Anonymity and secrecy options of recipient couples and donors, and ethnic origin influence in three types of oocyte donation

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BACKGROUND: This study compares recipient couples’ and donors’ motivations towards the type of donation and attitudes concerning secrecy or disclosure of the mode of conception in three oocyte donation groups: couples and their donor for a known donation, couples and their donor for a permuted anonymous donation (known-anonymous) and couples without a donor, on a waiting list for a donation (anonymous).

METHODS: Data collected by two psychologists through semi-structured interviews of 135 recipient couples and 90 donors before oocyte donation were analysed retrospectively.

RESULTS: In known donation (42 couples), donors were preferentially family members with a blood tie (54.7%). Choosing their donor seemed mainly for the couple’s reassurance rather than to access the child’s origins as 50% wanted secrecy. On the other hand, in known-anonymous donation (48 couples), donors were more frequently chosen among friends (41.6%; \( P = 0.038 \)). These couples were either open to disclosure (45.8%; \( P = 0.002 \)) or remained hesitant (39.6%). In anonymous donation (45 couples), 49% chose not to seek a donor mostly in order to maintain secrecy towards the child (77.3%). Among the 51% who sought but could not find a donor, only 30.4% wanted secrecy. Recipients from North Africa and from Europe preferred anonymous or known-anonymous donation (83.3 and 75.6%), whereas sub-Saharan Africans opted more often for known donation (63%; \( P < 0.001 \)). Among Europeans (90 couples), 50% were in favour of disclosure compared with only 8.9% of recipients from North or sub-Saharan Africa (45 couples; \( P < 0.001 \)).

CONCLUSIONS: A diversity of attitudes and cultural differences exist among recipient couples and donors regarding oocyte donation; this pleads for maintaining access to different types of oocyte donation as well as for psychological counselling prior to treatment.

Key words: oocyte donation / psychology / anonymity / secrecy / cultural influence

Introduction

Oocyte donation, a technique that appeared in the early 1980s (Trounson et al., 1993), was developed in the aftermath of the progress in IVF. This alternative parenthood allows women with infertility problems due to ovarian failure or insufficient oocyte quality to achieve pregnancy and give birth. Nevertheless donor availability is an ongoing issue for numerous fertility clinics, mainly in countries where paid donation is forbidden. To supply enough oocytes to fulfill the need, different donating practices [such as anonymous or known donation and oocyte sharing (Englert, 1996)] have appeared in several countries and assisted reproductive centres. Among donors, some are altruistic while others receive financial compensation. In Belgium, oocyte donation legislation was passed on the 6th of July 2007, which prohibits remuneration of donors, except for reasonable reimbursement of their expenses (Le Moniteur belge/Belgisch staatsblad, 2007). At the Erasme hospital, three options are available for couples wishing to undergo oocyte donation (Delbaere et al., 2002):

(i) Known donation: Here, the couple receives the oocytes of the donor they brought to the programme. The donor must have had children and if possible be a maximum of 35-year-old. However, donors between 36 and 39 years of age can be accepted in the programme after appropriate counselling.

(ii) Known-anonymous donation: It is based on permutations of donors (Figure 1) (Englert et al., 1996; Englert and Govaerts, 1998). In this case, each recipient brings a donor to the programme whose oocytes are usually shared among four other recipients.
In return, each recipient can have up to four or five successive oocyte donation cycles, receiving each time a share of the oocytes from other donors brought to the programme by other recipient couples. Donors must be a maximum 35-year-old and if possible (but not absolutely mandatory), already have had children.

(iii) Anonymous donation: It concerns couples who do not bring a donor to the programme.

This third option is rendered possible, thanks to the specificity of the known-anonymous oocyte donation programme, which optimizes the use of donated oocytes by sharing them between three or four recipients. Once a recipient from the known-anonymous oocyte donation programme has an ongoing pregnancy, her scheduled position in a subsequent cycle can then be allocated to a recipient from the anonymous oocyte donation programme waiting for a donation. This is feasible as a result of the high success rate of this programme (about one pregnancy per donation) obtained by using nearly exclusively fresh embryos, minimizing the embryonic loss occurring after cryopreservation. Due to the high demand, most of these anonymous recipients only have access to a single oocyte donation cycle with a limited number of oocytes.

For ethical reasons, oocyte sharing is not practiced at Erasme hospital (Delbaere and Englert, 2001).

