dynamics of obligation and reciprocity within the workplace. The program created a culture of donation in these organizations whereby employees who had not previously considered donating blood felt a certain level of obligation to do so in order to maintain their status in a social network that they valued. The motivation to donate blood in these cases therefore emerges less from intrinsic altruism and more from a desire to act in ways congruent with the values of the workplace as a donating site. In this way, social capital exerts a normative influence on individuals who are non-donors but become donors as a result of their investment in trusted networks of peers. Creating a blood donation culture in the workplace thus constitutes an effective tool for increasing blood donor rates and meeting blood needs.

Blood donation in the context of community

Another prominent role of the CDCs was to increase awareness of blood donation in the community. For this purpose, they participated in commemorative parades and fundraising events on behalf of the blood clinic. Clinic A's CDC described the importance of these activities as follows:

Volunteering in your community is very, very important. We have to look like we're giving back to the community and stop asking: "Come on, come on, give blood, come, come, come." If you network yourself and say, you know what, those Canadian Blood Services people were at our run for Joe Schmo, then they're more willing to roll up their sleeves. So community involvement is very, very important.

Other clinic staff also promoted blood donation within the community, albeit in less formal ways. Nearly all of them lived in the catchment area of the blood clinic and often reminded people about donating blood whenever they were out running errands or shopping. One nurse spoke about how she and several of her co-workers who had purchased new cars at a dealership lobbied the owner and his employees to donate blood in appreciation of the clinic staff's patronage. These informal donor recruitment efforts proved effective primarily because clinic staff had been imbedded as respected members of various social networks in their community (e.g. churches, volunteer organizations, little league clubs). As one clinic nurse explains:

Well again we're in a unique position, because we are all from this community, have all been here for years and we all have connections to the community as does our community development coordinator. And so that brings local knowledge and connection to the people that walk in the door.

This quotation demonstrates how CBS staff effectively mobilized their own social networks to increase blood donation.

Clinic staff also took various initiatives to make their clinic a meaningful "community destination" for donors. One initiative involved relocating Clinic A to a small strip mall in the core of the city's shopping district. Staff selected this location to increase the clinic's visibility in the community but also to make it more convenient for donors to drop in before heading off to do their shopping. The intention was to normalize blood donation as a routine activity (like shopping) and dispel the sense of the blood donation procedure as medical, painful, and time consuming--all common barriers cited by non-donors. Another initiative was to hold regular art exhibitions of local artists known in the community. These exhibitions often became the focal point of animated discussions between staff and donors, discussions that made the process of donating blood both pleasant and social.

In addition, clinic staff implemented several strategies to increase the "fun-factor" of donation. For example, they greeted donors by name and made an effort to engage them in friendly banter during the donation process. As one clinic nurse remarked:

I think a lot of us make the rewards come out of the contact with the donors. That's the part where we remember people's names, we remember their birthdays, you know, have a chat with them when they come in, so they're ... they're almost like family members when they come back.

One donor at Clinic B also identified the positive atmosphere at the clinic as a factor that encouraged him to donate blood:

The people there are always friendly, always really quite pleasant environment to be in, as long as you don't mind needles. But you know, setting aside that one small thing, you know...they're all very caring. So yeah I'm quite...pleased and impressed and general speaking with the set up.

Overall, staff in both clinics sought to imbue their clinic with a feeling of and support for community. This community atmosphere contrasts with the more medicalized atmosphere we found in the other (less successful) clinics in our sample. Staff members expressed pride in these initiatives and felt they greatly contributed to the clinic's success in attracting repeat donors. As one staff member noted, "We get regular people and I believe personally that a lot of the people who come back to our clinic come back because of us."

Civic reciprocity and repeat blood donation

First-time donors in our sample spoke primarily of the role of workplace dynamics in motivating them to donate blood. We also interviewed long-term repeat donors. These donors had been donating blood on a regular basis for several years and played an important role in motivating their co-workers to donate for the first time. Only 5 repeat donors we interviewed singled out intrinsic altruism as the primary reason for donating blood. They used terms such as "the gift of life" and "doing the right thing." For example, one donor said: "I guess it's the proper thing to do, who knows sort of like karma, one day I might need and I'd appreciate if somebody donated then so why don't I donate now and if I never need it so much the better."

Other repeat donors used a different vocabulary of motivation: they spoke of donating blood as a way to reciprocate for the benefits they enjoyed by belonging to a community that they greatly valued. As one long-term donor put it:

It's all about community. This is how I choose to give back to the community. You can choose to do whatever you want to do, but this is how I choose to give back to the community, and if you want to join with me and give back to the community this way, well hey, wonderful, let's do it together.

Other repeat donors expressed this motivation in similar terms, talking about donation as a way to match the kindness of fellow citizens in other areas of civic life (e.g. coaching little league baseball, volunteering with seniors). These comments suggest that civic reciprocity derived from membership in a valued community significantly influences long-term blood donation. Our analysis of staff interviews lends support to this interpretation, as illustrated by this comment from a nurse:

I think it comes back to the local connection in the community. When donors donate, they don't really donate nationally, they donate locally. They believe this is their blood system.

Although these donors believe their blood is used locally, it is actually sent along with the blood of all Canadian donors to a national laboratory where it is tested, pooled, processed, and redistributed as transfusion-ready blood and blood products. These donors thus inadvertently donate to a much larger community than the local one they identify in their comments on blood donation.

