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## **The UK's gamete donor 'crisis' – a critical analysis**

### *Abstract*

Since April 2005, individuals donating sperm, eggs or embryos for the treatment of others in the UK have been required to agree to the disclosure of their identity to any child conceived as a result of their donation on reaching the age of 18. The main arguments advanced against the removal of donor anonymity are: first, it is responsible for a dramatic decline in the number of donors; second, it causes particular problems for donors in egg sharing programmes; and third, that it will increase the unwillingness of parents of donor-conceived children to tell their children about their conception. This paper analyses these arguments and points to flaws in both the evidential base and the argumentative strategies of these claims. The authors argue for a proactive approach to donor recruitment that reflects the contemporary context for the provision of donor conception services in the UK.

**Key words:** donor anonymity, donor recruitment, public policy

### **Introduction**

Since April 2005, a condition for donating gametes (eggs or sperm) or embryos for the treatment of others in the UK has been the donor's consent that any child conceived as a result of their donation may, on reaching the age of 18, request disclosure of the donor's identity.<sup>1</sup> This legislative change was promoted by groups representing donor-conceived individuals, parents of donor-conceived children, children's rights and social work interests and has been opposed by the major medical professional bodies involved in the provision of assisted conception services fearing that it would result in fewer donors and,

consequently, reduced donor services. The main arguments advanced against the removal of donor anonymity are: first, the legislative change has been held responsible for a dramatic decline in the number of donors; second, it is held to cause particular problems for donors in egg sharing programmes; and third, that it will discourage parents of donor-conceived children from telling their children about their conception.

This paper analyses these arguments, identifying flaws in both the evidential base and the argumentative strategies of these claims. Space precludes an exposition of the paper’s implicit endorsement of the case for disclosure of donor identity, although we have outlined this elsewhere (Blyth, 2002; Blyth and Farrand, 2004; Frith, 2001a). Further, by pointing out the shortcomings of the case against the legislative change and accepting the government’s determination that this decision is not negotiable (Department of Health, 2006), we argue for a proactive approach to donor recruitment that reflects the contemporary context for the provision of donor conception services in the UK.

## Background

In 1991 the UK implemented the Human Fertilisation and Embryology Act 1990 (hereafter ‘the Act’). One of the Act’s key provisions regarding donor conception was the legal protection of donor anonymity. Accepted practice prior to this had been not only to safeguard the donor’s identity but also – at least until the late 1980s – to keep secret the fact of donor conception (RCOG, 1987). These practices were prompted by the stigma of infertility (in particular male infertility), the uncertain social acceptability of donor conception, and fears for the integrity of family relationships (Blyth and Moore, 2001; Novaes, 1998). Such practices also served the purpose of protecting the medical profession from potentially critical external scrutiny of a practice that had dubious social acceptability (Haimes, 1993a). Since egg and embryo donation were dependent on technologies that were not developed until the 1980s, it is important to acknowledge that early discussions concerning donor conception were conducted entirely within a framework dictated by issues relating to male infertility and donor insemination (DI).

The Warnock Committee, whose report provided the basis for the 1990 legislation, challenged the primacy of secrecy. It did so on the following grounds: that secrets in families were unhealthy and that donor-conceived people were entitled to some information about their origins. However, it was wary of undermining donor anonymity for fears that doing so would compromise family functioning in families that had used donor conception (Department of Health and Social Security, 1984). The Committee recommended that – on becoming adults – donor-conceived people should be provided with some non-identifying information about their donor and that the fact of donor conception should be recorded at registration of the child's birth (Frith, 2001b).

The Act endorsed the principle of donor anonymity and made provisions for some unspecified non-identifying information about the donor to be released to donor-conceived people reaching the age of 18, although the Committee's proposals regarding birth registration were not implemented. Importantly, the government signalled the possibility of future change, specifically referring to the history of adoption legislation in the UK. Until 1976, the UK (with the exception of Scotland, which had always permitted an adopted person to access his or her original birth and adoption records) had operated a system of 'sealed record' adoptions. The 1976 Adoption Act allowed an adopted person to obtain their original birth records. Unusually, this provision was applied retrospectively, so long as adopted persons seeking their birth records who were adopted before 1976 received counselling. The government indicated that donor conception might, in time, follow a similar path (Bottomley, 1990; Department of Health and Social Security, 1987) and this possibility was drawn to the attention of the medical community by Braude et al. (1990). The government gave an assurance, however, that if donor anonymity were to be removed in the future, any retrospective application would require fresh primary legislation and the government had no intention of promoting such a move (Clarke, 1990).

