Sperm donor recruitment, attitudes and provider practices—5 years after the removal of donor anonymity

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STUDY QUESTION: Has the change in donor anonymity legislation in UK affected the recruitment of men wanting to be sperm donors and also affected the attitudes of the practitioners who provide donor sperm treatment?

SUMMARY ANSWER: We have performed fewer IUI and IVF treatments using donor sperm following the change in legislation in April 2005 than before. However, we have seen an overall increase in men wanting to donate their sperm, including a small increase in men from ethnic minorities.

WHAT IS KNOWN ALREADY: Sweden, which removed donor anonymity in 1985, had an initial drop in men wanting to donate and then 10 years later started to have an increase. The Human Fertilisation and Embryology Authority (HFEA) and other studies in the UK have shown an overall downward trend, but have not been able to compare large time scales either side of the change in legislation.

STUDY DESIGN, SIZE, DURATION: This was a retrospective descriptive study that looked at all men who approached the clinic between the years 2000 and 2010, i.e. 5 years either side of the change in legislation (April 2005). Overall, we had 24 men wanting to be donors prior to the rule change and 65 men after the rule change. We also investigated the total number of all treatments with donor sperm, and this included a total of 1004 donor sperm treatments prior to the change in legislation and 403 donor sperm treatments after the change in legislation.

PARTICIPANTS, SETTING, METHODS: The study was set in an NHS IVF clinic in South East London. We compared the indicators of service provision, provider practices and donor attitudes, in the period between April 2000 and March 2005 (Group A) with those between April 2005 and March 2010 (Group B), i.e. 5 years either side of the change in legislation.

MAIN RESULTS: There were 875 IUI treatments and 129 IVF or ICSI treatments in Group A and 325 IUI and 78 IVF/ICSI treatments in Group B with the use of donor sperm, of which, 11.9% (119 out of 1004) in Group A and 39.5% (159 out of 403) in Group B were with donor sperm recruited by our unit. The clinical pregnancy rate per cycle of treatment in Group A was (86 out of 875) 9.8% for IUI and (27 out of 129) 20.9% for IVF/ICSI and in Group B (32/325) 9.8% and (28 out of 78) 35.9%, respectively. There was a sharp yearly fall in donor sperm treatments from 2004. Twenty-four men were screened in Group A, of which 18 (75.0%) were recruited for long-term storage and 12 (50%) were registered as donors with the HFEA when the sperm was used, whereas in Group B, 65 men were screened, 53 (82.0%) were recruited and 24 (36.92%) were registered as donors. Six (24.0%) men in Group A failed in screening because of poor semen analysis when compared with 9 (13.8%) men in Group B. The majority of post-recruitment dropouts were because of loss of follow-up or withdrawal of consent. More donors in Group A were white (92.0 versus 77.0%) and born in UK (92.0 versus 68.0%) when compared with those in Group B. Donors in Group B were more likely to be single (46.0 versus 4.0%) and to have informed their relevant partner of donation (71.0 versus 54.0%) when compared with those in Group A. 83.0% of donors in Group A were heterosexual when compared with 69.0% in Group B. The primary reason for donating in both groups of potential donors was ‘wanting to help’ (46.0% ‘altruistic donors’ in Group A versus 72.0% in Group B). Fewer donors in Group B (37%) had specific restrictions about the use of their sperm when compared with 46.0% in Group A.

LIMITATIONS, REASONS FOR CAUTION: As this was a retrospective study, there is a chance for the introduction of bias.
**WIDER IMPLICATIONS OF THE FINDINGS:** We have shown that despite no active in-house recruitment procedures, we are managing to recruit more potential sperm donors after the change in UK legislation, and we are able to meet the demand for treatments with in-house recruited donor sperm that is a reassuring finding for donor sperm treatment services in the wider UK.

