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Cross-Border Paid Plasma Donation among Injection Drug Users in Two Mexico-U.S. Border Cities

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Abstract

Objective—Paid plasma donation has contributed to HIV epidemics in many countries. Eleven million liters of plasma are fractionated annually in the U.S., mainly from paid donors. Deferral of high risk donors such as injection drug users (IDUs) is required for paid donations. We studied circumstances surrounding paid plasma donation among IDUs in two Mexican-U.S. border cities.

Methods—In 2005, IDUs ≥ 18 years old in Tijuana (N=222) and Cd. Juárez (N=206) who injected in the last month were recruited through respondent-driven sampling. Subjects underwent antibody testing for HIV and HCV and an interviewer-administered survey including questions on donating and selling whole blood and plasma.

Results—Of 428 IDUs, HIV and HCV prevalence were 3% and 96%, respectively; 75 (17.5%) reported ever having donated/sold their blood or plasma, of whom 28 (37%) had sold their plasma for an average of \$16 USD. The majority of IDUs selling plasma were residents of Ciudad Juárez (82%); 93% had sold their plasma only in the U.S. The last time they sold their plasma, 65% of IDUs had been asked if they injected drugs. Although the median time since last selling plasma was 13 years ago, 3 had done so within the prior two years, one within the prior 6 months; of these 3 IDUs, 2 were from Cd. Juárez, one from Tijuana; all 3 had only sold their plasma in the U.S.

Conclusions—Although selling plasma appears uncommon among IDUs in these two Mexican border cities, the majority sold plasma in the U.S and only one-third were deferred as high-risk donors. Paying donors for plasma should be a matter of public inquiry to encourage strict compliance with regulations. Plasma clinics should defer donors not only on behavioral risks, but should specifically inspect for injection stigmata.

Keywords

injection drug use; Mexico; plasma center; plasmapheresis; HIV; blood trade

Introduction

Globally, the pharmaceutical industry annually fractionates 28 million liters of plasma, the majority of which is provided by paid donors (Volkow & Del Rio, 2005). The practice of paying plasma donors has been strongly criticized, since plasma donors tend to be over-represented by economically disadvantaged persons such as injection drug users (IDUs) (James & Mustard, 2004). In settings where collection and handling of plasma products has been sub-optimal, paid plasma donation has led to massive outbreaks of HIV and viral hepatitis among plasma product recipients, who include hemophiliacs, agammaglobulinemia patients, and Rh-negative women who are injected with anti-Rho during pregnancy or at birth (Anonimo, 1994; Bresee et al., 1996; Craske, Kirk, Cohen, & Vandervelde, 1978; Echevarria et al., 1996; Goedert et al., 1985; John et al., 1979; Koerper, Kaminsky, & Levy, 1985; Lawlor et al., 1999; Lefrere et al., 1996; Machin, McVerry, Cheingsong-Popov, & Tedder, 1985; Madhok et al., 1985; Mathez, Leibovitch, Sultan, & Maisonneuve, 1986; Melbye et al., 1984; Ragni et al., 1986; Verani et al., 1986).

As in several countries, the practice of paid plasma donation was banned in Mexico since 1987, after it was recognized that outbreaks of HIV infection had occurred in both paid plasma donors and recipients (Alvarez-Suarez, Marin-Lopez, Lobato-Mendizabal, & Galindo-Rodriguez, 1989; Avila et al., 1989; Sepulveda Amor, de Lourdes Garcia, Dominguez Torix, & Valdespino Gomez, 1989). However, some U.S. states (e.g., California and Texas) permit paid plasma donation provided that plasmapheresis centers screen and defer high risk donors such as IDUs, and inactivate potential blood-borne pathogens through pasteurization or detergent treatment. After learning that some plasma clinics in the USA were engaging in promotional activities to attract paid plasma donors from Mexican border cities, we studied the frequency and circumstances of paid plasma donation among IDUs in two Mexican-U.S. border cities.

