

The rough guide to insemination: cross-border travelling for donor semen due to different regulations

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Abstract

Donor insemination is one of the main treatments for which patients cross borders. The present paper presents the data from a Belgian and a European study. Sperm donation in Belgium is mainly performed for single and lesbian women coming from France. The other main host country for sperm donation, Denmark, has a much more diverse group of visitors from Sweden, Norway and Germany. 74% of all Swedish women leaving the country, went abroad for semen donation, compared to 57% from France and 51% from Norway. In all other countries, the proportion was much lower. For all nationalities (apart from the Netherlands) the majority of the patients indicated that they went abroad because of legal restrictions in their home country. This is unlikely to change and travelling to obtain donor insemination will continue in the future.

Keywords: Cross-border reproductive care, donor semen, ethics, law, reproductive tourism.

Introduction

Cross-border reproductive care is a multifaceted phenomenon (Pennings, 2004). It refers to movements by candidate service recipients from one institution, jurisdiction or country where treatment is not available for them to another institution, jurisdiction or country where they can obtain the treatment they desire. These movements have raised many ethical questions: is it acceptable that rich people buy their way out of the legal restrictions of their country? Are people's rights violated when they are forced into reproductive exile? Can standards of safety and efficiency be maintained when patients travel? What is the responsibility of the different doctors involved? (ESHRE Task Force on Ethics and Law, 2008).

Different kinds of cross-border movements can be distinguished by looking at the moving parts: the material (gametes or embryos), the recipients and the donors. The 'standard' meaning, most in accordance with normal tourism, is when patients move to other countries to obtain the treatment they cannot get in their home country. The data presented in this article are mainly focussed on the travelling patients but I

start with a short discussion on the two other forms because I believe they are equally important.

Different forms of crossing borders

Given the alternatives (mainly shipping of sperm itself), movements by sperm donors are not evident. When donors cross borders, they most likely have an additional reason for travelling. Nevertheless, several examples can be found that reveal the differentiation and complexity of the phenomenon. In the United Kingdom, the percentage of overseas sperm donors among all sperm donors was 12% in 2005, 24% in 2006, 12% in 2007 and 17% in 2008 (Human Fertilisation & Embryology Authority, 2009). It is unclear how this percentage can be explained. Are these British citizens of foreign origin or are these foreign students, immigrants or what? According to the Human Fertilisation & Embryology Authority document, foreign refers to the country of residence. This seems to suggest that these are temporary visitors. In India, foreign donors of fair skin are much in demand because parents want a fair child. Especially exchange students studying medicine and

engineering are recruited as commercial donors (Bakshi, 2008). An Australian clinic made a fairly drastic step by trying to recruit foreign donors with a package worth more than US\$5000 (including a return flight, accommodation for a fortnight and a daily allowance (Anonymous, 2003). This also gives a whole new meaning to travel expenses.

The most important form of movement is the import and export of sperm. Sperm can be easily transported from one country to another. Import and export of semen is regulated by national laws. Import of anonymous sperm is limited or banned in the United Kingdom, the Netherlands, Norway, Sweden, Austria, Switzerland, New Zealand and Australia precisely because of the donor anonymity. One would expect countries to impose the same rules and restrictions on imported semen as they do on locally obtained semen, including rules of anonymity and payment of donors. Most of the sperm originates from Denmark where, for unknown reasons, many more sperm donors are found than in the other European countries. Although part of the explanation is the payment of the donor, this certainly cannot explain the difference between Denmark and the rest of Europe. In 2005, Ole Schou, director of Cryos International Sperm Bank, stated that about 10,000 units per year (approximately 70%) of donor semen from Cryos is exported to other European Union countries (Schou, 2005). In a 2009 newspaper article, it is reported that by then Cryos exports 85% of the 20,000 sperm donation to about 400 fertility clinics in 60 countries (Anonymous A, 2009). The largest buyers of sperm are clinics in Ireland, Belgium and Finland (Pavia, 2006). Every sample shipped across borders is one patient less who has to make the reverse journey. This certainly is a much more patient-friendly way than asking or forcing patients to travel. Taking into account that there are more large sperm banks in Europe who also ship sperm across the world, this is an important part of the total phenomenon of cross-border reproductive care.

The shipping of semen from one country to another is not limited to Europe. In Canada, for instance, there are at the moment 33 semen donors on a population of 33 million inhabitants (Anonymous B, 2009). With a recruitment rate around 1% of the donor candidates, it is extremely difficult to maintain a sufficient number of donors (Bradley *et al.*, 2005; Said and Del Valle, 2008). This shortage of candidates is mainly explained by the prohibition on payment introduced by the Assisted Human Reproduction Act of 2004. The law foresaw a transition period (that is extended until today) during which sperm could be imported. It is estimated that about 80% of children born in Canada by donor

semen have an American donor (Bissessar, 2005). Interestingly, this means that these donors were paid for their donation. The advantage in terms of abidance by the ethical rule of non-remuneration is difficult to see.