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**Key words:** donor / sperm / anonymity

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**Background**

In 1982, ‘The Warnock Committee’ debated all aspects of human fertilization and embryology, including the ethical and moral issues surrounding donor treatments and recommended that donor anonymity be preserved (Warnock Report, 1984). Donated sperm is used by heterosexual couples, lesbian couples and single women. In heterosexual couples, it is used when a male partner is azoospermic or to avoid genetic inheritance of certain diseases (Clarke et al., 1997). The first use of donor sperm in the UK for insemination was reported in 1945 (Barton et al., 1945), and in keeping with the socio-political climate of the time, it was met with condemnation. Although the use of donor sperm became more widespread thereafter, it continued to attract serious ethical and parliamentary debate particularly on the issue of donor anonymity. This recommendation was subsequently incorporated into the Human Fertilisation and Embryology Act 1990 and thereafter by the Human Fertilisation and Embryology Authority (HFEA), into its ‘Code of Practice’.

There was an increasing awareness and discussion about the welfare and rights of children born from gamete donation from the 1990s onwards, especially with regards to providing them more information about their genetic origins (Shenfield and Steele, 1997). There is evidence to suggest that parent who use donor sperm are open about this with their donor conceived offspring and that this has a positive aspect on families (Scheib et al., 2003). The first country to remove donor anonymity was Sweden in 1985, and it was felt that rates of donor recruitment would naturally fall (Gottlieb et al., 2000). Although this was seen initially, by 1995 there was an overall increase in the number of sperm donors recruited (Daniels and Lalos, 1995). Despite these positive results from the ‘Swedish Model’ when donor anonymity was removed with effect from 1 April 2005, significant fears about a shortage of donor sperm were expressed in the UK. Currently, any person born from gametes donated after this date is legally entitled to information will not be provided until they are 18 (HFEA Act 2008).

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**Materials and Methods**

This is a retrospective descriptive study of all sperm donors and donor sperm treatment between April 2000 and March 2010 at a tertiary referral clinic. All donor codes were identified using prospectively maintained databases.

Sperm used for treatments was either imported from other clinics (in the UK or overseas) or from donors recruited in-house at our clinic. All men screened for in-house donation were either self-referred or referred via a friend or family member requiring fertility treatment. The screening process involved is as described.

All men underwent an initial seminal fluid analysis, and suitability for donation was determined by normal ranges described by the World Health Organization’s (WHO) guidelines relevant to the time of donation. All men completed a structured questionnaire and were reviewed by a consultant gynaecologist, where a full medical, social and family history study was undertaken. A physical examination was performed where necessary, and men were screened for HIV 1 and 2, Hepatitis B, Hepatitis C, Syphilis, human T-lymphocyte virus I and 2, Gonorrhoea and Chlamydia, karyotype and cystic fibrosis and where applicable sickle cell, thalassemia alpha and beta and Tay–Sachs disease screening.

Men who cleared the screening process were invited to donate (donors recruited), and relevant tests repeated after a quarantine period of 6 months before their sperm was cleared for use. All men were reviewed by an independent counsellor on at least one occasion prior to long-term storage of sperm.

As per law, only men whose sperm was used for treatment were registered with HFEA as donors (donors registered).

Donors and donor sperm treatments between March 2000 and March 2005 (Group A) were compared with those between April 2005 and March 2010 (Group B).

Continuous variables are expressed as means with standard deviation or as medians depending on their distribution. Data for categorical variables are shown as the number and percentage in each category. Data were collected and entered into an Excel™ spreadsheet (Microsoft Corporation, Redmond, USA) for analysis. All statistical analysis was carried out with GraphPad™ (GraphPad Software Inc., CA, USA).

