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The opinions expressed in this report are those of the authors and do not necessarily represent those of Health Canada.

The full report, which includes bibliography and appendices, is available upon request by writing to: AHRIO, Suite 350, 200 Promenade du Portage, Gatineau Québec, K1A 0K9; or by sending an email request to:
ahr-pa@hc-sc.gc.ca

ALTRUISTIC GAMETE DONATION

PHASE 1

Research commissioned by
the Health Policy and Communication Branch,
AHR Implementation Office of Health Canada
and undertaken by
The Reproductive Endocrinology and Infertility (REI) Program
London Health Sciences Centre (LHSC), London, Ontario

Prepared by:

Valter Feyles, MD, PhD, FRCSC LHSC REI Program

With the assistance of:

Ken Daniels, MA	Canterbury University, Christchurch, New Zealand
Jean Haase, MSW, RSW	LHSC REI Program
Deborah Isacsson, MBA	LHSC REI Program
Chris Newton, PhD	LHSC REI Program
Jane-Ann Parker, RN	LHSC REI Program
Francis Tekpetey, PhD	LHSC REI Program

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EXECUTIVE SUMMARY

It is rare to find any clinic, or in fact any jurisdiction, that says it has sufficient numbers of gamete donors to meet the needs of third party reproduction. This shortage exists whether gamete donors are paid or not paid. Legislation currently before the Senate has the provision to ban payments for reproductive materials. Concerns have been raised by reproductive health clinics and professionals on the possible effects of banning payment for donor gametes.
Relevant studies are available in the literature on donor recruitment strategies utilized in other jurisdictions, where regulations of various types have already been introduced. The following points can be summarized from the literature review

- Personal recruitment, and therefore personal donation, is more prevalent and acceptable in oocyte donation than sperm donation. One study indicates that the motivation of women to donate would increase significantly if the recipient was a sister.
- There is a need for more public education concerning gamete donation, this being seen as a contributor to changing the culture of third party reproduction.
- It is important to acknowledge and respond to the self-esteem needs of donors.
- For a number of sperm donors there is an important benefit from feeling needed and valued as a result of their donation.
- In one study the majority of the potential donor group was in favour of paying sperm donors, as were the infertility patients. In contrast, the general public was not.
- In areas where gamete donations is not paid, although recruitment is more difficult, the image of donors in the eyes of the requesting couple and the public opinion in general may be enhanced, since it is based entirely on altruism.

Some argue that prohibition of payment for sperm donation requires a rethinking of alternative methods of donor recruitment to reach and target potential donors who are motivated more by meeting self esteem needs than payment. To redirect recruitment strategies the following information should be considered:

- The higher the mean age of donors, the lower the interest in payment as a motivating factor
- The higher the percentage of donors who are fathers and/or men in permanent relationship, the lower the interest in payment as a motivating factor
- The reproductive centre policy/approach is an important factor in determining how sperm donation is viewed – gift giving or for payment

The survey conducted on methods of gamete donor recruitment suggests that most clinics experience difficulties in recruiting donors, however there are individuals who are prepared to donate altruistically. This seems more prevalent for oocyte donation than sperm donation. Most clinics recognize the need to provide for the psychosocial needs of donors to make them feel valued. New and innovative ways have to be developed to respond to new policy. It cannot be expected that traditional methods will work in the new environment.

The following considerations are relevant for planning the recruitment strategies for gamete donation.

- A pilot project is needed to evaluate ideas and strategies. During the pilot project a variety of recruitment means could be used, including the internet.

All the material utilized should be prepared professionally. Full time dedicated staffing, without conflicts with other duties are instrumental in the success of donor recruitment.
Pilot recruitment programs should be based on a specific clinic/service, thus allowing for the 'personal relationship' aspects to be utilized in the recruitment process.
All inquiries should be acknowledged and every effort should be made to make the potential donor feel that their interest is appreciated. Any inquirer potentially becomes another recruiter as they talk with friends or relatives about their experience. This approach is in keeping with the philosophy of donor seeing themselves as part of the health care team.
The administrative requirements should be kept to a minimum during the initial phases of the contact and only completed once the "engagement" or commitment phase is reached.

Based on the overall information available it is recommended that pilot programs for altruistic gamete donor recruitment be established in different regions of Canada. It is anticipated that the level of funding required would be comparable to a multidisciplinary / multi-centre project sponsored by a national granting agency such as the Canadian Institutes of Health Research (CIHR).
It is also recommended that Health Canada facilitate regular meetings between the donor recruiters in the different programmes with a view to their working collaboratively and providing support for each other.

If the proposed legislation is passed, the implementation phase, through the regulatory process, should follow a stepwise progression, in order to allow the development of adequate strategies, based on scientific evidence, for the recruitment of altruistic gamete donors.

SECTION 1: INTRODUCTION / BACKGROUND

The Royal Commission on New Reproductive Technologies (1993) reported that Canadians had told them that reproductive materials should not be commercialised because such practice "violates the principle of respect for human life and dignity".

Legislation currently before the Senate encapsulates this principle in its provision to ban payments for reproductive materials.

The contract between Health Canada and the Reproductive Endocrinology and Infertility Programme, London Health Sciences Centre, emerges from this proposed legislation and the implications of this for the recruitment of altruistic gamete donors. The contract calls for a review of the relevant literature, a survey of current recruitment practice and the formulation of recommendations. Three issues need to be raised in terms of providing general background to this report:

(1) It is extremely rare to find any clinic, or in fact any jurisdiction, that says it has sufficient numbers of gamete donors to meet the needs of third party reproduction. This shortage exists whether gamete donors are paid or not paid. The underlying reason for this is that providing gametes for others to whom you have no previous connection/association is something that comparatively few persons wish to do.