Sperm donation in Belgium

Belgium is the only country in the world for which (almost) complete and reliable data exist regarding incoming patients for medically assisted reproduction (Pennings *et al.*, 2009). The majority of foreign patients seeking treatment in Belgium are French women for sperm donation. This group largely consists of lesbian couples and single women. These women have no access to medically assisted reproduction in France since treatment is restricted to heterosexual stable (co-habiting for at least 2 years) couples (Pennings, 1997). Of all patients coming from France to Belgium for assisted reproduction, 73% came for sperm donation. When we turn the picture around and focus on all foreign patients coming to Belgium for sperm donation, the French women make up 80% of all requests.

The data show a clear correlation between legal prohibitions in the home country of the patients and the number of patients who look for a solution abroad. These prohibitions may not directly concern the patients or their characteristics but may target certain guidelines that have an impact on the number of donors and/or sperm banks. The data presented above on Canada illustrate this point. When countries abolish donor anonymity or make payment for donors illegal, this has an impact on the number of candidates (Pennings, 2001). Moreover, more stringent requirements for donor screening (testing, quality standards etc.) and semen storage and distribution make things much harder for sperm banks (Yee, 2009). As a result, only a fraction of the candidates are retained. In the Newcastle clinic in the United Kingdom, 3.6% of all candidates finally are allowed to donate (Paul *et al.*, 2006). This proportion of lost and/or excluded candidates is typical of many sperm banks in the United Kingdom (British Fertility Society, 2008). This leads to higher costs, more investment of time and personnel and decreased efficiency. The cost per donor was estimated as high as £ 2700 (3000 €) per donor (British Fertility Society, 2008). Not surprisingly, many sperm banks in Canada decided that it was no longer worthwhile and voluntarily closed their doors. A very similar evolution took place in the Netherlands. The number of donors decreased by more than 70% and the number of sperm banks by 50% in the last 15 years (Janssens *et al.*, 2006). This was a consequence of the long-lasting debate (15 years) on donor

anonymity eventually resulting in the Law on donor data of 2004 that abolished donor anonymity. The effect could immediately be seen in Belgian clinics, especially those located near the Dutch border (Ombelet, 2007). The diminished offer on the Dutch side combined with the conviction of some Dutch couples that donor identifiability was not acceptable for them led to a steep increase in patients going to Belgium where anonymity is maintained. Between 2004 and 2005, the number of Dutch patients going to Belgium for donor insemination almost doubled from 57 to 99 patients (Pennings *et al.*, 2009).

European data

In 2008, the European IVF Monitoring (EIM) and the Task Force on Ethics and Law of the European Society of Human Reproduction and Embryology (ESHRE) started a study to collect data on cross-border reproductive care. The Task Force on Cross-border Reproductive Care, coordinated by Françoise Shenfield, designed 2 questionnaires that were distributed in centres of 6 European countries: Belgium, Czech Republic, Denmark, Switzerland, Slovenia and Spain. The centres that agreed to participate handed the patient form to all women coming from abroad for infertility treatment during one calendar month. The patient form contained socio-demographic characteristics (age, marital status, sexual orientation, patient's and partner's education), the main reasons for crossing the border, the type of treatment sought, the information received by the patients, the reimbursement situation and the degree of support received from the doctor at home. The patients were asked to indicate the reasons for travelling (more than one reason could be given). They were offered the following options: the treatment you want is not legal in your home country; you cannot obtain treatment because of age, unmarried, single, sexual orientation etc.; treatment is not easily accessible because of long waiting list, distance to the centre, cost etc.; you expect better quality and/or outcome in this centre than in your home country; you want anonymous / known / iden-

tity release donation of sperm / egg / embryo; and you had a previous treatment failure at home. The survey was conducted between October 2008 and March 2009. The patient questionnaire contained no patient or centre identification. The study was approved by ethics committees, according to the rules of each specific collaborating country.

The general data can be found in the article of the Task Force (Shenfield *et al.*, 2010). The data presented here focus on the use of donor semen and were not analysed in the general paper.