**Results**

**Yearly trend in all donor sperm treatment cycles (IUI/IVF/ICSI)**

There were a total of 1004 donor sperm treatment cycles in Group A and 403 in Group B. The overall number of both IUI and IVF/
ICSI donor treatments remained steady between 2000 and 2004. Following 2004, there was a downward trend for the total number of donor treatments, with a sharp fall after 2007. We also investigated the number of donor sperm treatments as a percentage of overall treatments in each Group. In Group A, 4.1% (129 out of 3132) of all IVF/ICSI treatments were with donor sperm, and in Group B 3.70% (78 out of 2103) of all IVF/ICSI cycles were with donor sperm. This result is not statistically significant. However, when comparing IUI, in Group A, 82.2% (875 out of 1064) of IUI cycles were with donor sperm, and in Group B, 67.0% (325 out of 485) of IUI cycles were with donor sperm. This is statistically significant ($P = 0.016$ (Fisher’s two-tailed test)) (Fig. 1 and Table 1).

**Total number of treatments and comparison of clinical pregnancy rates (CPRs) between Group A and Group B**

There were a total of 1004 donor sperm treatment cycles (IUI/IVF/ICSI) in Group A and 403 in Group B. This included a total of 129 IVF/ICSI cycles in Group A, a total of 78 in Group B and a total of 875 treatment cycles of IUI with donor sperm in Group A and 325 in Group B. Comparison of donor sperm treatment cycles as a percentage of all treatment cycles between Group A (1004 out of 4196) and Group B (403 out of 2588) (Fisher’s exact two-tailed test) shows statistical significance ($P = 0.0001$) and represents a significant fall in donor sperm treatment cycles between the two groups (Fisher’s exact two-tailed test) (Fig. 1 and Table 1).

Clinical pregnancy rates (CPRs) for donor insemination were 9.8% (86 out of 875) for Group A and 9.8% (32 out of 325) for Group B. CPRs for IVF/ICSI were 20.9% for Group A (27 out of 129) and 35.9% (28 out of 78) for Group B, not statistically significant ($P = 0.09$) (Fisher’s two-tailed test). The proportion of IVF/IVF+ICSI donor sperm treatment cycles was 107 out of 129 (82.9%) in Group A and 43 out of 78 (55.1%) in Group B, not statistically significant ($P = 0.08$) (Fisher’s two-tailed test).

**Donor screening, recruitment and registration**

In total, there were 24 donors in Group A and 65 donors in Group B who were screened as potential sperm donors during the period of time investigated. A total number of 241 donors were used for treatment cycles (IUI/IVF/ICSI) in Group A and 52 donors in Group B. In Group A, 229 (95.0%) of treatment cycles were with sperm from donors recruited by other clinics and imported for use at our clinic, and 12 (5.0%) treatment cycles were with sperm from donors recruited in-house. The numbers in Group B are 38 (73.1%) and 14 (26.9%), respectively (Figs 1, 2a and 2b).

Twenty-four men were screened in Group A, of which 18 (75.0%) were recruited for long-term storage and 12 (50%) were registered as donors with the HFEA when the sperm was used, whereas in Group B, 65 men were screened, 53 (82.0%) were recruited for long-term storage and 24 (36.92%) were registered as donors. Although the

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**Table 1** The total number of donor sperm treatment cycles, success rates and percentage of treatments with in-house-recruited donor sperm for Group A (March 2000–March 2005) and Group B (April 2005–March 2010).