(2) It is inherently difficult to build an altruistic system of gamete donation into a profit making, competitive environment. Economists talk of the "market" having difficulty in accommodating altruism and gift giving. The commercial sperm bank model currently dominates donation provision in Canada. Available information strongly suggests that semen donors are mainly being recruited in Quebec at the present time, and that oocyte donation programs rely on patient recruitment of their own donors or on oocyte 'sharing'.

(3) The proposed legislation has been the cause of considerable concern, especially amongst reproductive health clinics and doctors. Some consumer organisations have also expressed concern that non-payment will mean that donors will not be able to be recruited and third party reproduction will not be able to be provided. This report has therefore been prepared for Health Canada to help address these concerns.

SECTION 2: REVIEW OF THE LITERATURE

The growing literature on issues to do with recruitment of gamete donors is listed in Appendix I. This literature includes commentaries/viewpoints, studies of donor recruitment, and reports of recruitment strategies. For the purpose of this report the focus will be on relevant studies and the reports on recruitment strategies. The latter cover both altruistic and paid gamete donation. It should be noted, however, that some of the literature on commentaries/viewpoints is relevant to the culture of gamete donation referred to later in this report.

The literature on gamete donation in general tends to be dominated by a consideration of the debates concerning secrecy and anonymity. This contentious area has been the subject of many studies. These studies have frequently explored the issues of donor recruitment and the impact any change concerning offspring having the right to access the identity of the donor might have on recruitment. The arguments presented, especially by doctors, are that abolishing anonymity will lead to a decline in the number of men (in particular) who are prepared to become donors. Similar arguments are made in relation to removing payment to donors.

The literature regarding gamete donation recruitment does not reflect a major focus on the issue of altruism versus payment, the predominant focus tending to be on the issues surrounding the sharing of information and in particular, the anonymity or otherwise of the donors. The studies do, however, seem to suggest an important relationship between the two areas in the case of sperm donation, i.e. men who are more willing to be identified to offspring in the future seem to share similar demographic characteristics to men who are prepared to donate altruistically. Likewise, men who expect to be paid are more likely to want to remain anonymous. A number of the sperm donor studies referred to in this report deal with both anonymity and altruism/payment.

The literature that has been cited in this section of the report has been chosen because of its relevance to the development of recruitment strategies in Canada. It has not been practicable to review all of the literature, due to its availability and to the time constraints of the project. The literature that is cited, however, is sufficient to provide a comprehensive overview of factors to be considered in the development of recruitment strategies within a policy of altruistic gamete donation.

The literature review is presented in relation to firstly oocyte donation and then sperm donation. Within each of these sections an overview of the studies will be presented, focusing in particular on who donates, why they donate and how they were recruited. Conclusions emerging from these studies will be presented, followed by an overview of non-study based literature that discusses recruitment issues.

Oocyte Donor Recruitment

Appendix I presents data emerging from 23 studies undertaken since 1984. It will be noted that the majority of studies have taken place in the last nine years. The studies were carried out in Canada, USA, UK, France, Finland, New Zealand, Spain, Australia and Belgium. The conclusions that may be drawn from these studies are:

1. *Who becomes a donor?* When payment is provided it is more likely that slightly younger women who are less likely to be married or have children are attracted. Conversely, those donating without payment are much more likely to be older, married and have children.

2. *What motivates oocyte donors?* Altruism is overwhelmingly cited as the major factor contributing to becoming a donor when payment is not involved. Concern for the infertile seems to emerge from donors own experiences of infertility, their knowledge of those with fertility difficulties, or their pleasure at having children and wanting others to share this experience. For some donors the ability to help known friends or relatives is an important motivator. Most of those donating altruistically are opposed to the notion of payment. For those who have been paid, it seems as if altruism was also a factor, although in one study only 11% of paid donors would be prepared to donate if there was no payment. (Klock, 2003).

The location of the studies is an important consideration. Payment for egg donation is accepted practice in the USA, whereas in some other countries payment is not allowed by law or by the policy of professional organisations.

In the situation of personal donation, i.e. donating to a known person, relative or friend, payment does not seem to be a consideration.

3. *How are oocyte donors recruited?* Recruitment strategies include those initiated by the recipient and those initiated by the clinic. The use of recipients to recruit their own donors is used by many clinics.

Clinic-initiated recruitment includes the use of advertising, both in newspapers and women's magazines, use of television and radio, notice boards, posters, flyers, recruiter advertisements and word of mouth. The advertising that emphasises payment and attracts younger students is targeted primarily at University/College settings.

4. *Other relevant literature contributing to the understanding of recruitment: A Swedish study in 1998 (Westlander et al.) of four groups of women – women undergoing IVF treatment, infertile women during work-up, recently delivered women and women applying for a therapeutic abortion – were surveyed to ascertain their willingness to donate oocytes. Those in IVF treatment (77%) were most willing, followed by infertile women (66%), those seeking abortion (54%) and recently delivered women (47%). The results also showed that 57% described an increased motivation to donate if the recipient was a sister. Payment to donors which resulted in financial gain was not considered desirable by any of the groups.*

The research undertaken in the United Kingdom by Byrd et al. (2002) led to these researchers making recommendations regarding recruitment. They argued for far more open discussion and public awareness to occur, for health staff involved in contact with potential donors to be helpful and responsive, for a national support and information network to be established, for provision for donating locally, and for reimbursement of expenses – but not payment – to be available.

Another UK study (McLaughlin et al., 1998) covered both oocyte and semen donation. They had a two year recruitment program that utilised posters and leaflets, professionally designed radio advertisements, and articles in newspapers. The response rate was higher for oocyte than semen donation, but they concluded that advertisements alone were not enough and that payment was needed to act as an incentive.