In 2000, almost a decade after implementation of the Act, and in the absence of any evident government action to address the issue of information for donor-conceived people, Joanna Rose, a donor-conceived adult, and an unidentified donor-conceived minor, jointly initiated a human rights challenge to the legislation in the English High Court. They claimed that the statutory enforcement of donor anonymity

contravened their right to ‘respect for private and family life’ guaranteed by Article 8 of the 1950 European Convention on Human Rights and Fundamental Freedoms (*Rose and Another v. Secretary of State for Health and Human Fertilisation and Embryology Authority*, 2002).

While this case was being heard, the government launched a public consultation in December 2001 seeking views on what – if any – information should be provided for donor-conceived people. The government reasserted the previous administration’s position that: ‘there is no question whatsoever in making any changes in the law which would allow the identification of people who have already donated sperm, eggs or embryos. Such a change – if made – would only apply to donations made after the introduction of new legislation’ (Department of Health, 2001: para. 1.3).

The consultation ended in July 2002 and in January 2003 the government made public both the substance of the responses to the public consultation and its initial plan of action (Blears, 2003; Department of Health, 2003a, b). A significant majority of respondents endorsed the provision of non-identifying donor information to donor-conceived people, while a smaller proportion of respondents proposed the complete removal of donor anonymity. Responding to the consultation, the minister for public health, Hazel Blears, indicated the government’s acceptance of ‘a strong argument in principle for children conceived using donated sperm, eggs or embryos being able to find out the identity of their donor’. After further consultations (Daniels et al., 2005; Frith et al., 2007) in January 2004, Blears’ successor, Melanie Johnson, announced that with effect from 1 April 2005, all new donors would be required to agree to their identity being disclosed to any individual conceived as a result of their donation, if so requested, once they reached 18 (Human Fertilisation and Embryology Authority, 2004; Johnson, 2004).

### *Responses to the change in the law*

The abolition of donor anonymity was not generally welcomed by fertility clinicians and their professional organizations (the British Fertility Society (BFS); the British Medical Association (BMA); and the Royal College of Obstetricians and Gynaecologists (RCOG)). Given that the government had discounted their views, each organization

used the review of the Act undertaken by the House of Commons Science and Technology Select Committee during 2004 and 2005 to reinforce their objections (BFS, 2004; BMA, 2004; RCOG, 2004). The BFS, for example, urged reconsideration of the 'double-track' system which would allow a donor to choose to be either anonymous or identifiable and recipients to choose whether to use gametes from either an anonymous or identifiable donor (Pennings, 1997). This was a model endorsed by the Select Committee itself in preference to the total abolition of anonymity (House of Commons Science and Technology Select Committee, 2005: para. 158). One of the Committee's members, Dr Evan Harris, ventured that the removal of donor anonymity was 'stupid and misguided' (cited in Woolf, 2006), reinforcing sentiments previously expressed by one of the country's best-known fertility clinicians (Winston, 1999).

Hence, the medical profession cast itself as a strong advocate for the retention of donor anonymity, largely on the grounds that its removal would adversely impact on donor supply. However, removal of anonymity also undermined the accepted medical model of donation as a medical technique (Haimes, 1993a) in which the social implications of donation (i.e. the conception of children, family-building and parenthood) were underplayed or even ignored (Donovan, 1993).

In September 2006, Lord Winston (2006) and two former chairs of the regulatory body, the Human Fertilisation and Embryology Authority (HFEA), Sir Colin Campbell (2006) and Baroness Deech (2006), added their condemnation of the change in legislation; Campbell and Deech specifically calling for a policy reversal. The key charges laid by all three – echoing those made by others – are that: first, the change in legislation is responsible for the decline in donors (Campbell, Deech and Winston); second, it poses particular risks for women who donate eggs as egg sharers (Winston); third, it will make it less likely that parents of donor-conceived children will tell their children about their conception (Winston). Deech also criticized the campaign to remove donor anonymity for drawing an erroneous parallel with adoption. Since the intention of this paper is to focus on arguments concerning the consequences of the legislative change, space does not allow for the inclusion of discussion of the complex issues concerning appropriate comparisons between donor conception and adoption.