Materials and Methods

As previously described, we conducted a cross-sectional study of behavioral and contextual factors associated with blood-borne infections among IDUs in the Mexico-U.S. border cities of Tijuana (population 1.3 million) and Ciudad Juárez, México (population 1.2 million) (INEGI, 2000). These cities are located adjacent to San Diego, CA and El Paso, TX, respectively. Both cities are economically disadvantaged compared to U.S. border cities, are located on major drug trafficking routes and have large IDU populations (Bucardo et al., 2005). Eligibility criteria for the study included: having injected illicit drugs within the past thirty days, confirmed by inspection of injection stigmata ('track marks'); aged 18 years or older; willing and able to provide informed consent; and not having previously been interviewed for the study. Study methods were approved by the Ethics Board of the Tijuana General Hospital, the Human Research Protections Program of the University of California, San Diego, and by senior staff of Programa Compañeros (a non-governmental organization assisting IDUs in Cd. Juárez).

Between February and April 2005, respondent driven sampling (RDS) was used to recruit IDUs in Tijuana (15 seeds, 207 recruits over 8 waves) and Ciudad Juárez (9 seeds, 197 recruits over 8 waves), as described previously (Frost et al., 2006). A diverse group of "seeds" heterogeneous in age, gender, drug of choice, and recruitment venue who met study eligibility criteria were interviewed and given three uniquely coded coupons to refer their peers, receiving \$5 compensation for each seed recruited.

Interviews were conducted in Spanish at the NGO-sponsored clinic of Programa Compañeros in Ciudad Juárez and in the mobile clinic of the Patronato Pro-COMUSIDA (the municipal HIV/AIDS program in Tijuana). All participants received up to \$20 USD compensation for

completing the survey, administered by trained staff who elicited information on socio-demographic and behavioral characteristics, including socioeconomic and demographic profiles, drug use history and practices, incarceration and medical history. Subjects were also asked questions about donating and selling their blood or plasma. Specifically, subjects were asked the following series of questions: 1. “Have you ever donated or sold your blood, or part of your blood, to a hospital or clinic?; 2. (If yes), when was the last time you donated blood without being paid? (responses coded in months or years ago); 3. When was the last time you sold your blood? By this I mean your whole blood, not just part of your blood. (responses coded in months or years ago); 4. Have you ever sold your plasma? (interviewer reads: Plasma is the clear part of your blood. If you sold your plasma, the red part of your blood may have been returned to your body). 5. How have you donated your plasma? (responses were: a) connected to a machine; b) manual plasmapheresis (small bags were used remove my blood then, my red cells were returned back into my body); c) both; d) other); 6. The first time you sold your plasma, how did you find out about it? (open-ended response); 7. When was the last time you sold your plasma? (responses coded in months or years ago); 8. Where did you last sell your plasma, in Mexico or the US? (Specify city, state or other country). 9. The last time you sold your plasma: a) how much were you paid? (responses recorded in pesos or U.S. dollars); b) did the clinic or hospital arrange for transportation for you?; c) did anyone ask you in you had ever injected drugs?; d) what was the name of the hospital or clinic?

Participants were screened for HIV and HCV antibody using standard enzyme immunoassays. Reactive or indeterminate HIV antibody tests were confirmed with Western Blots. HCV antibody testing was performed using an enzyme immunoassay (EIA) test (Ortho Diagnostic Systems EIA 3.0, Raritan, NJ, USA). Reactive specimens were retested in duplicate using EIA and determined to be positive if either or both of the repeat tests were reactive. This method has been used in prior studies and found to be reliable due to the high positive predictive value of this testing algorithm when used in high prevalence populations. Pre- and post-test counseling and referral to treatment, where indicated, was provided to all participants, consistent with guidelines published in the U.S. and applicable in Mexico. Syphilis antibody was detected with the rapid plasma reagin (RPR) and *Treponema pallidum* particle agglutination assay (TPPA). In the absence of clinical information, samples with syphilis titers $\geq 1:8$ were considered suggestive of incident syphilis. Hepatitis B core antibody testing was available only for subjects in Ciudad Juarez.