The National Gamete Donation Trust in the UK undertook a study (2000), looking at recruitment of oocyte and semen donors. The results, which are quite extensive and cover a survey of 64 clinics, found that 89% recruited women with partners and that altruism and a strong desire to help were the primary motives. Staff in clinics felt that payment of expenses – there was no actual payment – rarely featured in the woman's decision to donate her oocytes. Almost three-quarters of clinics asked recipients to recruit by advertising anonymously in the local press. Recipients were offered considerable assistance in the framing of advertisements. Three-quarters of clinics used oocytes from a donor whom the recipient knew. Almost all clinics (93%) contacted the woman after her donation. Thirty eight percent wrote a letter and 42% gave a gift such as a bouquet of flowers. The report notes that the amount of money and time spent on recruitment had a significant impact on the numbers of men and women coming forward to donate.[1]

In 1998 the Human Fertilisation and Embryology Authority in the UK initiated a consultation on the implementation of withdrawal of payments to donors. The document prepared as part of the consultation covers oocyte and semen donation, and concludes that the supply of oocyte donors will not decrease simply as a result of payment being withdrawn. It points out that issues surrounding oocyte donation are different than those surrounding semen donation, a matter referred to later in this report. The report argues for a cultural change concerning gamete donation, this being necessary as a part of moving to an altruistic system. It suggests the following strategies for recruitment of both oocyte and semen donors: general recruitment approaches, including advertising articles in magazines/newspapers and television programmes, talks and speeches, videos or tapes and word of mouth. The report also discusses more specific and focused strategies, including word of mouth, patients recruiting donors including relatives and friends.

Some conclusions that may be drawn from the above information are:

1. Married women with children (and therefore older) are more likely to be attracted to

[1] This study was also reported in a published paper by Murray and Golombok, 2000.

altruistic oocyte donation than single, younger women. The latter are more likely to be influenced to donate by monetary considerations.

2. Altruism seems to be much more a component of oocyte donation than sperm donation. Most women recruited as altruistic donors are opposed to payment.

3. Personal recruitment, and therefore personal donation, is more prevalent and acceptable in oocyte donation than sperm donation.

4. There is a need for more public education concerning oocyte donation, this being seen as a contributor to changing the culture of third party reproduction.

5. It is important to acknowledge and respond to the self-esteem needs of donors.

Sperm Donor Recruitment

Table 2 provides an overview of 22 studies reported between 1980 and 2003. These studies were located in France, Australia, New Zealand, USA, UK, Belgium, Denmark and Sweden. There were 12 studies in the 1980s, nine in the 1990s and only one since 2000. This would suggest a declining interest by researchers in the motivations and views of sperm donors. This may in part be accounted for by the declining use of DI and the increasing use of ICSI as an alternative.

1. *Who becomes a donor?* The studies would suggest this depends on motivational factors and on the policy of clinics in terms of who they 'target' for recruitment. Married men with children seem to be more interested in altruistically helping others, while younger men have a higher interest in payment. It may be that older men are more likely to know of persons who have experienced infertility.

2. *What motivates sperm donors?* As in (1) above, there are important differences between younger and older donors, although it cannot be assumed that all younger donors, for example, will be motivated by financial considerations. It is also important to note the results of studies which show that many donors who were recruited within a financial recompense system indicate they would donate without payment.

3. *How are sperm donors recruited?* Not a great deal is reported on recruitment strategies used, but it seems that advertising and word of mouth/personal contact are the dominant means. This is not to suggest that personal semen donors are used to the same extent as personal oocyte donors, but there is some evidence of this. Where students are being targeted, it is clear the student notice boards are used extensively.

4. Other relevant literature contributing to the understanding of recruitment: A study by Emond and Scheib (1998) of 101 psychology students in the USA (non-donors) aged between 18 and 37 found that 46 students said they would donate sperm. Of these, 67% were willing to donate for research purposes, whereas 24% were prepared to donate for reproductive purposes. The reasons given for donating were money and helping, whereas the most popular of several reasons for not donating was the knowledge that children who would never be known may be produced.

Lui and Weaver (1996) studied the views of three groups of men: 97 childless semen donors, 56 childless non-donors and 44 mature non-donor fathers. It was found that relatively more donors than non-donors endorsed the importance of financial incentives for donating; non-donors who were also fathers favoured involvement with recipients and offspring more often than did non-fathers; and all groups stressed the importance of confidentiality and guaranteed anonymity. This study took place in the UK.

Another UK based study by Lyall et al. (1998) surveyed 717 men in three different groups: the general public, students (potential donors) and infertility patients (potential recipients). The majority of the potential donor group was in favour of paying sperm donors, as were the infertility patients. In contrast, the general public was not. Prior awareness of the existence of

payment significantly correlated with being in favour of payment. There was strong support from the public for the use of donor insemination. The authors raise questions concerning the extent to which the views of potential recipients and donors should be considered in the formation of policy.

A follow-up study of altruistic donors in a clinic in London, England (Daniels et al. 2003) – not yet published – showed that 85% of past donors indicated their reason for donating was a desire to help others become parents. Almost 30% wanted to share the joy of parenting with others. For a number of donors there was an important benefit from feeling needed and valued as a result of their donation. For a third of respondents the partner's influence was said to be significant.[2]

A New Zealand study by Purdie et al. (1994) involved circulating an anonymous questionnaire to 54 parents of young children, antenatal patients and their partners attending private obstetricians, and 138 couples with pre-school children at Kindergartens or Playcentres. There was just under a 50% response rate. About half the men and women recalled seeing or hearing publicity about the need for sperm donors, representing one partner or both in 78% of all couples. One or other partner had considered sperm donation in 26% of all couples. For 13 % of all couples, one or other partner had considered donation and neither partner had listed any objections in their questionnaire. However, only two men had contacted the clinic. The population of the city in which the study took place was one million. The authors concluded that the main aim for future publicity will not be to reach more people, but to give a stronger message to those already reached.

The survey of clinics undertaken for the National Gamete Donation Trust (which covered oocyte and sperm donation and which has already been mentioned under the oocyte donation section) showed that clinics most frequently used advertising in universities and colleges as their means of recruitment – more than 70% of potential donors were recruited in this way. Advertising in hospitals and male-oriented work settings was not found to be so productive. The media was also used extensively. Just over half of the clinics reported that potential donors had contacted them through word of mouth from existing donors. In 40% of clinics, existing donors were asked to recruit other donors. The majority of donors were students and all but one clinic paid the donors. The majority of the clinics (86%) believed payment was the primary motivation of students to donate.