## The change in legislation is responsible for the decline in donors

The change in legislation was predicted to effect a dramatic impact on service provision. For example, Pennings claimed that, 'the number of donors will decrease by approximately 80% in most Western countries where donor anonymity is abolished' and that the UK's donor recruitment campaign 'will help partially, but will not compensate entirely for the loss caused by abolishing anonymity' (2005: 307). Serhal predicted: 'I can guarantee that as far as egg-sharing is concerned, you might as well forget about the programme' (cited in Henderson, 2004). Such dire forecasts were subsequently echoed by other clinicians, for example Craft (2006), who described the loss of anonymity as a 'killer blow' to egg donation, and in media bylines such as 'Where have all the donors gone?' (Craig, 2006) and 'Releasing donors' names causes sperm bank crisis' (Henderson, 2006). In the autumn of 2006, the BBC reported that almost 70 per cent of UK fertility clinics it had surveyed claimed that they either had insufficient supplies of donor sperm or had no access to donor sperm at all – for which the removal of donor anonymity was held accountable (BBC, 2006; Dreaper, 2006). The survey also found that six clinics accounted for three quarters of donors and that of the country's 169 registered donors, 162 were in England, six were in Wales, one in Scotland and Northern Ireland had no registered donors at all.

However, a somewhat different picture – and one that failed to endorse the view that the change in legislation had exerted a significant negative impact on donor recruitment – was revealed by figures released by the HFEA in November 2006. These showed that 133 sperm donors were registered in the period April–October 2004 and that in the comparable period shortly after the removal of anonymity, April–October 2005, 143 sperm donors were registered, an increase of 10 donors since the removal of anonymity (HFEA, 2006). More recent HFEA data, published in May 2007 indicate a 6 per cent increase in the number of registered sperm donors in the 12-month period following the removal of donor anonymity compared with the previous 12 months (HFEA, 2007a).

These short-term figures should be put into the context of longer-term trends that point to a reduction both in the number of children born as a result of DI and in sperm and egg donor recruitment. Table 1 illustrates these historical trends in both sperm and egg

**Table 1** Micromanipulation cycles and sperm and egg donor recruitment 1991–2006

<i>Year</i>	<i>Micromanipulation cycles<sup>a</sup></i>	<i>New registrations – sperm donors<sup>b,c</sup></i>	<i>New registrations – egg donors<sup>b,c</sup></i>
1991	33	—	—
1992	128	369	456
1993	578	431	545
1994	1284	422	751
1995	3822	418	772
1996	6176	421	839
1997	8917	356	949
1998	11906	265	1021
1999	12077	308	1160
2000	12728	325	1242
2001	13858	328	1315
2002	14921	278	1179
2003	15521	255	1056
2004	16698	248	1063
2005	17523	260	958
2006	19506	160 (January–June)	440 (January–June)

*Sources:*

<sup>a</sup> HFEA (2007b). These data refer almost entirely to ICSI cycles, although for historical reasons, the HFEA has collected statistics for micromanipulation cycles rather than for ICSI alone.

<sup>b</sup> New registrations – sperm and egg donors; 1992–9: HFEA, personal communication 5 March 2007.

<sup>c</sup> New registrations – sperm and egg donors; 2000–6: HFEA [<http://www.hfea.gov.uk/en/1462.html>].

donor recruitment and the increasing use of intracytoplasmic sperm injection (ICSI)<sup>2</sup> between 1991/2 and 2006. According to HFEA data, the number of children born as a result of DI peaked in 1994, ten years before the government announced the pending abolition of donor anonymity (HFEA, 2007b). Of the UK clinics that ever recruited sperm donors, most stopped doing so well before the change in legislation.

Donor shortages are also evident globally, including in jurisdictions where donor anonymity continues to receive legal 'protection'. Where donor numbers have been systematically recorded, the decline began well before any change in legislation concerning donor anonymity. For example, sperm donor recruitment in France peaked in 1984, declining subsequently (Hennebicq, 2004). The 'nationalized' French sperm donor system has always promoted donor anonymity and a campaign challenging this has gathered momentum only in the last couple of years.

