

# Lapses in Blood Screening - Tamil Nadu Case

### Why in news?

 $n\n$ 

A 23-year-old pregnant woman in Tamil Nadu tested positive for HIV after receiving a unit of blood at a government hospital blood bank.

 $n\n$ 

#### What is the mandate?

 $n\n$ 

\n

- Testing all donated blood units for a number of transfusion-transmissible infections, including HIV, is mandatory in India.
- The ELISA test is used in all blood banks to screen for HIV.
- Notably, ELISA test has very high levels of sensitivity to diagnose samples positive for the virus.

\n

• Since 2004, the National AIDS Control Organisation (NACO) Action Planspecified guidelines are being followed.

- All blood banks are required to obtain from donors a written consent on their wish to be informed about a positive test result.
- In case of testing positive for HIV, blood banks are required to refer the donors to designated voluntary counselling and testing centres (VCTCs) for disclosure and counselling.
- VCTCs are required to inform the blood bank of a donor's status only when the confirmatory test done at the VCTC too is positive.
- This is to stop the person from donating blood in the future.

 $n\n$ 

What happened in the recent case?

 $n\n$ 

\n

• The donor's HIV-positive status became known in 2016 when he donated blood at the same blood bank.

۱n

- $\bullet$  This particular donor had consented to be informed of a positive result.  $\ensuremath{\backslash n}$
- It is said that the blood bank tried but failed to contact the donor in 2016 to inform him of his HIV positive status.
- But recently he had found out elsewhere that he was HIV-positive, and dutifully contacted the hospital.
- But his blood (recent donation) had already been transfused to the pregnant woman.

\n

 $\bullet$  The donor passed away after consuming poison following the incident.

 $n\n$ 

### What is to be done?

 $n\n$ 

\n

- Blood banks in India have a success rate of less than 50% in contacting donors testing positive for transfusion-transmissible infections.
- Only half of the consented donors are contactable and even fewer visit a VCTC.

\n

- So NACO should address the lapses in screening procedures and also find a viable alternative to contact them without compromising the donor's identity.
- The focus should also be on creating awareness among donors to visit a VCTC to confirm their HIV status when alerted by blood banks.

 $n\n$ 

 $n\n$ 

## **Source: The Hindu**