In France, the professional federation of sperm banks (CECOS) has, for more than 25 years said that sperm donation must be free and anonymous. This has subsequently become the law. Guerin (1998) says that these requirements have made the recruitment of donors more difficult and that there are resultant disadvantages – longer waiting lists and use of mediocre quality sperm. He argues, however, that the advantages are great, in particular with regard to health security and the image of sperm donors in the eyes of the requesting couple and the public opinion in general, since it lies entirely in altruism. In France a large percentage of donors are recruited through the efforts of recipient couples. The following table regarding donors in France is taken from Guerin's paper.

[2] This follow up study was for the men from Clinic A in the Daniels et al. study of 1996 (see Table 2).

TABLE 1: MODES OF SEMEN DONOR RECRUITMENT
(DOCUMENTS OF THE FRENCH CECOS FEDERATION) (Guerin, 1998)

Years	1980		1985		1990		1995	
Personal approach	87		133		167		281	
Approach by recipient couples	247		187		325		223	
Candidates for vasectomy	89		201		128		98	
Approach by a gynaecologist	23		41		-		24	
Relationships with the medical staff	27		13		-		-	
Others	45		38		69		21	
Total no. of donors proposing a donation	518		613		690		647	
Total no. donors accepted	349	(67%)	446	(73%)	451	(65%)	384	(59%)
No. candidates (couples) for artificial reproductive techniques with donor semen	3041		3730		4000		2690	

Daniels and Hall (1997) have argued that prohibition of payment for sperm donation requires a rethinking of alternative methods of donor recruitment. They argue that there are a large number of current and potential donors who are motivated more by meeting self esteem needs than payment, and they suggest ways in which the enhancement of self-esteem can become the driving force for recruitment programmes. This underlying principle is already operating in some clinics and jurisdictions. The proposed recruitment strategies that are part of this report are based on this culture of gift-giving and enhancement of self-esteem.

Some conclusions that may be drawn from the above information are:

1. There is a strong relationship between the higher mean age of donors and payment not being a motivating factor.

2. There is a strong relationship between the percentages of men who are married or in a permanent relationship, and payment not being a motivating factor.

3. There is a strong relationship between men who are fathers and payment not being a motivating factor.

4. There is a strong relationship between single, younger men and money being a major motivating factor.

5. A variety of recruitment strategies are used by different clinics, but advertising and word of mouth are prominent.

6. Clinic policy/approach is an important factor in determining how sperm donation is viewed – gift giving or for payment.

SECTION 3: SURVEY OF RECRUITMENT PROGRAMMES

The choice of clinics to be surveyed was influenced by the following factors:

1. International coverage.
2. Clinics that recruited altruistic donors.
3. Clinics that were in jurisdictions that had legislation which impacted on practice.
4. Availability of team member to personally contact some clinics.

Recruitment of Egg and Semen Donors
Survey Results

Number of clinics surveyed: 20

Location of clinics:

New Zealand	10
Australia	3
France	1
UK	1
Germany	1
Netherlands	1
Sweden	1
USA	2

Number of clinics offering egg donation: 12/20

Number of clinics offering sperm donation: 13/20

Number of clinics offering both egg and sperm donation: 5/20

Rated degree of difficulty recruiting donors:

From 1 ("not at all difficult")… to….. 7 ("very difficult")

Rating	Egg Donation	Sperm Donation
Average	5.0	4.5
"7"	30% (3/10)	15% (2/13)
"6"or "7"	50% (5/10)	30% (4/13)
"1"or "2"	10% (1/10)	15% (2/13)

Methods For Recruiting Egg Donors:

Twelve clinics reported 6 different strategies

1.	Newspaper advertisements	(4/12 clinics)
2.	Magazines	(2/12)
3.	Recipients to donor recruiting	(11/12)
4.	Posters	(1/12)
5.	Radio/TV	(1/12)
6.	Donor to donor	(1/12)

Two clinics reporting "no difficulty" or lesser difficulty (rating=3) in recruiting; both employed *recipient to donor* recruiting and one used *magazine advertising.*
Two clinics reporting "great difficulty" employed *recipient to donor* and *newspaper advertising* as recruitment methods.

Thus there was no obvious relationship between recruitment methods and rating of difficulty is recruiting egg donors.

Methods For Recruiting Sperm Donors:

Thirteen clinics reported 9 different strategies

1.	Newspapers	(10/13 clinics)
2.	Recipient to Donor	(4/13)
3.	Radio/TV	(3/13)
4.	Donor to donor	(2/13)
5.	News stories	(2/13)
6.	Posters	(2/13)
7.	Newspapers (National)	(2/13)
8.	Internet	(1/13)
9.	Other	(1/13)

Clinics reporting "no difficulty" or minimal difficulty (rating=2) in recruiting, utilized *local newspaper advertising* (2 clinics), *recipient to donor* (1 clinic) or *donor to donor* (1 clinic) recruiting methods.

Four clinics reporting "great difficulty" employed *local newspaper advertising* (3 clinics), *recipient to donor* (2 clinics), national *newspaper advertising* (2 clinics), *posters* (1 clinic), and *radio/TV* (1 clinic) as recruitment methods.

Thus there was no obvious relationship between recruitment methods and rating of difficulty is recruiting sperm donors.

Policy Concerning Payment of Donors:

Egg Donation

Clinics recruiting only paid donors	0/11
Clinics recruiting only unpaid donors	9/11
Clinics recruiting both paid and unpaid donors	2/11
Clinics where information not obtained	1
Clinics providing expenses to all donors	12/12

Sperm Donation

Clinics recruiting only paid donors	2/12
Clinics recruiting only unpaid donors	10/12
Clinics recruiting both paid and unpaid donors	0/12
Clinics where information not obtained	1
Clinics providing expenses to all donors	12/12

Does clinic have policy to provide expenses to all egg donors?