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<tbody>
<tr>
<td>Total number of treatments (IUI/IVF/ICSI)</td>
<td>4196</td>
<td>2588</td>
<td></td>
</tr>
<tr>
<td>Total number of donor sperm treatment cycles (IUI/IVF/ICSI)</td>
<td>1004</td>
<td>403</td>
<td>0.0001*</td>
</tr>
<tr>
<td>Donor IUI/total number of IUI (%)</td>
<td>875 out of 1064 (82.2)</td>
<td>325 out of 485 (67.0)</td>
<td>0.016*</td>
</tr>
<tr>
<td>CPR per treatment cycle of donor IUI (%)</td>
<td>86 out of 875 (9.8)</td>
<td>32 out of 325 (9.8)</td>
<td>1.00</td>
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<tr>
<td>Donor IVF/ICSI/total number of IVF/ICSI treatment cycles (%)</td>
<td>129 out of 3132 (4.12)</td>
<td>78 out of 2103 (3.70)</td>
<td>0.515</td>
</tr>
<tr>
<td>CPR donor IVF/ICSI (%)</td>
<td>27 out of 129 (20.9)</td>
<td>28 out of 78 (35.9)</td>
<td>0.09</td>
</tr>
<tr>
<td>Treatments with in-house-recruited donor sperm (%)</td>
<td>123 out of 1004 (12.2)</td>
<td>159 out of 414 (38.4)</td>
<td>&lt;0.0001*</td>
</tr>
</tbody>
</table>

*Statistically significant (Fisher’s exact two-tailed test).
The effect of removal of donor anonymity

initial number of potential donors was much larger in Group B, there was no statistical significance when comparing the final number of registered donors in each Group ($P = 0.52$).

In Group A, six (25.0%) men failed in screening because of their semen analyses being below the normal range threshold when compared with nine (13.8%) in Group B. These results are not statistically significant with $P = 0.36$. The majority of post-recruitment dropouts were due to loss of follow-up or withdrawal of consent [Group A 16.7% (4 out of 24) loss of follow-up; Group B 15.4% (10 out of 65)], $P = 1.00$. The most common means of finding out about becoming a donor was via the National Gamete Donor Trust (NGDT) and the HFEA. This applied to 8 (33.3%) men in Group A and 30 (46.2%) men in Group B. The second most common source of information about sperm donation was when it was triggered by a request from a friend or family member to become a known sperm donor. This applied to 6 (25.0%) men in Group A and 15 (23.1%) men in Group B. Other information sources were via a newspaper article or the radio.

We investigated the distances travelled by men to donate their sperm. We further subdivided this into known donors who were donating for a friend or family member and anonymous (or unknown). In Group A, known donors travelled a median distance of 4.9 miles with a range of 1.2–201 miles, and anonymous donors travelled a median distance of 25.0 miles ($P = 0.08$), with a range of 1–240 miles. In Group B, known donors travelled a median distance of 11.3 miles with a range of 1.5–408 miles, and anonymous donors travelled a median distance of 10.2 miles ($P = 0.02$) with a range of 2.2–198 miles.

Characteristics and attitudes of men wanting to donate (analysis of donors screened)

In Group A, the mean ($\pm$ SD) age was 38.7 ($\pm$ 6.5) years and in Group B, 38.0 ($\pm$ 7.2) years (Table 2).

For all screened donors residing in the UK, home postcodes were obtained prior to recruitment or registration. In Group A, (all screened donors) the median distance in miles (range) to our clinic was 9.5 (1.0–290) miles. For screened known donors in Group A, the median distance to the clinic was 8.9 (1.2–200) miles. In Group B (all screened donors), the median distance was 11.2 (1.2–480.0) miles. For screened known donors, only the median distance was 11.3 (2.2–198.0) miles.

More men in Group A were born in the UK than in Group B [22 out of 24 (91.7%) when compared with 44 out of 65 (67.7%)]. A higher percentage of men in Group A were white than in Group B, 22 out of