For recipients, opting for one or the other type of donation implies a thorough reflection about future implications of each possible option, especially in terms of the possible impact on the development of their future child. In Belgium, since the law of 2007, it is mandatory that fertility centres supply psychological counselling to the interested parties, before and throughout the assisted procreation procedures (Le Moniteur belge/Belgisch staatsblad, 2007). In our clinic, psychological counselling has always been required before oocyte donation in order to take into account the questions and emotions involved for couples facing these choices. The aim of counselling is to ease the couples’ decision-making process by helping them express their motivations and by giving support to their reflections on the specific questions related to their choice as well as those concerning their future child. Counselling, after the birth of a child, is offered to all patients but not mandatory.

Oocyte donation is indisputably an interesting field psychologically and ethically (Englert, 1996; Kalfoglou and Gittelsohn, 2000; Sauer and Kovic, 2006; Hershberger and Klock, 2007). This study based on the data collected during psychological counselling, compares motivations, choices and attitudes of recipient couples in the three types of donations: known donation, known-anonymous donation (with donors’ permutations) and anonymous donation for couples without a donor. This study also assesses the motivations of the donors in known and known-anonymous programmes.

Materials and Methods

Data were extracted and analysed retrospectively from semi-structured counselling sessions performed between 1 January 2005 and the 31 December 2006 by two psychologists working in our fertility centre for all couples, and donors that wanted to undergo oocyte donation. The recipient and her partner were counselled together during the same session by one of the psychologists. When the couple brought a donor to the clinic, the recipient couple and donor were counselled by the same psychologist but in separate psychological counselling sessions in order to insure confidentiality. The couples’ counselling focused on the choice of the type of donation and on secrecy or disclosure towards the social environment and towards the future child. The present relationship between a recipient couple and donor and expectations for the future were also discussed in order to anticipate the possible relational implications of the project. The donors’ counselling focused on clarifying her engagement and her expectations concerning the donation as well as on her voluntary participation and willingness. Her attitudes towards disclosure towards the future child were also discussed. In the case of a known donation, the presence of the donor’s partner was mandatory in order to discuss the implications due to the genetic link between the future child and the donor as well as between their children and the future child. Interview data were retrospectively coded and analysed by both psychologists together. To avoid heterogeneity in the studied population, the study was limited to heterosexual couples and to couples not yet having had a child by gamete donation. To better focus our study on oocyte donation, we did not include couples asking for a double donation (oocyte and sperm).

Before any treatment of assisted procreation, patients must sign a convention with the Fertility Clinic in which it is specified that their clinical data can be used anonymously for scientific purposes. All patients signed an informed consent to one or the other type of oocyte donation programme.

Population description

According to our inclusion criteria, a total of 135 recipient couples and 90 donors were included in this study. The average age of these recipient women was 38, with ages ranging from 25 to 47. Of these couples, 90 (66.7%) came with a donor and 45 (33.3%) came without. Of the total 135 couples, 45 (33.3%) already had a child. It is in the known-donation group that this percentage was the highest (23/45; 51.1%)
compared with 12/45 (26.7%) in the known-anonymous group and 10/45 (22.2%) in the anonymous group. The children were either the woman’s from a previous relationship (8; 5.9%), the man’s from a previous relationship (24; 17.7%) or from both partners of the recipient couple (13; 9.6%). Indications of oocyte donation are detailed in Table I. Most patients had functional ovaries and the major indication was IVF failure in the three subgroups. The ethnic origin of the oocyte recipients is shown in Table II. There were 90 (66.7%) originating from Europe, 27 (20%) from sub-Saharan Africa and 18 (13.3%) from North Africa. However, a great majority of our population resided in Europe, mainly in Belgium (63; 46.7%) and in France (56; 41.5%). The others lived in other European countries (8) or outside Europe (8).

Data analysis
Differences in ethnic origin, in the link with the donor and in the attitudes towards disclosure of the mode of conception to the child between the different types of donation were analysed using \( \chi^2 \) tests associated with Fisher’s exact tests (PASW18 2009-SPSS inc.).

Results
Recipient couples
Link with the donor
Donors can be classified into four categories:
(i) family donors with a blood tie to the recipient,
(ii) other family donors,
(iii) friends and acquaintances and
(iv) donors unknown before the donation project (an acquaintance of an acquaintance, a new encounter, someone recruited through the Internet or advertisement).

Differences in the links with the donor between the different types of oocyte donation were significant \( (P = 0.033) \). In known donation, donors with a blood tie to the recipient (sisters, cousins and nieces) were chosen preferably \( (23/42; 54.7\%) \), whereas in known-anonymous donation, donors were preferably chosen among friends and acquaintances \( (20/48; 41.7\%; P = 0.038) \). It is noteworthy that 14% of donors in each group (known-anonymous seven; known six) were unknown to the couple prior to the donation project (Table II).