8/12	Yes
4/12	No

Does clinic have policy to provide expenses to all sperm donors?

11/13	Yes
2/13	No

Clinic estimate of % of egg donors willing to donate without payment

100% -	9/11 clinics
30% -	1/11 clinics
5%-	1/11 clinics

Issues Identified As Important For Recruitment:

	Number of Clinics Using This Strategy	
	Egg Donation	Sperm Donation
1. Counseling Session	12/12	9/13
2. Verbal Reinforcement/Support	6/12	4/13
3. Quality of Interpersonal Relationships	4/12	8/13
4. Amount of Staff time Given to Donation	3/12	4/13
5. Outcome Information Provided	2/12	9/13
6. Follow-up Contact/Update of Information	1/12	2/13
7. Involvement of Spouse	0/12	4/13

Staffing:

From the open-ended questions, it became obvious that the personality, motivation and time availability of the staff member undertaking the recruitment was of central importance. Those respondents who had mixed feelings about undertaking this work, or who had competing work interests, seemed to be less successful as recruiters. They also seemed less innovative in their choice of recruitment strategies. This was reflected in one country (Holland), where there were media reports that the availability of semen donors had all but ceased. This was attributed to a change in the law regarding the abolition of donor anonymity. However, the person interviewed from Holland reported that his clinic had no shortage of semen donors and in fact, most donors approached the clinic. He and his colleagues had established an innovative approach, which included the clinic being open at hours convenient to donors, a club atmosphere for donors to enjoy, the sending of gifts to donors four times per year, and a very personal interest being taken in the donors and their families. The staff member believes this innovative approach has been very successful compared to other clinics having difficulty recruiting donors. The conclusion that may be drawn is that if policy/legislation is changed, then new methods of recruitment must be developed. In this case it was effective when anonymity had been removed but the same principle is almost certainly likely to apply when payment is removed.

Conclusions emerging from survey:

1. Most clinics experience difficulty in recruiting donors.

2. A variety of recruitment means are used. There does not seem to be a clear pattern suggesting that one strategy is more successful than any other strategy.

3. There are donors who are prepared to donate altruistically. This seems more prevalent for oocyte donation than sperm donation.

4. Most clinics recognise the need to provide for the psychosocial needs of donors and do this via a variety of strategies. Respondents reported that the meeting of psychosocial needs is seen as important by donors in that it makes them feel valued.

5. New and innovative ways have to be developed to respond to new policy. It cannot be expected that traditional methods will work in the new environment.

Overview of Gamete Donation Services in Canadian Clinics:

It should be noted that individual clinics were not contacted directly for the purposes of this report. However, information from 2 sources is summarised below as follows:

Table 2: Donor Gamete Services in Canadian ART Programs (Fluker & Tiffin, 1996)

Service	# Programs Offering Service (n=14)
Donor Insemination	11/14 (78.6%)
Donor Oocyte - known only	1/14 (7.1%)
Donor Oocyte - known and anonymous	7/14 (50.0%)

1. 14 clinics were surveyed
2. 79% provide donor sperm services
3. 7% provide only known donor oocyte services
4. 50% provide both known and anonymous donor oocyte services

Table 3: Donor Gamete Services in Canadian ART Programs: 2004 Website Survey

Service	# Programs Offering Service (n=14)
Donor Insemination (n=20)	20/20 (100%)
Donor Oocyte (n=20)	16/20 (80%)

1. 20 Clinic websites were surveyed
2. All (100%) provide donor sperm services
3. 80% provide donor oocyte services:
    - 3 clinics provide only known oocyte donor services
    - 1 clinic provides only egg sharing services
    - 3 clinics provide both known and anonymous oocyte donor services
    - 3 clinics provide both known donor and oocyte sharing services
    - 6 clinics did not indicate what type of oocyte donor service they provide
    - Known donors are presumably recipient recruited, and may not necessarily be altruistic.
    - Anonymous donors are presumably clinic or third-party recruited, and are likely not altruistic.
    - Egg sharing is typically not altruistic.

Note:
The figures reported in Table 3 regarding Donor Insemination (DI) do not represent the entire picture of the provision of DI given that smaller centres and individual physicians also perform inseminations with donor sperm, but are not accounted for in the websites of assisted reproduction clinics.

SECTION 4: STRATEGIES FOR THE RECRUITMENT OF ALTRUISTIC GAMETE DONORS

This section of the Report begins with a consideration of some of the wider cultural factors that impact on how third party reproduction is viewed, and within that, donor recruitment. Consideration is given to the need for public education and information, along with the need for education of professionals. Against this background, specific recruitment strategies are outlined.

Cultural Factors Impacting on Providing Gametes

The current culture of gamete provision is characterised by:

1. Seeing gamete provision as a morally questionable activity, especially where masturbation is involved.

2. Doctors and health professionals not according gamete provision a high priority or value.

3. Payment of money conveying the meaning that providing gametes is a service, rather than an act of helping and giving.

An ideal/new culture of gamete provision would be characterised by:

1. Normalising family creation in different ways and by different means. A broader concept of family being accepted. Difference not being equated with bad/negative/worse.

2. Recognition that infertile couples/persons need assistance rather than pity/misunderstanding.

3. Donors helping to build families by aiding in the creation of a child.

4. Donors being rewarded for their contribution by knowing that they have 'helped' and are valued by parents, staff and the community.

5. Self-esteem being enhanced as a result of helping others.

6. Donors seeing themselves as a vital part of the health care team.

Strategies Designed to Change the Present Culture to the Desired Culture

The following strategies are based on information emerging from the fields of public health, education, social policy, attitudinal change, and marketing.

A) Public education and information.