<table>
<thead>
<tr>
<th>Table II</th>
<th>Characteristics and attitudes of men wanting to donate (donors screened).</th>
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<tbody>
<tr>
<td></td>
<td>Group A (March 2000–March 2005)</td>
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<tr>
<td></td>
<td>Group B (April 2005–March 2010)</td>
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<tr>
<td></td>
<td>($n = 24$)</td>
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<tr>
<td>Age of donor in years (mean $\pm$ SD)</td>
<td>38.7 $\pm$ 6.5</td>
</tr>
<tr>
<td>Ethnicity of Donor n (% of total)</td>
<td>White: 22 (91.7)</td>
</tr>
<tr>
<td></td>
<td>Black: 0 (0)</td>
</tr>
<tr>
<td></td>
<td>Chinese: 1 (4.2)</td>
</tr>
<tr>
<td></td>
<td>Indian: 1 (4.2)</td>
</tr>
<tr>
<td></td>
<td>Other: 0 (0)</td>
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<tr>
<td>Sexuality of donor n (% of total)</td>
<td>Heterosexual: 20 (83.3)</td>
</tr>
<tr>
<td></td>
<td>Homosexual: 3 (12.5)</td>
</tr>
<tr>
<td></td>
<td>Bisexual: 0 (0)</td>
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<tr>
<td></td>
<td>Not known: 0 (0)</td>
</tr>
<tr>
<td>Donor reservations for sperm use n (% of total)</td>
<td>No reservations: 13 (54.2)</td>
</tr>
<tr>
<td></td>
<td>Heterosexual couples only: 3 (12.5)</td>
</tr>
<tr>
<td></td>
<td>Known donor: 6 (25.0)</td>
</tr>
<tr>
<td></td>
<td>Not for IVF: 1 (4.2)</td>
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<tr>
<td></td>
<td>Other: 0 (0)</td>
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<tr>
<td>Reasons for donation n (% of total)</td>
<td>Known donor: 6 (25.0)</td>
</tr>
<tr>
<td></td>
<td>Wanting to help: 14 (45.8)</td>
</tr>
<tr>
<td></td>
<td>Wanting children: 4 (16.7)</td>
</tr>
<tr>
<td></td>
<td>Other: 0 (0)</td>
</tr>
</tbody>
</table>

Figure 2 The number of donors screened, recruited and registered—reasons for screen failure and dropouts.

[Diagram showing reasons for screen failure and dropouts in Groups A and B]
of 24 (91.7%) compared with 50 out of 65 (76.9%). There were 15 out of 65 (23.1%) men in Group B who classified themselves as either ‘black’, ‘Chinese’, ‘Indian’ or ‘other’ when compared with just 2 (8.3%) in Group A. In Group A, 1 out of the 2 ethnic minority men was a known donor, when compared with 4 out of the 15 ethnic minority men in Group B.

Nearly, half of the men were single and not in a relationship at the time of screening in both Groups [10 (42.0%) in Group A and 30 (46.2%) in Group B]. In Group A, 20 (83.3%) were heterosexual compared with 45 (69.2%) in Group B. In Group A, there were 3 (12.5%) men who were homosexual and 10 (15.4%) in Group B. In Group A, 13 (54.2%) men were either cohabiting or married when compared with 31 (47.7%) men in Group B. From the potential donors in a relationship, more donors in Group B (22 out of 65 = 33.9%) had informed their partners of their donation when compared with donors in Group A (7 out of 24 = 29.1%).

In both groups, the primary reason for wanting to donate was a ‘desire to help’, and this reason was given by 14 men (48.5%) in Group A and 47 men (72.3%) in Group B. In comparison with Group A, fewer men in B wanted to donate because they wanted to have children [4 (16.7%) versus two (3.1%)].

Men in both groups were asked about any restrictions they would have for their sperm being used. Seven (10.8%) men in Group B when compared with three (12.5%) in Group A wanted their sperm to only be used by heterosexual couples and not lesbian couples or single women.