The situation of couples without a donor
In this group, half of the couples \( (22/45) \) deliberately chose not to seek a donor, whereas the other half \( (23/45) \) was simply unable to find a donor within their family circle and friends.

Choice of the type of donation
Among the couples who brought a donor to the programme \( (n = 90) \), 42 (46.7%) opted for a known donation and 48 (53.3%) for a known-anonymous donation. The other couples who did not bring a donor to the programme took part in the anonymous programme. Taking ethnic origin into account, we notice that Europeans prefer to choose the anonymous donation programmes \( (68/90; 75.6\%) \), and couples from North Africa even more so \( (15/18; 83.3\%) \). On the

Table I  Indications of oocyte donation.

<table>
<thead>
<tr>
<th></th>
<th>Known donation ( (n = 42) )</th>
<th>Known-anonymous donation ( (n = 48) )</th>
<th>Anonymous donation ( (n = 45) )</th>
</tr>
</thead>
<tbody>
<tr>
<td>Functional ovaries (%)</td>
<td>29 (69%)</td>
<td>36 (75%)</td>
<td>32 (71%)</td>
</tr>
<tr>
<td>IVF failure</td>
<td>23</td>
<td>31</td>
<td>24</td>
</tr>
<tr>
<td>Age/diminished ovarian reserve</td>
<td>6</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Genetic indication</td>
<td>–</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Non-functional ovaries (%)</td>
<td>13 (31%)</td>
<td>12 (25%)</td>
<td>13 (19%)</td>
</tr>
<tr>
<td>Premature ovarian failure</td>
<td>9</td>
<td>11</td>
<td>13</td>
</tr>
<tr>
<td>Menopause</td>
<td>4</td>
<td>1</td>
<td>–</td>
</tr>
</tbody>
</table>

Table II  Ethnic origin of oocyte recipients and their link with the donor.

<table>
<thead>
<tr>
<th></th>
<th>Known donation ( (n = 42) )</th>
<th>Known-anonymous donation ( (n = 48) )</th>
<th>Anonymous donation ( (n = 45) )</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ethnic origin</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Europe (%)</td>
<td>22 (24.4%)</td>
<td>37 (41.1%)</td>
<td>31 (34.4%)</td>
</tr>
<tr>
<td>North Africa (%)</td>
<td>3 (16.7%)</td>
<td>9 (50%)</td>
<td>6 (33.3%)</td>
</tr>
<tr>
<td>Sub-Saharan Africa (%)</td>
<td>17 (63.0%)</td>
<td>2 (7.4%)</td>
<td>8 (29.6%)</td>
</tr>
<tr>
<td>Link with the donor</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family (with a blood tie) (%)</td>
<td>23 (63.9%)</td>
<td>13 (36.1%)</td>
<td>–</td>
</tr>
<tr>
<td>Family (other relatives) (%)</td>
<td>2 (20%)</td>
<td>8 (80%)</td>
<td>–</td>
</tr>
<tr>
<td>Friends/acquaintances (%)</td>
<td>11 (35.5%)</td>
<td>20 (64.5%)</td>
<td>–</td>
</tr>
<tr>
<td>Unknown before the project (%)</td>
<td>6 (46.2%)</td>
<td>7 (53.8%)</td>
<td>–</td>
</tr>
</tbody>
</table>
other hand, couples from sub-Saharan Africa mainly opted for a known donation (17/27; 63%) (Table II). A significant group difference was found in the ethnic origin between the three types of donation (P < 0.001). When the analysis was performed two by two between groups, differences reached significance only between known donation and known-anonymous donation (P < 0.001).

When looking at the place of residence, besides the recipients residing in Belgium, the majority reside in France (56/135; 41.5%). The main motive for having chosen cross-border reproductive care was because of restrictive legislation in their homeland. For some recipients in the anonymous group (14/56; 25%), it was because they had no donor, which is mandatory to access treatment in France. The situation is identical for all those motivated to do a known donation (14/56; 25%) since this type of donation is also forbidden in France. Among the recipients coming for a known-anonymous donation (28/56; 50%), some were refused in France (either for an age criterion (9/28; 32.1%) or because their donor had not yet had a child (4/28; 14.3%)) and others chose to come to Belgium rather than be treated in France (either to diminish the waiting delay (6/28; 21.4%) or for the better success rates of our known-anonymous programme (4/28; 14.3%). The other recipients (5/28; 17.9%) in this group first came to Belgium with the intention of undergoing a known donation and after counseling, they decided to pursue a known-anonymous donation.