The need for a planned and co-ordinated approach is required. The use of staff with expertise in public health would seem crucial – learning from what has worked and not worked in other areas of health education.

The focus of such an approach would be the six points listed in the ideal/new culture outlined above. The major strategy would be the involvement of all branches of the media, from stories of infertile couples to TV plays that focus on infertility and assisted human reproduction. The focus of such presentations should be the needs of persons, how those needs are met and the grateful thanks of those who have been helped. Presentations will need to include men and women and portray both as having needs. This is designed to break down some stereotypes concerning the causes of infertility. In particular, magazines should be targeted, preferably where the stories of more than one set of parents can be presented. All such presentations should include a contact phone number/email address for readers/listeners/viewers who may want more information or wish to consider donating gametes. Donors of gametes should also feature in articles, talking of their experiences, their motivations and their rewards – self-esteem.

Written material (pamphlets) needs to be prepared for distribution through doctors' waiting rooms, maternity services, child and baby organisations, and service groups. Such material needs to include photos and stories of parents who have become parents through gamete donation. Again, donors should also be included. The focus of this material should again be in line with ideal/new culture's characteristics.

Consumer group contact points might be considered for inclusion in the brochure, but this would depend on the support, active involvement and ability of such groups to respond appropriately.

B) Education of professionals.

The 'targeting' of professionals who are known to be committed to, and supportive of, altruistic gamete donation needs to be considered. Enlisting their support/involvement may have a beneficial impact as they talk with colleagues.

Professionals will also need to receive information concerning the strategies being adopted. While mailing of this information is likely to be cheaper, it needs to be considered whether a person/s might offer to visit clinics/individuals to meet with them, listen to their concerns and seek to enlist their support. As a minimum, such visits should be educational.

If Health Canada was to consider the production and sending of a newsletter to all clinics – covering implementation issues arising from the legislation – regular information/updates on gamete recruitment could be included.

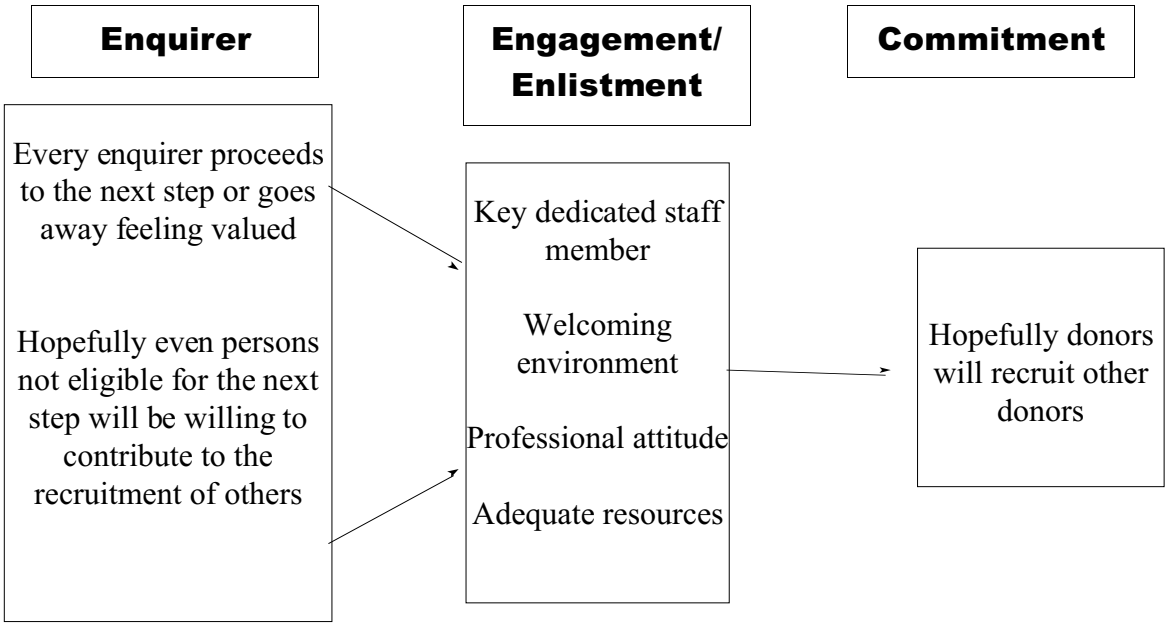
It is not recommended that conference presentations be the primary mechanism for disseminating

information about recruitment strategies. Instead, individual approaches to persons and clinics are likely to be much more effective educationally. Clinics and staff need to know that there will be a 'lead in' time before implementation of the legislation and that during this period Health Canada is promoting pilot projects to trial different recruitment strategies. The pilot projects could well provide the opportunity for clinics undertaking the pilots to develop collaborative approaches with each other. The competitive approach between clinics is counter-productive to changing the culture of gamete provision and to establishing new approaches/strategies.

Strategies Designed to Recruit Gamete Donors

The following process model has been designed to highlight the three stages of donor recruitment: enquirer stage, engagement/enlistment stage and commitment stage. Specific strategies are recommended relating to each of these stages outlined.

Donor Recruitment Model



Strategies for the enquirer stage:

These strategies are sub-divided into those that are recipient-initiated and those that are clinic-initiated. The goal in this stage is to elicit large numbers of enquiries.

(a) recipient initiated

Historically, recipients have relied on clinics to recruit donors. It is suggested that in line with the policy and practice in France, as well as the approach adopted by many lesbian couples,

recipients (patients) be encouraged to consider self-recruitment i.e. the asking of someone known to them. Such donors are often referred to as 'personal donors' in that they donated for a specific couple/person. There is some research evidence that suggests women donating eggs are more interested in meeting the recipient than are semen donors and therefore personal donation may be more appropriately targeted at egg than semen donation.

An alternative is that recipients seek to recruit donors who become part of the pool of donors, but that their gametes are specifically not used for the recipient who recruited them. Two principles underlie this approach: (1) recipients accepting that they can be recruiters and therefore not dependent on clinics and (2) that friends/relatives who know of the infertility are more likely to want to help (see research quoted in the literature review section).