To adjust for possible bias in sampling, RDS adjustments for each infection were calculated in RDSAT software (version 5.6.0, October, 2006, Cornell University), which applies overall sampling and degree weights to account for the effects of differential recruitment and network size and to estimate an ‘equilibrium’ ratio applied to sample frequencies of each group (Heckathorn, 2002). Descriptive statistics were generated.

Results

Of 428 IDUs studied, 222 were from Tijuana and 206 from Ciudad Juarez. Participants in both cities were similar in gender, age, marital status and income. Almost all (91.8%) participants in both cities were male, median age was 34 years and median age of first injection was 19 – 20 years. In Tijuana, the RDS-adjusted prevalence of syphilis was 25% [95% confidence interval (CI), 12 – 40], compared to 3% (95% CI, 0.6–6.4) in Ciudad Juarez. The RDS-adjusted HCV antibody prevalence was 97% (95% CI, 94–99.5) in Tijuana and 96% (95% CI, 93–98) in Ciudad Juarez and HIV was 0.6% in Tijuana (95% CI, 0.1–1.3) and 2.9% (95% CI, 0.5–6.0) in Ciudad Juarez. Prevalence of Hepatitis B core antibody was high (85% overall); only one individual was positive for HBV antigen.

Among all 428 subjects, 75 (17.5%) reported ever having received money for donating blood or plasma. Of these, twenty-eight (37.8%) had ever sold their plasma, of whom the mean amount received per visit was \$16 USD (range \$5–30 USD). Plasma donors tended to use drugs more frequently (92.9% vs. 78.0% injecting multiple times per day, $p=0.06$) compared to non-donors. The majority of IDUs selling plasma were residents of Cd. Juarez (82.1%). Almost all (93.1%) had sold their plasma only in the U.S. Most (86.2%) heard about plasma selling from a friend or a relative; others had learned from newspaper and television (6.8%) or passing by the clinic (3.4%). Nine (31.0%) had donated their plasma through a plasmapheresis machine and 75.9% had donated through manual plasmapheresis.

The last time participants sold their plasma, 3 (10.3%) were provided with transportation by the hospital or clinic, and only 65.4% had been asked if they injected drugs. Although numbers were low, plasma donors who were asked if they injected tended to be frequent drug injectors (62.5% vs. 37.5% injecting multiple times per day) and, among males, have a history of sex with a man (37.5% vs. 11.1%). Although the median time since last selling plasma was 13 years ago, 3 had done so within the prior two years, one 6 months ago; of these 3 IDUs, 2 were from Cd. Juarez, one from Tijuana; all 3 had sold their plasma only in the U.S.

Discussion

Our study of active IDUs in two Mexico-U.S. border cities found that selling of blood and plasma was not common, with one sixth having done so in their lifetimes. The majority of IDUs who had sold their plasma had done so in the distant past. However, an important finding was that plasma selling occurred almost exclusively in the U.S and not Mexico which is not surprising since selling of plasma and blood were banned in Mexico over two decades ago.

Of concern were the findings that only one-third of IDUs who reported selling their plasma in our study were potentially deferred as high risk donors the last time they sold their plasma, and that a few IDUs had reported selling their plasma within the prior two years. In the interest of public safety, these observations led our research team to share a de-identified summary of these data with public health authorities in Ciudad Juarez and Tijuana, as well as the adjacent U.S. border cities (El Paso, TX and San Diego, CA), and the U.S. Food and Drug Administration which is responsible for monitoring plasmapheresis clinics. In one case, the investigation revealed that the clinic involved was located in a northern U.S. state and had been shut down.

Our findings should be interpreted with caution for a number of reasons. The number of IDUs reporting plasma selling was small, which precluded meaningful comparisons by site. We included probes through which interviewers explained the difference between whole blood and plasma to study participants, but it is possible that some mis-reporting may have occurred. Since these data were collected in 2005, we cannot infer that these findings reflect current practices at plasmapheresis clinics on either side of the border. However, even in 2008, we are aware of anecdotal reports that some IDUs in Ciudad Juarez continue to travel to the U.S. to sell plasma.