Motivations towards type of donation

Almost all couples came to the psychological counseling session with a clear idea of the type of donation they wanted to pursue. After counseling, six couples changed their mind (6/135; 4.4%), all of them switching from known donation to known-anonymous donation and doing so after discussing the relational complexities and potential consequences of known donation and/or in order to increase their chances of success. Two other couples (2/135; 1.5%) initially in the known-donation programme, ended up in the anonymous-donation project because of the withdrawal of their donor.

Motivations towards type of donation are shown in Table III. Each couple had the opportunity to express one or several motivations. Hence, the percentages do not total 100.

Reassurance seems the salient element for choosing known donation, this reassurance being determined as much by the genetic link to the donor as by the emotional tie (fondness of or closeness). Others are motivated towards known donation by the child’s access to his/her origin and in a smaller proportion by their wish to maintain secrecy of the mode of conception to their future child. It is noteworthy that five couples (11.9%) accepted to undergo a known donation but with the need to keep a certain emotional or geographical distance with the donor. In known-anonymous donation, not knowing the woman biologically related to their child, in order to better establish clear boundaries between everyone, was the main motivation. Avoiding any interference of the donor in the future mother–child relationship was also essential. Disclosing or keeping the donation secret were also motivating reasons in this group. Finally, the matching of physical characteristics and better chances of success in this programme were sometimes considered a motivation towards this type of donation. In the anonymous group, what appeared to be salient was that more than half of these couples simply did not find a donor either because of a very limited family and social circle (7/23; 30.4%) or because potential donors were too old or lived too far away (9/23; 39.1%), or because the potential donors they had asked did not accept (7/23; 30.4%).

Motivating reasons appeared to be determined mostly by the desire to maintain clear boundaries and roles. For the couples who deliberately chose not to search for a donor, their main motivations were to protect the mother/child relationship and to better maintain secrecy. Maintaining clear boundaries and roles were also cited. It is noteworthy that for two couples not having found, and eight couples not having searched for a donor (10/45; 22.2%), notions of guilt and/or the need to avoid indebtedness towards a donor explained their difficulty to search for or find help.

Secretly or disclosure of his/her origins to the child

Couples’ attitudes towards disclosure of the mode of conception to the child are described in Table IV.

Table III Motivations towards the type of donation.

<table>
<thead>
<tr>
<th>Known donation (n = 42)</th>
<th>Known-anonymous donation (n = 48)</th>
<th>Anonymous donation (n = 45)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Genetic link and physical resemblance with the donor</td>
<td>6 (15.4%)</td>
<td>27 (56.2%)</td>
</tr>
<tr>
<td>Emotional tie with the donor</td>
<td>25 (59.5%)</td>
<td>20 (41.7%)</td>
</tr>
<tr>
<td>Child’s access to his/her origins</td>
<td>7 (16.7%)</td>
<td>4 (8.3%)</td>
</tr>
<tr>
<td>To maintain secrecy</td>
<td>5 (11.9%)</td>
<td>4 (8.3%)</td>
</tr>
<tr>
<td>Anonymous donation not possible</td>
<td>4 (9.5%)</td>
<td>3 (6.2%)</td>
</tr>
<tr>
<td>Same religious background</td>
<td>2 (4.7%)</td>
<td>3 (6.2%)</td>
</tr>
<tr>
<td>Requested by the donor</td>
<td>2 (4.7%)</td>
<td>3 (6.2%)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Did not find a donor (n = 23)</th>
<th>Did not search for a donor (n = 22)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clear boundaries and roles</td>
<td>6 (26.1%)</td>
</tr>
<tr>
<td>Known donation not possible</td>
<td>4 (17.2%)</td>
</tr>
<tr>
<td>To maintain secrecy</td>
<td>2 (8.7%)</td>
</tr>
<tr>
<td>Limited search for a donor to avoid indebtedness</td>
<td>2 (8.7%)</td>
</tr>
<tr>
<td>Supports and protects the mother/child relationship</td>
<td>1 (4.3%)</td>
</tr>
<tr>
<td>Not specified</td>
<td>8</td>
</tr>
</tbody>
</table>

Each couple had the opportunity to express one or several motivations. Hence, the percentages do not total 100.
Out of all couples, 52 (38.5%) chose to maintain secrecy of his/her origins to the child. Couples in known donation or anonymous donation were the ones most determined to keep the mode of conception secret: 50% or more in both groups (21/42 and 24/45, respectively). In the anonymous group, when distinguishing those that searched for a donor without finding one (23) from those who deliberately chose not to seek for one (22), we notice that 30.4% of couples in the first group opted for secrecy (7/23), whereas up to 77.3% in the second group had the same intention (17/22).