In addition to civic reciprocity, some long-term donors talked about donating out of a sense of religious obligation. The following quotation from a regular donor illustrates this finding: "I would say it's coming down to my faith. As a Christian, they teach you that you should do for others things you can do." This statement highlights the role of reciprocity in the context of diverse communities, including more narrowly defined communities such as a church or faith group.

Several repeat donors also spoke of being influenced in their decision to donate blood by friends, family, or a close relative. The following comment from a younger donor suggests the nature of this influence:

I think originally it was as a student and at the time I think my brother was donating and he suggested I donate, and we went down and got my first donation and then it just then it went from there, then it really became a habit.

Similarly, another repeat donor credits his parents for teaching him the value of donating blood as he grew up:

I think it's probably it grew up with me. My parents always donated blood and my mother still donates blood on a regular basis. It's just a normal thing in my family, I don't know, and if you grow up in a sharing family, a family of sharing, it's automatic. It's expected of you.

These quotations suggest that family forms another social network that influences the process of blood donation. However, this network exerts influence differently from other networks (e.g. community, workplace) in that the pressure to donate blood begins at a younger age and is likely more intense if family members share a strong bond.

The decision not to donate blood

We also interviewed 11 participants who did not donate blood. First, 5 non-donors said they could not donate because they had been deferred from donating for health reasons. The other 6 non-donors mentioned several reasons for their unwillingness to donate blood that echoed concerns reported in previous surveys about blood donation (for example, see Ipsos-Reid, 2001). Two non-donors said they did not donate for cultural or religious reasons. Three non-donors specifically cited fear of needles and discomfort at the sight of blood as reasons for not donating. The following comment is typical in this regard: "I don't want to. Just plain and simple don't want to.... [I]f they could drain it out some other way I probably would, but no, no, I hate needles." One non-donor mentioned having previously donated but no longer doing so because of the donor screening process, singling out its length and the kinds of questions asked by staff. These questions single out risk factors for blood contamination such as drug use or sexual practices deemed risky. This non-donor characterized the screening process as invasive and embarrassing. The following comment from a nurse makes clear some non-donors' discomfort with aspects of the screening process:

There was some stuff around homosexuality in the questionnaire that annoyed a lot of people and they said, on principle, they didn't want to donate because of it. Some people were quite angry.

Interestingly, several first-time and repeat donors mentioned concerns similar to those cited by the non-donors. Nearly 40% percent of donors mentioned finding the donor screening process annoying or invasive. In particular, these donors singled out having to answer the same identification questions despite the fact they had been donating repeatedly for several years at the same clinic. The following comment is typical:

It's not that I'm there once in a blue moon I'm there every third month, and every time I've been asked, at least 4 times in that period: "What's my name?" and "What's my address?" That's ridiculous. That's what annoys me.

Other repeat donors spoke of still "fearing the needle" despite having donated blood dozens of times over the years.

Given non-donors' various reasons for not donating blood, we surmise that non-donors could lack the kind of social capital that would allow them to

overcome their concerns about blood donation. The following quotation from a first-time donor lends some credibility to this hypothesis:

I worked for the credit union down there as well, and blood donation was something that a bunch of people at work had already done, so I thought, okay, there's only one way to get over my fear of blood, and that's just to start giving. So that's what I did.

Such donors' embeddedness in social networks, however, may enable them to overcome their frustration about the screening process or their concern with the needle, whereas non-donors' lack of social capital prompts them to reject the possibility of donation.

Discussion and Conclusion

Following Healy's (2000) suggestion that collection regimes produce different donor populations, we explored how CBS used the processes of social capital formation to recruit donors in two cities with significantly above-average blood donation rates. We described how staff in the blood clinics serving these cities and their adjoining semi-rural catchment areas engaged in initiatives that tied donation to meaningful aspects of donors' community and culture. We also showed how the clinics' CDCs successfully fostered cultures of blood donation in business, not-for-profit, and governmental organizations through a program of competitive blood donations. These activities minimized appeals to altruism and instead emphasized how individuals could enhance the status of their organization, give back to their community, and perform a civic duty. We found these activities to provide a plausible explanation for the success of the clinic in attracting a large number of first-time donors. We also discussed how individuals construct their motives and orientations toward blood donation in the context of valued relationships with others and in relation to valued membership in their community. Additionally, we found that family and religious networks play an important role in motivating individuals to donate blood.

Overall, our study demonstrates the important role played by social context in the motivation to donate blood. While we acknowledge earlier findings that altruism plays a role in donation, our findings suggest that donation is largely contingent on community. Recruitment strategies that tie blood donation to meaningful aspects of donors' social networks and community are thus more effective than appeals to altruism. Our findings therefore challenge psychosocial research that identifies intrinsic altruism as the primary

explanation for blood donation. Instead, we find that the processes of social capital formation and civic reciprocity more convincingly explain why people engage in this vital activity. Our study therefore has important implications for blood donation recruitment strategies, whose success might be considerably augmented by focusing on social networks and community rather than intrinsic altruism. Further studies will help researchers and blood agencies to refine our understanding of the complex phenomenon of blood donation in the context of social networks and community.

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