The long-term effect of changed legislation or practice regarding donor anonymity in other jurisdictions is also inconclusive since all such changes are relatively recent and there is often limited systematic recording of donor numbers. Sweden, for instance, removed anonymity in 1984, and the number of sperm donors and the demand for DI declined following the introduction of this legislation. However, this decline was subsequently reversed (Daniels and Lalos, 1995). In Victoria (Australia), the decline in the number of donors was evident before the removal of donor anonymity in 1998. While subsequent donor numbers declined further, slight increases were recorded in 2000 and 2001 (Johnson, 2006). In March 2005, a doubling of the number of donors in Victoria during the previous two months was reported following a high profile recruitment campaign launched by Monash IVF, the state's largest DI programme (Nader, 2005). The Australian Reproductive Technology Accreditation Committee (RTAC) introduced guidelines in January 2006 requiring all Australian fertility clinics to cease using anonymous donors. Unlike at least some of his British peers, Martyn Stafford-Bell, the medical director of Canberra Fertility Centre refused to hold RTAC's decision responsible for a decrease in the supply of sperm donors. While admitting that he would 'love to blame [RTAC] for the reduction in donors . . . the reality is it has not made much difference' (cited in Powell, 2006).

Donor anonymity was removed in the Netherlands in 2004 and trends in recruitment are very similar to the UK's. Janssens et al. (2006) report 479 sperm donors in 2003, before the passage of the legislation, and 404 in 2005, following the change in legislation. In addition, the authors of a study commencing immediately prior to, and continuing after the legislative change, involving two Dutch DI clinics, reported that neither clinic experienced a shortage of donors, despite the legislative change (Brewaeyts et al., 2005).

In New Zealand, where, for several years, it has been customary to recruit only identifiable donors, in 2004, Dr Richard Fisher, head of an Auckland fertility clinic, commented that the number of men willing to donate sperm had fallen to its lowest ever level. However, Fisher refused to blame pending legislation mandating the recruitment of identifiable donors only. Rather, he claimed that it was more about attracting men who fit the criteria: ‘. . . people who are socially aware, people who are in their 20s to 40s, who preferably have children of their own, with a high degree of awareness about what family is and what it means’ (TVNZ, 2004).

Therefore, it appears that jurisdictions that have removed anonymity for sperm donors have tended to experience a modest decline in donor numbers. However, this decline can be either encouraged (Godman et al., 2006) or reversed (Adams et al., 2006) by clinics’ recruitment efforts. Clinicians in Manchester, for example, have outlined their strategies for identifiable donor recruitment and argue: ‘We certainly do not have a shortage of potential donors in Manchester but donor recruitment requires a dedicated team who recognize and support the wisdom underlying the change in the law. Changing the law is not the answer, what is necessary is a change in attitude of those who wish to provide donor treatment with donor sperm’ (Adams et al., 2006).

In conclusion, the recent decline in donor numbers in the UK fits in with the longer-term trend of the reduction in DI, and figures from the HFEA point to the fact that, at least in the short term, removing donor anonymity has not had a dramatic impact on donor numbers. Hence, it is far from clear that the removal of donor anonymity is solely responsible for the general decline in donor numbers or indeed whether it exerts a significant adverse impact on gamete donors at all.

### **The specific problems of donor identification for egg sharing**

As a consequence of this legislation . . . a woman donating eggs to another infertile woman during her own treatment may learn years later after her own treatment has failed that she has a genetic child of whose existence she was not aware. (Winston, 2006)

There is an inherent risk of paternalism in such views that because women might make choices they could later regret (for example if the recipient's treatment is successful and the donor's is not), they should not be allowed to make them in the first place. It not only fails to take account of a range of situations in which decision-making may be circumscribed (but which are not generally regarded as being equally problematic (O'Neill, 2002) but also seems to rest on an idealized perception of consent giving that often bears little relation to the real world in which people have to make difficult – and invariably constrained – decisions. Donors themselves seem to feel adequately equipped to make valid choices about participating in egg sharing (Ahuja et al., 1996, 1997, 1998; Rapport, 2003) – and some women who contemplate egg sharing decide not to proceed after they have had the opportunity to consider its implications for them (Blyth, 2004). There has been no long-term evaluation of participants' experiences of egg sharing and their views on the implications of identity disclosure, which needs to be undertaken to establish the validity of critics' concerns. Therefore, Winston's claims that the removal of anonymity is particularly problematic for those women engaging in egg sharing are not supported by any empirical evidence.