Couples having a donor and opting for a known-anonymous donation were more open to disclosing the mode of conception to the child; 14.6% (22/150) of known donors and 39.6% (19/48) of known anonymous donors disclosed the mode of conception to the child. Couples in known donation or anonymous donation were the ones most determined to keep the mode of conception secret: 50% or more in both groups (21/42 and 24/45, respectively). In the anonymous group, 30.4% of couples in the first group opted for secrecy (7/23), whereas up to 77.3% in the second group had the same intention (17/22).

Table IV: Couples’ attitudes towards disclosure of the mode of conception to the child.

<table>
<thead>
<tr>
<th></th>
<th>Known</th>
<th>Known-anonymous</th>
<th>Anonymous</th>
</tr>
</thead>
<tbody>
<tr>
<td>Secrecy (%)</td>
<td>21 (50%)</td>
<td>7 (14.6%)</td>
<td>24 (53.3%)</td>
</tr>
<tr>
<td>Disclosure (%)</td>
<td>12 (28.6%)</td>
<td>22 (45.8%)</td>
<td>15 (33.3%)</td>
</tr>
<tr>
<td>Ambivalence (%)</td>
<td>9 (21.4%)</td>
<td>19 (39.6%)</td>
<td>6 (13.4%)</td>
</tr>
<tr>
<td>Total</td>
<td>42</td>
<td>48</td>
<td>45</td>
</tr>
</tbody>
</table>

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When taking ethnic origin into account, it appeared that 25.6% of Europeans (23/90) and 48.9% of non-Europeans (22/45) were clearly in favour of secrecy (P < 0.001). Among those determined to disclose, 50% (45/90) were Europeans and only 8.9% (4/45) were non-Europeans (none being in the known donation group; P = 0.002).

Motives for secrecy or disclosure of the mode of conception to the child are listed in Table V. They are listed by frequency, with each couple having had the opportunity of giving one or more answers.

No differences were observed between the three donation groups. It is noteworthy that among all couples, 60.7% (82) revealed the mode of conception to one or several family members or friends (in addition to the donor). Among these couples, 41.5% (34/82) were either determined to maintain secrecy or were still hesitant. This discordance stands out more in the anonymous group [known 8/24 (33.3%), known-anonymous 12/31 (38.7%) and anonymous 14/27 (58.3%)].

Donors

Motivations

A total of 90 donors participated in the study. Sixty donors (66.7%) expressed motives concerning the pursuit of personal valorization and/or their emotional link with the recipient couple. They expressed personal and family values such as generosity, responsibility, notions of mutual aid and sharing, and compassion towards the pain and suffering generated by the lack of children.

Some more-specific motivations were in relation with the tie existing between the donor and the recipient couple. For donors who were family members (n = 46), we found in both donation groups, notions of responsibility, indebtedness, guilt and/or the wish to make amends for an injustice (17/46; 37%) and this was the case especially when donor and recipient were sisters. For donors who were friends or acquaintances (n = 31), we only seldom found similar notions of guilt and indebtedness (2/31; 6.5%). In this group, the specific motivation that sometimes oriented their choice was the desire for more closeness with the recipient couple (5/31; 16.1%). Finally, for unknown donors (n = 13) in addition to the general motivations, what was salient was their desire to make amends with a specific family history and/or personal real-life experience (6/13; 46.2%).

In known donation (n = 42), 23 donors (54.8%) did not suit the required criteria for the anonymous-donation programme (either the age criterion or because of the need for ethnic matching). However, these donors, prior to making their decision to help the recipient couple, were aware when giving their approval that only a known donation was possible. Therefore, we did not deem necessary to distinguish their motivations from those of the other donors in the known donation group. Ten donors in this group (23.8%) considered that the choice of the type of donation was mostly the recipient couple’s choice and that they followed their decision. Among the specific motivations for known donation, 13 donors mentioned the idea that it represents a benefit for the future child (31%): it can reinforce the sense of belonging to the family, thanks to the shared genes and offer the possibility for the child to access his/her biological origins, which lays the foundations for his/her identity development.
and may be useful in the eventuality of a disease needing the donor’s intervention. Along with these positive aspects, 11 donors (26.2%) showed some ambivalence through ideas such as the importance of not being geographically too close to the recipient couple, neither being too intimate with them, or of having already had their own children. Regarding the child’s access to his/her origins, attitudes were congruent between recipient couples and donors except for two donors who were still hesitant while both couples intended to disclose. Both these donors accepted to pursue the donation, one deciding not to implicate herself in the relationship with the child, the other accepting the couples’ decision.