Results

For the whole study, we received 1230 forms from 46 clinics participating in the 6 countries: 29.7% from Belgium, 20.5% from the Czech republic, 12.5% from Denmark, 16.3% from Switzerland, 15.7% from Spain, and 5.3% from Slovenia. Patients came from 49 countries, among which four countries were particularly represented, with more than 100 forms each: Italy (31.8%), Germany (14.8%), the Netherlands (12.1%) and France (8.7%). More than 50 forms were returned by patients from Norway (5.5%), the UK (4.3%) and Sweden (4.3%). Civil status varied according to the countries of residence. In total, 69.9% of women were married, 24.0% cohabiting and 6.1% single. Most Italian women were married (82.0%) whilst 50% of French women and 34.9% of Dutch women were cohabiting. In Sweden 43.4% were single (Shenfield *et al.*, in press).

The number of patients (N = 270) coming for donor insemination includes those who mentioned this in the questionnaire and the single women and lesbian couples who have no other way of treatment. Most patients came from 6 countries (see Table 3).

The majority of the women arriving in Belgium for donor insemination came from France (Fig. 1). This confirms the broad picture in the Belgian study (Pennings *et al.*, 2009). The second largest group were the Dutch patients followed by the Italians.

When one analyses the patients going to Denmark, there are 2 almost equally large groups, i.e., the Swedish and the Norwegian patients (Fig. 2).

Table 1. — Percentage of patients from a certain country for donation.

Home country	Number of forms	Semen	Oocyte	Embryo
Italy	391	15.6%	17.9%	2.3%
Germany	177	13.6%	42.4%	6.2%
The Netherlands	149	15.4%	8.1%	0.7%
France	107	57.0%	20.6%	5.6%
Norway	67	50.7%	1.5%	1.5%
United Kingdom	53	17.0%	60.4%	11.3%
Sweden	53	73.6%	5.7%	1.9%

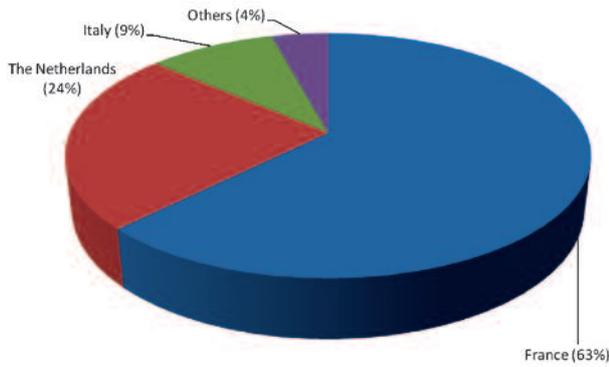


Fig. 1. — Home country of patients going to Belgium for sperm donation.

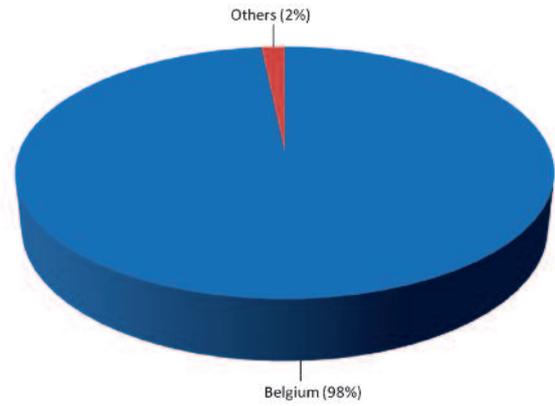


Fig. 3. — Host country of patients coming from France for sperm donation.

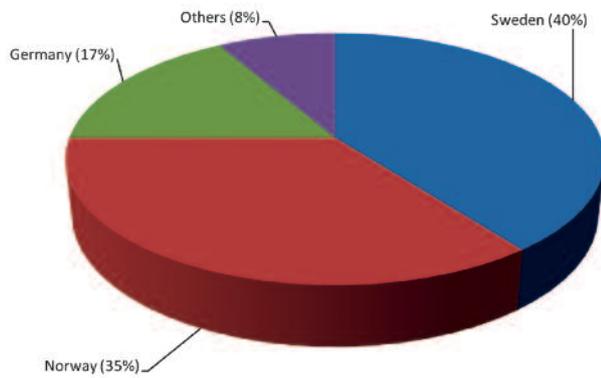


Fig. 2. — Home country of patients going to Denmark for sperm donation.

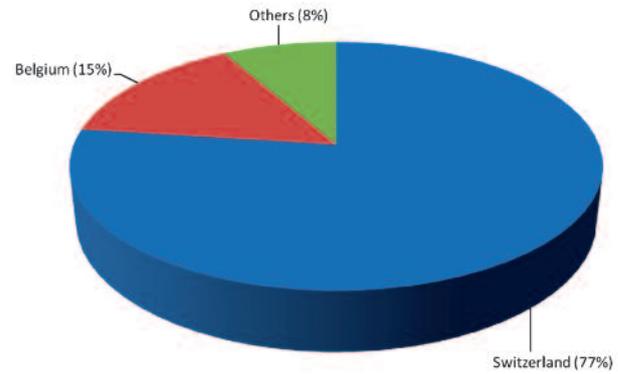


Fig. 4. — Host country of patients coming from Italy for sperm donation.