Discussion

There has been a significant increase in treatments with in-house recruited donor sperm, following the legislative change of 1 April 2005, although, the overall number of donor sperm treatments in our clinic has fallen significantly. The exact underlying reasons for the decline are difficult to ascertain. The relative number of donor IVF/ICSI treatments as a proportion of all IVF/ICSI treatments has remained the same throughout, whereas, the number of donor IUI treatments, as a proportion of all IUI treatments, has fallen significantly, following 2005. A fall in overall IVF/ICSI and IUI treatment numbers at our clinic means that we are performing less donor treatments than before. The advent of ICSI in 1992 (Palermo et al., 1992) led to a decrease in the reliance on donor sperm for many fertility treatments. We introduced ICSI into our routine clinical practice as far back as 1994, and, therefore, its use is unlikely to explain the fall in donor sperm treatments. We routinely screen and examine all men who are referred with azoospermia or severe male factor abnormality and offer a surgical sperm retrieval where appropriate. All our doctors perform PESA, TESA and TESE in-house. Our protocol for managing these men has not changed during the study period and, therefore, unlikely to have had a significant impact on donor sperm requirement and treatments. There certainly is less donor sperm available, following the change in legislation as evidenced by the severe reduction in sperm imported from other clinics within UK. We are often able to meet patient’s demands for racial matching, if, however, these demands cannot be met, then patients are encouraged to import sperm from another clinic in the UK or from overseas. However, a fall in demand as a result of wider awareness of donor sperm treatments in other clinics primarily through the use of the Internet and patients going abroad for medical treatment cannot be ruled out. Further research is needed to evaluate this and assess the motives and factors influencing decision making in this cohort of patients.

Our study shows that more men approached the clinic wanting to donate (following the change in legislation) as a result of which the number of donors recruited has more than doubled. There is no obvious explanation to this welcomed increase in numbers as we do not have a policy of active recruitment. We have not explored the full potential of direct appeal via advertisement in newspapers, magazines, news forums and social media. It appears that most men make initial enquiries with the NGDTS website (www.ngdts.co.uk) and, thereafter, select our clinic based on geographical and other criteria available on the public domain. The NGDTS launched its website (www.ngdts.co.uk) in 2005 and prior to this, dealt with enquires via telephone and post. The HFEA had a limited website launched in November 1998 and has had a more comprehensive one since April 2009. We feel that due to the time period that we are looking at this will not have introduced a significant amount of bias between the two groups. The strengths of this study are that we have been able to look at a large number of cases, in a single unit, that have been within a good proportion of time prior to and after the change in donor legislation. The obvious limitation of our study is that it is retrospective and, therefore, allows for the introduction of bias.

Although the number of men clearing the screening is satisfactory, the high dropout rate due to the loss of follow-up or withdrawal of consent following the change in legislation remains a concern, and research is needed to explore this further. Paul et al. (2006) showed that 3.63% of men initially screened went on to be donors at their unit, whereas we are managing to recruit and register at least 36.9% of men initially seen. The same paper mirrored our results which showed that the main reason for screen failure or dropouts was concerns about the semen analysis or loss of follow-up and change of mind. Our acceptability criteria for normal forms have been altered over the years in line with similar reductions in acceptability criteria in the World Health Organization Laboratory Manual for the Examination and Processing of Human Sperm (WHO Department of Reproductive Health and Research 2010). Our study dates back to before the previous WHO manual that stated that each laboratory should determine its own lower limit for normal morphology. Although the most recent guidelines from the WHO suggest a normal forms criterion of 4%, our current criterion is set at 6%, as determined by in-house quality control and audit of success rates. In spite of lowering the threshold criterion for acceptable normal forms over the duration of the study period, we have not seen a reduction in success rates with donor IUI. The overall CPR for IUI in both groups was 9.8%, which is comparable to national average [live birth rate of 11.5% (Fertility Facts and Figures (2008) www.hfea.gov.uk)], despite the majority of recipients (69.1% in Group A and 72.0% of recipients in Group B) being aged 35 years or older.

At the time of writing this paper, there was no waiting time for in-house-recruited white sperm donors, if recipients were happy with donor characteristics. However, the demand for sperm from black and other ethnic minorities continues to be difficult to meet. This could be due to a general negative attitude towards gamete donation being secondary to religious and cultural beliefs (Burr, 2010) prevalent in these groups. There is an increasing ethnic diversity in our local population of South East London (London’s Poverty
Profile, www.londonpovertyprofile.org.uk), which may lead to an increase in potential donors from ethnic minority backgrounds in years to come.