In known-anonymous donation (n = 48), three donors (6.3%) refused to enter the known-donation programme and three others (6.3%) could not enter it because of a blood tie to the recipient’s spouse. Three donors (6.3%) considered that the choice of the type of donation was mostly the recipient couple’s choice. The most frequent motivations favouring known-anonymous donation were similar between recipients and donors. There were 38 donors (79.2%) who mentioned the need to avoid a strong emotional involvement that was bound to occur if they had a genetic link with the child. Donors felt that anonymity had clearer boundaries, was less binding and/or was better limited in space and time. It was also felt as more reassuring, especially when the relationship with the recipient couple was quite recent or not very intimate. Even though donors in known-anonymous donation were well aware that their oocytes were likely to be allocated to four unknown recipients, helping these other recipients was seldom mentioned (3/48; 6.3%) as a motivation for donation, which emphasizes the fact that the relationship established with the recipient couple was essential to bring the donor to the programme and that these donors probably would never have taken the necessary steps to become spontaneous donors.

## Discussion

Our study comparing three donation options singles out specific motivations and attitudes regarding the type of donation and the issues of secrecy/disclosure in each donation group. Since a third of our population originates from sub-Saharan Africa and from North Africa, our research adds data to the field assessing the influence of couples’ ethnic origin in assisted reproduction. Finally, as a part of our population comes from abroad, it also brings some insight on the motivations for choosing cross-border reproductive care, a well-known phenomenon in most of the Belgian clinics (Pennings et al., 2009) as well as in other European countries where patients travel mostly to evade restrictive legislation in their own country (Shenfield et al., 2010).

### Type of donation and relation to the donor

Several studies comparing known and anonymous donation have found that recipient couples preferred a known donation when the option was available (Sauer et al., 1991; Leeton et al., 1993; Pettee and Weckstein, 1993; Baetens et al., 2000) even if it has been noted that most recipients in gamete donation currently prefer donor anonymity (Ethics committee, ASRM, 2004). In our study, a higher number of couples opted for an anonymous donation. This may be explained by the fact that besides the known-donation programme, our clinic offers two anonymous programmes (known-anonymous and anonymous). As usually reported in donations when recipients bring a donor, most of our couples choose their donor in their immediate family or social circle (Baetens et al., 2000; Yee et al., 2007; van Berkel et al., 2007), with a minority not acquainted with the recipient couple (14.4%), having met for the purpose of the donation (Baetens et al., 2000; Greenfeld and Klock, 2004; Karpel et al., 2005). This percentage confirms that when couples have difficulties finding a donor, searching outside their family and/or social circles may offer them additional chances. Nevertheless, couples usually feel more reassured by an ongoing relationship with the donor.

In our sample, couples in known donation were reassured by the emotional tie with the donor as well as by preserving a genetic link with the future child when the donor had a family tie. In this case, sharing genes gives the mother a better sense of continuity of oneself and is also viewed as an asset for the forthcoming mother–child relationship. As a consequence, they tended to more often choose a donor with a blood tie. Baetens et al. (2000) described fears associated with anonymity and the trust the couple had in ‘their’ donor as the main motivations for a known donation and noted that a genetic link with the donor was important for one-third of the recipients. Other authors pointed out that recipients preferred a known donation when the donor was a sister (Bartlett, 1991; Lessor, 1993; Greenfeld and Klock, 2004). A great willingness of family members, especially sisters, to volunteer for a known donation has also been described (Greenfeld and Klock, 2004; Yee et al., 2007) and may also have played a role in the couples’ decision. All this puts forth that what is essential for couples in choosing a known donation is a mixture of those factors: a genetic link to support the mother–child relationship and the child’s sense of belonging to the family as well as an emotional link and trust to help clearly define the roles, to respect the boundaries in order to limit the risk of interference of the donor in the mother–child relationship. According to one report (van Berkel et al., 2007), the ongoing relationships between recipient mothers, their known donors and children are described as friendly and with no boundary conflicts, but they noted that in many cases, an agreement was reached before the oocyte donation to restrict the influence of the donor in the child’s life. Similarly, some of our known-donation recipients chose to limit the future interactions between the donor and child by opting for a donor neither too close nor too intimate or by opting for secrecy towards the child. It is also noteworthy that only 16.7% of them want their child to meet his/her donor and that several couples in known donation, would have preferred an anonymous donation if possible. All these findings highlight some of the complex feelings surrounding known donation.

