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How professional discretion shapes participation in egg donation: a mixed-methods comparative study

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Abstract

Study Question: How are access-related decisions in egg donation, including donor and recipient eligibility, matching and allocation, regulated and operationalised in practice?

Summary Answer: Formal regulations set only broad parameters with the substance of access-related decisions determined at clinic level through provider discretion that was variable and often opaque.

What is Known Already: Clinic-recruited egg donation, in which people donate eggs to clinics or egg banks for allocation to recipients unknown to them, requires decisions about who can participate and under what conditions. These decisions can carry significant consequences for the reproductive opportunities of donors and recipients, yet little is known about how they are made in practice. Previous work has documented differences in the formal rules governing access to egg donation across jurisdictions. How these rules are applied in practice, and how clinics approach access-related decisions where formal regulation is absent or limited, remains poorly understood.

Study Design, Size, Duration: A mixed-methods qualitative design comprising an analysis of policy and governance documents and semi-structured interviews with key informants experienced in egg donation policy or practice. Analysis spanned eight jurisdictions: Australia, the Czech Republic, Denmark, Israel, Spain, New Zealand, the United Kingdom, and the United States. Interviews were conducted between September 2025 - April 2026.

Participants/Materials, Setting, Methods: Document analysis mapped the formal regulatory landscape in each jurisdiction, drawing on legislation, professional guidelines, grey literature, and publicly available clinic materials. Interviews explored how formal regulation is interpreted and applied, how decisions about eligibility, access, and allocation are made, and the ethical tensions and practical challenges these involve. The two data sources were integrated through a thematic comparative framework organised around four domains: donor eligibility, recipient access, matching and allocation, and underpinning rationales.

Main Results and the Role of Chance: Across all eight jurisdictions, formal regulation set broad parameters but left many access-related decisions unspecified, leaving these to be operationalised at clinic level through provider discretion. Donor eligibility was shaped less by legislation than by clinic-level interpretation, with providers applying additional screening and assessment criteria alongside formal requirements. Recipient access was similarly variable, shaped by clinic policy, donor availability, and financial capacity, with participants describing inequities between public and private systems and disparities in donor diversity across providers. Approaches to donor-recipient matching also varied from recipient-led selection to clinic-mediated approaches, with clinics in some jurisdictions directed by regulation to match on physical, cultural, or religious resemblance, and clinic discretion extending in some settings to overriding the preferences of both donors and recipients. Providers framed access-related decisions in terms of professional obligations to protect donors, ensure recipient suitability, and

safeguard the welfare of future children, but described some discomfort and uncertainty in making these decisions.

Limitations, Reasons for Caution: The regulatory analysis may have been limited by the accessibility and availability of key regulatory documents, particularly in non-English-speaking jurisdictions. Participants varied in professional background, which likely influenced their accounts and assessments of practice. Findings may not capture all variation in the global provision of egg donation.

Wider Implications of the Findings: Access-related decisions varied significantly between and within jurisdictions. These decisions carry real implications for fairness, equity, and the welfare of donors, recipients, and donor-conceived people. Future work should examine the limits of provider discretion and the principles needed to support transparent, accountable and consistent decision-making.

Introduction

Egg donation is a growing feature of contemporary assisted reproduction. The International Committee for Monitoring Assisted Reproductive Technologies estimated that in 2019 there were around 284,170 cycles of egg donation (including fresh and frozen transfers) across 63 countries (Dyer et al 2025), up from an estimated 89,751 cycles reported in 2014 (Chambers et al 2021). Egg donation occurs through two main pathways. In ‘known donation’, people seeking donor eggs recruit their own donor, often a family member or friend. In ‘clinic-recruited donation’, people donate eggs directly to clinics or egg banks for eggs to be allocated to recipients unknown to the donor.

Clinic-recruited donation requires decisions about who is accepted as a donor, who is eligible to receive donor eggs, and how donors and recipients are matched. Where demand exceeds supply, as it does in many countries (Dyer 2011; Kieu et al. 2024; Gorton 2019), decisions must also be made about how available eggs are allocated and which recipients are prioritised. Sourcing donors from particular ethnic groups can add further challenges for matching and allocation (Whittaker et al 2019; Heng 2007). Together, these decisions shape who can participate in clinic-recruited egg donation and under what conditions, with potentially significant consequences for people’s reproductive opportunities.