Two factors emerge from this proposal. The first is that for many seeking third party reproduction, there will have been or currently is considerable stress and trauma. This needs to be addressed by psychosocial counselling before the issue of their recruiting a donor is raised. The second factor is that not all recipients will want or be able to take such an initiative and no pressure should be exerted on them to do so.

Raising the possibility of recipients recruiting donors can only be considered if a comprehensive psychosocial counselling service is being provided by trained counsellors. In particular, concerns about the potential for emotional coercion would need to be addressed when personal donation is used.

Specific written material would need to be provided to recipients so that this could be passed on to potential donors. This would outline the two options cited above, personal donors and pool donors.

(b) <u>clinic or service initiated</u>

All strategies are designed to reflect the ideal/new culture described above. It is also recommended that the pilot recruitment programmes be based on a specific clinic/service, thus allowing for the 'personal relationship' aspects described in the research to be utilised. While a centrally located national recruitment programme may have economic advantages, its effectiveness will be limited by its impersonal nature.

The following specific strategies are proposed:

1) The research studies suggest that an increasing number of clinics overseas are using the internet to elicit enquiries. A website needs to be developed (or an existing one modified) that will highlight stories from recipients and donors. It will outline the general characteristics that the clinic is looking for, but it should not be designed to give the message that only people with certain characteristics are acceptable. Any enquirer potentially becomes another recruiter as they talk with friends or relatives about their experience.

2) Advertising in local and national newspapers, magazines, radio and television will bring

some enquiries. Local newspapers seem more effective than national newspapers. Advertisements should be personalised where possible. For example:

> My wife and I are infertile. To enable us to have the child we would dearly love, we need a man who is prepared to donate his sperm. We are patients at The Fertility Centre and if you could help, please phone the centre on...

> Hi, my name is Jane. As John and I were unable to conceive naturally we joined the Donor Insemination Programme at The Fertility Centre. We are very grateful to the semen donors who made it possible for our beautiful child to be born. We encourage other men to consider joining the Donor programme to help people like ourselves. For information, please phone...

> Seeking Egg Donor
>
> Finally I have found my prince and we would dearly love to experience the magic of having a child. Sadly we are unable to use my eggs and our only chance of having a baby is through someone giving us a wonderful gift of egg donation. If you can be our fairy godmother or would like some information, please call Fertility Associates on... *Still believing in the fairytale.*

This last advertisement is reported by staff in the clinic concerned to have had the largest ever response.

3) Professionally prepared and produced brochures are required. Again these should focus on the personal and hopefully contain pictures of families. A photo of the team at the clinic could be considered, along with an invitation to join the team by donating. The brochures should include a photo and message from the Clinic Director.

Several brochures may be prepared; one for gamete donation and one each specifically designed for egg and semen donation. The brochures might refer readers to a website for stories from other donors and grateful parents.

Distribution of the brochures should be to family doctor waiting rooms, obstetric departments, military and police establishments and wherever else parents of young children are likely to be found. There should be one telephone number and email address listed for contact.

4) Preparation needs to be undertaken of posters that can be placed in venues such as waiting rooms, blood donation centres etc, again with contact points for more information. These should be professionally designed and again focus on families and helping others (gift and giving). Specific posters may be prepared for lesbian groups and for minority ethnic populations. Any material drawn up for minority groups should be undertaken in consultation with representatives of those groups.

5) Selected staff should be made available to speak to service groups and organisations that are known to have regular speakers. While the members of many service clubs tend to be older (and therefore not suitable as donors), such persons should be encouraged to talk with others, including their own offspring. Talks to such groups also provide educational opportunities which are relevant to a change in the culture of gamete donation.

6) Some clinics surveyed provide newsletter updates for previous donors. Where there are previous donors, they could be contacted (by telephone in the first instance) to ask if they would like to receive information concerning the changes in policy and practice. They could also be asked if they would like brochures to pass on to friends/relatives who might be prospective donors. (See following section relating to commitment stage.)

7) Contact should be made with consumer support groups to discuss how they can contribute to donor recruitment. They could be asked to include brochures with their mailings – perhaps once a year.

8) Contact could be made with patients who have previously conceived with the assistance of egg donation to ascertain if they might be willing to talk with a staff member about the male partner becoming a semen donor. The reverse is also possible, that couples receiving semen donation may want to consider the female partner becoming an egg donor. These strategies are based on theories related to gift giving, namely that most people want to respond to a gift by themselves giving. Programs would need to be concerned about the potential for coercion of former patients.

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All of the above strategies are proposed as means of reaching potential donors. No one strategy on its own will be sufficient. It is recommended that in planning a recruitment campaign, all strategies are fully considered. Different strategies will appeal to different potential donors. Given the research evidence that suggests that many previous donors have known infertile couples/persons and that this has been a factor in their becoming a donor, this should be built into the choice of strategies.

Strategies for the engagement/enlistment stage:

Evidence from the published research, as well as from the survey undertaken as part of this project, strongly suggests that two factors are of importance in responding to the enquirers and moving some of these persons to the engagement and enlistment stage.

The first factor is the person who responds to the enquirer. Dealing with a wide range of people, with a variety of motives for making contact about gamete donation, is a challenging task that requires considerable skill, tact and empathy. The person responsible for recruitment must be carefully chosen. Where staff members have had this activity added to other duties, it seems as if the other duties frequently take precedence and recruitment drops down the order of priorities. It is not possible from the information available (research and survey) to recommend what characteristics the person appointed should have. There seems to be conflicting views regarding the gender of the person – in most situations reviewed it seems as if the person currently

undertaking recruitment felt that their gender was appropriate! It could be argued that male-to-male and female-to-female contact is most appropriate. It is likely, however, that the personality attributes and skills of the recruiter are as, if not more, important factors than the gender. The recruitment person must enjoy the confidence of the staff, be seen as an integral member of the team, and be well supported in their work.