Regarding ethnic origin, a very acute oocyte shortage has been described for ethnic minorities in anonymous donation (Murray et al., 2006). In a study comparing Asian and Caucasian British women regarding anonymous donation, Asian women were found less likely to donate than Caucasian women, showing how cultural values (including religious beliefs) influence some population’s attitudes and behaviours more than others (Purewal and van den Akker, 2006). In our study, more than two-thirds of sub-Saharan African couples did successfully find a donor, but most of them were for a known donation. The availability of known donation in

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our clinic may have played a role by allowing intra-familial donation. In our African subgroup in known donation, > 60% of the donors were family members, mostly sisters or cousins. In Non-Western cultures, women are often blamed for non-conception and are more vulnerable than men to the negative social and economical consequences of childlessness (Dyer et al., 2005; Culler et al., 2009). As a consequence, a very high level of distress in case of infertility has been observed (Fido and Zahid, 2004; Dyer et al., 2008) even for migrants living in a Western culture (van Rooij et al., 2007). In a British study regarding donors’ intention to donate (Purewal and van den Akker, 2009), a positive and strong attitude towards parenthood was linked to the more positive attitude towards donation. This link can be inferred to our African population, in which motherhood is highly valued. Nevertheless, since no one was a spontaneous donor, being directly solicited by the recipient, after witnessing her childlessness and suffering, may also have helped them to override eventual societal, cultural and/or religious objections.

Couples preferring anonymous donation consider in a large majority that it is less ambiguous than known donation. Not knowing the woman biologically related to their child seems to help them establish clear boundaries between everyone involved and avoid interference of the donor in the future mother–child relationship. Similar motivations for anonymous donation have been previously described (Bertrand-Servais et al., 1993; Baetens et al., 2000; Greenfeld and Klock, 2004). We notice that couples in this group choose their donors among friends and acquaintances as often as within the family circle despite the fact that known-anonymous donation allows a larger family choice (the donor can also belong to the spouse’s family). It is possible that because there was no genetic gain in having a family donor, some couples in known-anonymous donation may have preferred not implicating family.

Regarding ethnic origin, in our study, most of the couples from North Africa came for a known-anonymous or an anonymous donation. There is a larger access to the anonymous programmes for them than for sub-Saharan African recipients because they can also be matched with south European-typed donors. But since only five African known-donation recipients would have preferred an anonymous donation (if possible), differences observed may be due to cultural and/or religious differences. This subject should benefit from more in-depth studies, maybe with the contribution of medical anthropology. Inhorn (2006), for example, has described the links between religious moralities and assisted reproduction in the Muslim world.

Secrecy

Couples’ attitudes regarding secrecy or disclosure of the mode of conception towards the child and towards the social environment has always been an important part of the studies concerning gamete donation (Hershberger, 2004) and it is also viewed as a valuable topic for couples and/or donors in counselling sessions (Söderström-Anttila et al., 1998; Hahn and Craft-Rosenberg, 2002; Greenfeld and Klock, 2004; Hammarberg et al., 2008). As noted by Greenfeld and Klock (2008), there is a growing movement advocating disclosure to offspring about their donor gamete conception. Following one hypothesis, couples would opt for secrecy because anonymity renders impossible the disclosure of complete information to the child (Lindblad et al., 2000; Lycett et al., 2005). In our study, the opposite hypothesis is apparent as half the anonymous group chose not to search for a donor in order to better maintain secrecy. Nevertheless, despite their strong desire for secrecy, more than half had talked about their fertility problems to others. Hershberger and Klock (2007) noted in a phenomenological study that not only women’s values and beliefs but also social support, cultural background as well as family values influence disclosure decisions. Maybe these couples had encountered very little support and/or negative attitudes after disclosing to others, which made them opt for secrecy towards the child. Irrespective of the type of donation chosen, couples from sub-Saharan Africa and from North Africa were also found to be very secretive. A lower acceptance of infertility and/or third-party reproduction in their culture or in their religion has probably influenced couple’s decisions, even for those residing in Europe. As noted by Gacinski et al. (2002), migrants might hold more traditional values and beliefs than people living in their country of origin.

As observed in other studies (Greenfeld and Klock, 2004; Murray et al., 2006), we noted that whether they planned to disclose or not, recipients believed their decision to be in the best interest of the child. Murray et al. (2006), who pointed out a continuing high level of non-disclosure at adolescence suggest that parents’ experience of social stigma surrounding the mode of conception might be an explanation for concealing this from the child. In our results, couples determined to maintain secrecy expressed fears of negative social and familial consequences but also a possible negative impact to the mother–child relationship in case of disclosure. Therefore, recipients who confided their problem to others and perceived a social, cultural and/or religious negative attitude towards gamete donation should be counselled in order to cautiously balance these risks with those involved with late and/or incidental disclosure. In-depth studies on the links between maternal insecurity, supposed or effective lack of social support, secrecy and mother–child relationships should be pursued, especially among different cultural backgrounds.