When we switch perspective and look at the distribution of patients of a certain nationality going abroad, we see that the French women almost exclusively go to Belgium for donor semen (Fig. 3).

Patients from Italy on the contrary travel mostly to Switzerland and then to Belgium for donor sperm (Fig. 4).

Fairly large difference can be found for the donation of gametes (semen and oocytes) and embryos (Table 1). Patients from France, Norway and Sweden

travel considerably more for donor insemination than patients from the other countries. In the case of Sweden, almost 3 out of every 4 patients go for this type of treatment.

Regarding the distribution of the treatment type for which people travel to a certain country, it is clear, even with the limited data that were obtained from these countries, that Spain and Czech Republic were very popular for oocyte donation (Table 2). Belgium, Switzerland and Denmark, on the contrary, were more appreciated for donor insemination.

Table 2. — Percentage of patients travelling to a host country for donation.

Host country	Number of forms	Semen	Oocyte	Embryo
Belgium	365	26.3%	6.3%	0.3%
Czech Republic	251	9.2%	50.6%	12.0%
Switzerland	201	23.4%	1.0%	0.5%
Spain	193	4.1%	62.2%	4.7%
Denmark	154	61.7%	1.3%	0.6%
Slovenia	65	1.5%	0.0%	0.0%
Total	1229			

Table 3. — Reasons for travelling according to the home country of the patients.

Home country	Number of forms	Not legal in home country	Cannot obtain treatment (age,)	Treatment not accessible (list, ...)	Expect better quality	Anonymous donation	Previous failure
Italy	61	95%	5%	0%	26%	44%	16%
France	61	69%	30%	7%	13%	54%	5%
Sweden	39	54%	28%	13%	15%	21%	3%
Norway	34	65%	41%	0%	6%	24%	3%
Germany	24	67%	33%	8%	17%	13%	21%
The Netherlands	23	17%	13%	13%	26%	35%	9%

Table 3 gives the reasons why people go abroad when they go for donor insemination. Apart from the women from the Netherlands, the majority travel because of legal restrictions. The second most important reason is that they cannot obtain treatment at home because of a personal characteristic (too old, ...). Respondents could tick more than one reason and there probably was an overlap between these two reasons since in some countries the law excludes some groups from treatment on the basis of personal characteristics. A number of patients indicate that they went for anonymous donation but it is unclear to what extent this means that anonymity was their reason for travelling. Some countries, like France, have donor anonymity imposed by law and so French women do not have to travel to obtain anonymous sperm.

Discussion

The results of the ESHRE study should be taken with the necessary caution. When the data of the host countries are mentioned, one should take into account that for 3 countries (Spain, Czech Republic and Switzerland), only a small number of centres agreed to participate. The response rate for the 3 other host countries was 50% for Belgium (9/18), 100% for Slovenia (3/3), and 88% for Denmark (21/24). This implies that especially the data for the first 3 countries may show a distorted picture. For the home countries, it is obvious that if a major country of destination was not included or was badly represented, a large group of patients may have been missed. Anecdotal evidence indicates that Spain is very popular with Italians but the data are very limited. Nevertheless, this study is a starting point that should be amended by more detailed and more representative studies.

Patients preferentially travel to neighbouring countries (Shenfield *et al.*, in press). Nevertheless, much depends on what they need or want and where they can obtain it. In a questionnaire among Ameri-

can IVF clinics, it was found that patients sometimes travelled large distances to obtain donor insemination. This survey, performed in 2008, showed that 88 patients came from Canada, 44 from Europe and 73 from Latin America (Hughes and DeJean, 2010). One possible explanation for making this long journey could be that the recipients wanted to choose the donor on the basis of an extended donor profile. This possibility is only offered in the US or in commercial sperm banks.

Conclusion

Most patients who travel abroad looking for donor sperm cannot obtain this treatment at home due to legal restrictions. Single women and lesbian couples are denied access to assisted reproduction in many European countries. This is unlikely to change in the near future and so travelling for donor semen will continue in the future. It is a shame to Europe that, at a time when discrimination on the basis of sexual orientation is condemned as a violation of human rights, so many lesbian couples still have to travel to obtain elsewhere what they should be able to obtain at home.

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