In our view, plasma extraction procedures should rely on deferral of high risk donors, not solely on inactivation processes which while effective, have sometimes been known to fail. Such examples of HIV infection have been well documented among hemophiliacs in the nineties (Kleim et al., 1990), which was followed by several other outbreaks of blood borne pathogens worldwide, such as HCV (Bresee et al., 1996; Echevarria et al., 1996; Lawlor et al., 1999; Lefrere et al., 1996), Parvovirus 19, and Hepatitis A virus (Blumel et al., 2002; Jee et al., 2006; Johnson et al., 1995; Kupfer et al., 1995; Mannucci et al., 1994; Soucie, Siwak, Hooper, Evatt, & Hollinger, 2004). Since HIV incidence is rising along the U.S./Mexico border

(Strathdee & Magis-Rodriguez, 2008), it is worthy to consider that HIV antibody screening could theoretically miss a small number of HIV-infected IDUs in the window period. On the other hand, current practices such as nucleic acid testing of all donations, quarantine of units from first-time donors and lists of deferred/infected donors would probably prevent most contemporary window period HIV infections.

Despite the low risk of transmission, it should be recognized that due to extreme financial hardship, some IDUs may not admit having injected drugs, which suggests that clinics should inspect for injection stigmata. The practice of paying donors for plasma should be a matter of public inquiry and further measures should be taken to encourage strict compliance with regulations.

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Table 1

Characteristics of IDU plasma donors in Tijuana and Ciudad Juarez, Mexico, 2005

Characteristic	Tijuana(n=222)	Cd. Juarez(n=206)	Overall(n=428)
Median age	34 (29, 40)	33 (28, 42)	34 (28, 40)
Median age of first injection	19 (15, 24)	20 (16, 25)	19.5 (16, 25)
RDS Adjusted Prevalence (95% CI):			
HIV	0.6 (0.1, 1.3)	2.9 (0.5, 6.0)	2.6 (0.7, 4.5)
Syphilis	25.0 (12.0, 40.0)	3 (0.6, 6.4)	15.0 (7.4, 25.1)
Hepatitis C	97.0 (94.0, 99.5)	96.0 (93.0, 98.0)	96.2 (92.8, 98.0)
Ever donated/sold blood (or parts) to a hospital/clinic	31 (14%)	44 (21.4%)	75 (17.5%)
Last time donated blood (median years (IQR)) *	8 (3, 15)	11 (3, 15)	10 (3, 15)
Last time sold blood (median years (IQR)) *	8 (2, 15)	13 (9, 20)	12 (6.5, 20)
Ever sold plasma?	5 (16.1%)	23 (53.5%)	28 (37.8%)
Ever donated plasma through*:			
Machine	3 (60%)	6 (25%)	9 (31%)
Manually	2 (40%)	20 (83.3%)	22 (75.9%)
The first time donated plasma, found out through*:			
Friends/Relatives	4 (80%)	21 (87.5%)	25 (86.2%)
Passed by the place	0 (0%)	1 (4.2%)	1 (3.4%)
Newspaper	0 (0%)	1 (4.2%)	1 (3.4%)
Television	0 (0%)	1 (4.2%)	1 (3.4%)
Other	1 (20%)	0 (0%)	1 (3.4%)
Characteristics of last paid plasma donation*			
Median years ago (IQR)	10 (5, 18.5)	13.5 (9.3, 19.5)	13 (9, 19)
Location			
Mexico	1 (20%)	1 (4.2%)	2 (6.9%)
USA	4 (80%)	23 (95.8%)	27 (93.1%)
Payment received (median USD (IQR)) **	15 (7.5, 17.5)	18 (10, 20)	15 (10, 20)
Hospital/clinic provided transportation	2 (40%)	1 (4.2%)	3 (10.3%)
Asked if ever injected drugs	5 (100%)	12 (5.8%)	17 (65.4%)

* excluding those who have never donated

** pesos were converted to USD (exchange rate 1 USD = 10.5 pesos)

Inter-quartile range (IQR)