Regarding the right of the child to access his/her genetic origins, some countries are now allowing donor gamete offspring the right to obtain identifying information about their genetic parent (Janssens et al., 2006; van den Akker, 2006; Lalos et al., 2007; Daniels and Douglass, 2008). It is still unsure how these laws will impact couples’ disclosure decisions. Our results show that couples in favour of disclosure in the known donation group and who voiced the right of the child to access his/her origins were exclusively Europeans. It is possible that a law may have a positive societal impact on third-party reproduction, thus allowing more European couples to become open towards their child but the question remains concerning couples from different cultural backgrounds.

Donors

More donors in known donation than in anonymous donation had a family tie with the recipient but donors’ main motivations were similar in both donation groups. Two motivations particularly emerged: the strength of the emotional tie between the donor and the recipient couple as well as the desire to pursue personal values such as solidarity and mutual aid. These motivations were similar to the ones reported in the literature as recently reviewed (Purewal and van den Akker, 2009). For Yee et al. (2007), the act of donation can be intrinsically ‘rewarding’ for these women who could feel
reaffirmed as the result of their acts of feminine solidarity, kindness and generosity. This stands out even more with spontaneous donors, whose act is only sustained by this very gratification. Altruism, but also the need to make amends with previous difficult experiences, can be the basis of such an involvement.

Motivations concerning type of donation were similar to those of recipients. In anonymous donation, most donors personally took a stand about the type of donation they were comfortable with. In known donation, complex feelings of responsibility and indebtedness towards their family and/or of guilt sometimes appeared among donors with a family tie, especially when donor and recipient were sisters. As cited by Yee et al. (2007), ‘known donation is not without challenges and potential complexities because of the existing relationship and/or ongoing family ties between the donor and the recipient’. This might explain the fact that in known donation, fewer donors positioned themselves in regard to the type of donation and considered it the recipient couple’s priority. It is important to keep in mind that known donation is the only solution for most ethnic minority groups. For one of these donors, to refuse known donation would mean, in fact, refusing donation altogether, which is especially difficult to consider for a family member. Moreover, identification and/or relational consequences when taking a stand are stronger than towards a friend and may thus prevent these donors from setting their own boundaries. More donors than recipients expressed their relief of not being too close emotionally or/and geographically with one another. Donors also expressed their relief of already having had their own children. All this portrays known donation as a more challenging option than anonymous donation for both donors and recipients.

Limitations of the study

If the use of counselling interviews provides qualitative data, it is more often subject to bias than standardized research interviews and therefore may limit the validity of our results. Counselling being mandatory, some couples and donors may have perceived the counselling sessions as an assessment for suitability, which could have therefore affected their attitudes i.e. the quasi-absence of divergences between couples’ and donors’ attitudes regarding secrecy issues. Regarding known donors, differences in the interview setting (mandatory presence of the partner) may also have affected the results. Another methodological problem may be a possible ‘interviewer effect’ as the interviews were performed by two different psychologists even if, in order to limit this effect, all data were coded and analysed together. Despite the fact that our study provides some insight regarding the influence of cultural values on couples’ attitudes regarding oocyte donation, these findings are limited, to some extent, by the fact that for ethnic minorities in our clinic, anonymous donation is as yet not as easily available as known donation. We notice that Greenfeld and Klock (2004), comparing anonymous and known donation in the North American context, found no difference regarding ethnicity in the two groups, indicating that our results could be due to the lack of provision of anonymous donation for ethnic minorities. But as sharing an ethnic origin does not necessarily mean sharing the same cultural background, further studies are needed to answer this question. Finally, our study only assessed the period prior to treatment; we therefore cannot infer any definite attitudes couples and donors might have when facing the child. As noted by Yee et al. (2007), research is lacking to elucidate the subsequent relational challenges of oocyte donation. Some recipient satisfaction studies (Donegan, 1994; Smith et al., 2000) show that post-donation support and counselling is seen as beneficial. In our experience, despite the fact that such counselling is offered, very few couples ask for it spontaneously. On the other hand, when they come back to the clinic seeking treatment for a second child, they often bring up disclosure and relational issues in counselling. If an agreement was made with the couple during the first counselling sessions to contact them at a given time, this might circumvent this obstacle. Of course, post-donation counselling would remain a problem for patients coming from abroad because of geographical distance.

Conclusion

A diversity of attitudes exists among recipient couples regarding type of donation as well as secrecy issues. The influence of the societal trend to more openness regarding third-party reproduction clearly seems to impact people differently depending on their social and cultural background. Now that more and more professionals encourage disclosure, these issues should be taken into account in order to recognize cultural diversity and avoid any ethnocentrism. This stresses the fact that psychological counselling in oocyte donation is essential to discuss all these issues with the couples and donors before the donation process.

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