While, superficially, sperm and egg donation may appear gendered mirror images of essentially the same genetic phenomenon, the experience and meaning of gamete donation are significantly different for men and women. Contrasted with sperm donation, egg donation is unlikely to be perceived as quasi-adulterous. Further, egg donors are less likely to be subjected to adverse social consequences – indeed their efforts are often portrayed as heroic – largely because of the inconvenience, pain and potential risks to their health as a result of the medical regime to which egg donors commit themselves. Speirs (2007: 15) suggests that another significant difference is that egg donation is 'psychologically contrary to [women's] reproductive psyche' derived from the conventional process of conception in which the male *gives* and the female *receives*. These factors may well at least partly account for a greater inclination among egg donors to 'follow' their eggs on their 'ova pathways' (Konrad, 1996: 60). While variations in study design, chronology and cultural contexts in which different studies have been undertaken need to be taken into account when comparing and contrasting the views of egg and sperm donors, there seems to be some suggestion that, even in the context of anonymous donation, egg donors have expressed greater interest than

sperm donors in learning the outcome of their donation (see, for example, Kalfoglou and Geller, 2000; Klock et al., 2003; Partrick et al., 2001; Söderström-Anttila, 1995). Further, compared to sperm donation, personal recruitment and personal donation appear both more prevalent and acceptable in egg donation, and egg donors may be less likely to demand anonymity as a condition of donating (Baetens et al., 2000; Blyth, 2004; Braverman, 1993; Craft and Thornhill, 2005; Frith et al., 2007; Kalfoglou and Geller, 2000; Kalfoglou and Gittelsohn, 2001; Kirkland et al., 1992; Klock et al., 2003; Partrick et al., 2001; Power et al., 1990; Schover et al., 1992; Söderström-Anttila, 1995). Speirs (2007) notes that not only have UK egg donors tended to provide more information about themselves for potential offspring than have sperm donors, but that the nature of (ostensibly non-identifying) information provided by some past egg donors could enable their identity to be discovered.<sup>3</sup> Hence, the law change might not change the culture of egg donation in the same way it has for sperm donors.

### Parents are less likely to tell their donor-conceived children about their conception

As a consequence of this legislation, more couples undergoing these treatments state their firm intention to keep the method of conception secret from any child. (Winston, 2006)

This observation has been made previously. In its evidence to the House of Commons Science and Technology Select Committee, the BMA explained the anomalous position in which it had found itself on the subject of donor anonymity, with its ethics committee's recommendation of abolition rejected by its representative body (which ultimately defines BMA policy). One of the fears expressed by the Association related to 'parents' unwillingness to inform their children that they were conceived using donated gametes' (BMA, 2004).

Committee member Dr Evan Harris MP also advocated the view (Harris, 2004), which was ultimately endorsed by the Committee, which claimed that: 'a *powerful* argument that the ending of [donor] anonymity would result in a greater likelihood of parents not telling the child because the fear (rational or not) of rejection in favour of an identifiable biological parent outweighs the advantage of having

identifying information to transmit’ (House of Commons Science and Technology Select Committee, 2005: para. 157; our emphasis).

Since lack of information about the donor has been cited as a reason for not telling children about their conception (see for example, Cook et al., 1995), it seems counter-intuitive to suggest that access to the donor’s identity could discourage parents from doing so. Further, despite the Committee’s strong advocacy of this position, it was never presented with any evidence to substantiate the claim (nor did it offer any evidence of its own). In addition to the BMA’s unsubstantiated apprehensions, the transcript of evidence given to the Committee provides a single documented reference to the possible impact on parental disclosure of removing donor anonymity. Golombok referred to her research with families that had used donor conception:

... on asking parents about their feelings as the current law stands, you get a diversity of opinion about that because some parents say, ‘Oh, well, it will be much better because then the children can find out about their genetic origins. Therefore it makes it easier for us to tell them because they can then go out and find whatever they want’. Others will say, ‘Well, actually, this might make me less likely to tell them because, although it will ameliorate the secrecy, I am not sure how I feel about the possibility that they will be able to identify the donor’. We have heard both of these views coming from the parents in our study, but it is all very anecdotal. I really could not say what proportion felt they would act one way and what proportion felt they would act the other. (Golombok, 2004)

Despite extensive publications based on research with families using donor conception undertaken for more than a decade, Golombok and her team have never referred to this phenomenon, which at least suggests that such findings were insufficiently significant to warrant publication. At other times the Select Committee dismissed evidence of this nature as, ‘speculation based on surmise founded on anecdote’ (House of Commons Science and Technology Select Committee, 2005: para. 156), so it hardly seems to provide the basis for building a *powerful* argument.

The only other potential source of evidence is an abstract of an oral conference presentation given by the Select Committee’s medical advisor, reporting a survey of returning and prospective recipients of donated gametes at her clinic (Lockwood, 2004). The abstract provides

insufficient information about the underlying research methodology and analysis to determine its academic rigour, and – to date – no substantive paper based on the study has been published. However, since the Committee never acknowledged this paper, its influence on the Committee's deliberations is unclear.