The second factor regarding enquirers is access. Those making contact will want this to be a trouble-free and simple process. It may be off-putting for enquirers to have to go through the main switchboard and a clinic receptionist before speaking to the person responsible for recruitment, especially if there are time delays. Having direct dial access is recommended, with an answer phone that is continually updated regarding availability. If possible, a specifically designated line should be available for callers, in other words, the line is only used for that purpose. Every effort should be made to ensure callers' experiences are 'hassle free'.

During the pilot project it is recommended that all enquiries should be offered a face-to-face interview. Some clinics, because of financial and timing constraints undertake an initial selection over the telephone and only invite for interview those who meet agreed-to criteria. This approach is not recommended as it precludes the 'personal relationship' factor developing with the clinic. This factor can be crucial in encouraging that person to speak positively about the clinic and its needs to others. They therefore become a potential recruiter. A face-to-face interview is also more likely to provide for education and the engagement of the person in the development of the ideal/new culture of gamete donation. Not all persons will want to come for an interview and, for those who don't, every effort should be made to obtain an address to which brochures/information may be sent. Face-to-face interviews should be offered as close to the telephone call or email contact as possible and ideally there should not be a delay exceeding four days. This has implications for the staff member's commitment and will only be possible if during the pilot project the person appointed is in a full-time capacity. A strong emphasis should be placed on thanking enquirers for making contact and reinforcing their desire to help others. Self-esteem should be raised as a result of contact, even if it does not lead to a face-to-face interview.

Administrative requirements (form-filling, 'red tape') should be kept to a minimum and only completed after the person has been fully engaged. The venue for a face-to-face meeting needs to be considered carefully. It needs to be a specifically designated office that is easily accessible and has a warm and accepting 'feel'. Interviews should not be conducted in a room that is used for other purposes, e.g. a consulting room or a lab. The focus of the interview should be person-oriented rather than task-oriented. For some enquirers the session will be primarily information sharing at a general level, whereas for others it will be much more specific and may lead to decisions being made at that time. Some enquirers may wish to view the clinic or sections of it and when they visit the lab staff, for example, these staff will play a crucial role in supporting and encouraging the person's exploration of becoming a donor. Training programmes should be considered for all staff who may meet prospective donors. Follow-up interviews will vary according to the stage of consideration or decisions made. Those deciding not to proceed should be sent a message of thanks for coming and being interested, along with a request that they talk to others about the needs of the infertile, or that they pass on enclosed brochures. Where an

enquirer coming for an interview has a partner, the possibility of both coming should be raised.

Strategies for commitment stage:

If commitment seems likely, then an explanation would be provided (supported by written information) of the tests and procedures that are necessary. This will involve meeting other staff and it is desirable that such staff members are mentioned by name and if possible, that prospective donors have a chance to meet them at this point. If not, when they meet at a later date, every effort should be made for the recruiter to be present to provide a linkage. A careful balance needs to be maintained between encouraging participation and carrying out medical and psychosocial screening. Information should be sought on when or how often prospective donors might wish to have follow-up information e.g. if they want to be able to telephone in from time to time to know if conceptions/births have occurred as a result of their donations.

A newsletter for donors should be distributed every three months. It should be ascertained if prospective donors would like to meet actual donors, and if donors would like to get together for a social gathering. Newsletters have been reported to fulfil an important function for semen donors in one clinic and in another clinic, regular meetings – mainly social – for semen donors is cited by the organisers as being a major factor in their successful recruitment programme.

All consent forms will need to be fully understood before signing takes place and this phase should not be rushed or pressured. As soon as possible after this, a letter from the Clinic Director should be sent to donors, thanking them for being willing to participate and emphasising how much their altruistic act is appreciated and valued by the staff, and (if all tests prove satisfactory) how much it will be valued by the eventual parents.

Once all preliminary work has been undertaken and donations are being made, there should be a periodic contact from the recruiter, mainly to reinforce self-esteem issues and to seek advice on any ways in which the service could be improved. Where donors have partners and children, it will be helpful if the recruiter can enquire about their welfare, using their names. The experience from one very successful clinic suggests that this 'personalising' means a great deal to donors and contributes to their talking to others about donating.

A major focus at this time should be on encouraging donors to speak to friends/relatives who may be potential donors. This may include providing brochures and the name and telephone number of the person to contact. The goal is for donors to feel proud of how they have helped, to talk to others about this, and to encourage them to also contribute.

Donors who are prepared to be interviewed for stories or by the media should be sought. Not all donors will be willing to do this but all should be asked, it being explained that this is a way in which they can contribute to the ideal/new culture surrounding gamete donation. Permission should be sought to carry out a study of their views, attitudes and experiences within the next 12 months. This will provide information that will assist in the refining of recruitment strategies, as well as contributing important information for professionals who have been sceptical or resistant to altruistic gamete donation policy.

SECTION 5: RECOMMENDATIONS

(1) That pilot programmes for altruistic gamete donor recruitment be established in different regions of Canada.

(2) That the clinics chosen to provide these programs be asked to prepare a strategic plan based on the material contained in this report and to submit this to Health Canada for approval. This is to include budgeting proposals.

(3) That Health Canada provide funding for an initial period subject to further review. It is anticipated that the level of funding required would be comparable to a multidisciplinary / multi-centre project sponsored by a national granting agency such as the Canadian Institutes of Health Research (CIHR).

(4) That Health Canada facilitates regular meetings between the recruiters in the different programmes with a view to their working collaboratively and providing support for each other.

(5) That Health Canada commissions an evaluation study of the pilot programmes to commence before the establishment of the programmes.

(6) That the implementation phase of new legislation, through the regulatory process, follows a stepwise progression, in order to allow the development of adequate strategies, based on scientific evidence, for the recruitment of altruistic gamete donors.