Although there was no statistical significance in distances travelled by known and anonymous donors attending our clinic, there were very large ranges in both groups A and B for distances travelled. In Group A, there were very similar results between the known and unknown donors for ranges of distances travelled. But, the unknown donors still travelled to our clinic from further away. In Group B, known donors travelled from further away than unknown donors. Although it is clear from our data that a majority of unknown screened donors in both groups A and B resided within 15 miles of our clinic, a few unknown donors are willing to travel considerable distances to donate their sperm, and as there is a cap on the financial reimbursement, it seems unlikely that this would be a potential reason. It is difficult to ascertain exactly why this is. One reason may be that some men would prefer to donate further away from where they reside, if they already have families of their own, or perhaps they are unable to find clinics closer to them to donate to as these clinics no longer accept sperm donors. This is an area that needs further research.

Although more men were born outside of the UK in Group B, it must be acknowledged that these donors need not necessarily be from an ethnic minority. But, the small improvement in men from ethnic minority backgrounds who want to donate is very encouraging. Following the legislative change, there were 15 ethnic minority donors (4 known donors) when compared with 2 donors (1 known donor) prior to the change. Similar figures for potential ethnic minority donors have been reported from other urban areas such as Nottingham (Tomlinson et al., 2010), and this may represent a growing awareness of gamete donation in these populations, although like many centres, we struggle to get Asian (Indian, Pakistani or Bangladeshi) sperm donors (Murray and Golombok, 2000). Previous data published from our clinic suggested that a majority of donors were married and likely to have biological children of their own (Daniels et al., 1996). Our data show that a similar number of men wanting to donate in both groups were married; but men following the legislative were more likely to inform their partners of their decision to donate. This in turn could be a reflection of the emphasis placed on informing the partners during counselling post April 2005 due to the fact that any child born as a result of a donation might be able to contact the donor at the age of 18. It could also suggest a general change in attitude and an increasing awareness of sperm donation in the general public. It has been suggested that the removal of a monetary ‘reward’ for sperm donation is also more likely to attract men in a stable relationship rather than younger men who may find the incentive of payment an important aspect as well (Daniels and Hall, 1997).

Before the change in legislation providing donor anonymity, it was felt that a financial incentive would be important to encourage men to continue to donate (Frith et al., 2007). Currently, sperm donors in England can be given up to £61.28 per day for loss of earnings and up to a maximum total of £250 (www.hfea.gov.uk). We have shown as have many other studies that the majority of donors wanted to donate because they wanted to help people (Ekerhovd et al., 2008). However, a recent publication from the USA has reported that an equal number of donors were motivated by ‘financial payment’ as by ‘wanting to help other’ (Jadva et al., 2011).

We feel that the altruistic nature of sperm donation plays a very important part in understanding and acceptance for donor conceived children and that this may be negatively affected, if we start to pay donors larger sums of money for their sperm. With changes imminent in the financial reimbursement for donors, it will be interesting to investigate the potential impact of such change on service provision, donor attitudes and provider practices.

In conclusion, although there has been a significant decrease in the overall number of donor sperm treatments after the change in legislation, more donors are being screened and recruited than before. Donor attitudes and provider practices are changing with time; however, there remains an unmet need for black and other ethnic minority sperm. The current focus, both locally and nationally, has been on donor recruitment; however, there is also an urgent need to assess the impact of the legislative and other changes on the recipients.

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Authors’ roles
U.S., study design, data collection, data analysis and manuscript preparation; B.D., data collection and data analysis; M.J.P., data analysis and manuscript revision; H.H., data analysis and manuscript revision; M.S., manuscript revision; and N.N., data analysis, study design, and manuscript revision.

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Conflict of interest
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