Contrary trends in fact are suggested by a study of heterosexual and lesbian couples attending two DI clinics in the Netherlands who had been able to choose between an anonymous or an identifiable sperm donor under the clinics' 'double-track' regimes that were operational prior to the removal of donor anonymity (Brewaeyts et al., 2005). Sixty-three per cent of the heterosexual couples and 98 per cent of the lesbian couples had chosen an identifiable donor and most of these couples stated their belief that their child had a right to know his or her genetic identity.

To our knowledge, one published study only has made an explicit link between parental disclosure and the removal of donor anonymity, and this was to lament the fact that – despite the change in legislation in Sweden – a higher proportion of parents *were not* intending to tell their children (Gottlieb et al., 2000). However, this study concludes:

The results indicate that attitudes toward informing the child about DI have changed over time. The frequency of parents who had told their child increased from 6% in the group of children born 1983–1986 (i.e. before the new legislation) to 18% in the group born 1987–1990. Since the children were younger in the latter group, this difference will probably increase with time. (Gottlieb et al., 2000: 2054)

This study also identified a higher proportion of disclosing parents than an earlier Swedish study undertaken prior to the removal of donor anonymity in Sweden (Milsom and Bergman, 1982) – so there was absolutely no evidence that the change in law had made it *less likely* that parents would tell their children.

## Discussion

The three main arguments put forward against the legislation removing gamete donor anonymity cannot be substantiated by the available evidence. The fall in donor numbers has not been as severe as had been predicted and is not necessarily totally attributable to legislative

change. Donor recruitment can be facilitated by both national and individual clinic policies. Frith et al. (2007) proposed that donors' fears of the removal of anonymity could be reduced by the provision of mediation, support and counselling. Concerns that the removal of anonymity might cause particular difficulties for egg share donors are also not substantiated by the evidence – and potential donors who do have reservations are not obliged to – indeed, should not – proceed with donating. Finally, no evidence has been provided to support the assertion that the removal of anonymity would make it any less likely that parents would tell their donor-conceived child of the circumstances of their conception. This is an interesting argument to advance against non-anonymity, as historically medical professionals were opposed to, or at least ambivalent about, the utility of telling donor-conceived people about their conception (RCOG, 1987). The reason that was often given was that it was not in the best interests of the child to know (Braude et al., 1990). Snowden and Mitchell (1981) found that DI practitioners feared that telling the donor-conceived child how they were conceived would cause severe social and psychological problems.

Clearly, the notion of identifying gamete donors is premised on the assumption of the importance of biological origins and several authors have argued in favour of identity disclosure on these grounds (Freeman, 1996; McWhinnie, 2001). However, there is also an argument concerning parity and non-discrimination that can be advanced in favour of disclosure of donor identity: that donor-conceived people should not be the only group of people *legally* prevented from finding out their biological parentage.

## Conclusion

While there have been continuing calls for the repeal of the removal of donor anonymity, the government has made clear that it will not contemplate a reversal of this decision (Department of Health, 2006). Hence, realists have accepted the challenge that the new context of donor conception requires changing practices for donor recruitment, if clinics are to promote the best interests of patients, their children, and donors (Adams et al., 2006; Hamilton, 2006, cited in Horsey, 2006). It is to be hoped that other clinics and the reproductive medicine community will accept the challenge and channel their resources

into developing new donor recruitment programmes that reflect the contemporary context in which gamete donation operates.

## Notes

1. Except where a donor is already personally known to the recipient – usually as a friend or relative – the majority of donors are anonymous to recipients. This is unaffected by the change in law regarding donor anonymity, since it is donor-conceived individuals only who have a right to learn the donor's identity.
2. ICSI involves the injection of a single sperm into an egg to achieve fertilization. Since the first human birth from ICSI was reported in 1992 (Palermo et al., 1992), ICSI has become a standard procedure. It is now a 'treatment of choice', in preference to DI, for heterosexual couples with male factor fertility difficulties and has been associated with a decline in DI (Johnson, 2006).
3. In practice providers of assisted conception services and their professional bodies, who have actively promoted anonymity in respect of sperm donation, have sanctioned the recruitment of known or identifiable egg donors in order to address the shortage of donated eggs (International Federation of Fertility Societies, 2001; Murdoch, 2001).

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