Despite their significance (Kool et al 2018), relatively little is known about how these decisions are made in practice. Deng et al (2025) compared how egg donation is governed across several international jurisdictions identifying variation in donor and recipient age limits, restrictions on donation cycles and numbers of recipients or donor-conceived children, models of egg donation and donor identification. This work demonstrates important differences in the formal rules governing access to egg donation. However, formal rules provide only part of the picture of how access to egg donation operates. They do not show how eligibility criteria are applied, what considerations inform decisions about donors and recipients, how matching occurs, or how available eggs are allocated and prioritised.

Kool et al (2019) conducted semi-structured interviews with Dutch ART providers, donors and recipients on the ethical aspects of intake and distribution of donor eggs. Participants supported a gatekeeping

role for oocyte banks, framing the selection of donors and recipients as a means of protecting donor wellbeing and safeguarding the welfare of the future child, including through assessment of prospective recipients' parental capabilities. Yet there was no consensus on where acceptable thresholds should lie, particularly for heritable conditions, and they were divided on how recipients should be prioritised when supply was scarce. While these findings speak to the significance and challenges of access-related decisions, they do not explain how these decisions are made or applied and they report on the experience of a single nation. It remains unclear on what basis access-related decisions are made or whether and, if so how, these are approached differently across contexts.

This study extends Deng et al and Kool et al by examining how access to clinic-recruited egg donation is managed in practice across eight jurisdictions. We examine not only the rules and policies that govern access, but how they are applied within services and what informs decisions about donor and recipient eligibility, matching, allocation and prioritisation. Comparing jurisdictions allows us to examine what informs decisions about access across different regulatory, institutional and cultural settings, and how different systems put their governance arrangements into practice. Ultimately, a better understanding of how access decisions are made in practice can provide a foundation for developing robust approaches to decision-making that are transparent, consistent and capable of justification.

Methods

Study design

The study employed a mixed-methods qualitative design to examine the regulation and practice of egg donation across selected jurisdictions. This comprised a review of policy and governance documents and semi-structured interviews with key informants. Monash University Human Research Ethics Committee granted ethics approval on 5th November 2025 (#49919).

Eight jurisdictions were purposefully selected to reflect a range of regulatory models, cultural contexts, and operational approaches to egg donation. Table I summarises the jurisdictions and the rationale for their inclusion.

Table I: Jurisdictions included in analysis

Jurisdiction	Rationale for Inclusion
Australia	Reference jurisdiction; altruistic, identity-release system
Czech Republic	Commercially active reproductive travel hub with less regulatory oversight than many Western European jurisdictions
Denmark	Recent introduction of clinic-recruited egg donation
Israel	High uptake; distinctive ethical, cultural, and religious context
New Zealand	Altruistic, identity release system with framework similar to Australia but different approach to matching
Spain	Global leader in egg donation; major destination for cross-border reproductive travel
United Kingdom	Well-regulated system with centralised oversight and established clinic-recruited donation
United States	Highly commercialised model with wide variation in recruitment and allocation practices

Data collection

Document analysis

Document analysis was conducted across eight jurisdictions to map the formal regulatory landscape governing egg donation. Sources included national legislation, regulatory and professional guidelines, grey literature, and publicly available clinic policies and donor information materials. Sources published within the last 10 years were prioritised, with older texts included where foundational. Data were extracted on donor eligibility, recipient access, and matching and allocation practices.

Key informant interviews

Semi-structured interviews were conducted with key informants who had direct knowledge of or professional experience in egg donation policy or practice within the selected jurisdictions. Key informants were identified through professional networks, snowball sampling from initial contacts, and direct identification from relevant published literature. Participants were invited by email to participate in an online interview conducted by GF between September 2025 and April 2026, lasting approximately 60 minutes. Verbal consent was obtained at the start of the interview.

Interviews explored how formal laws and policies are interpreted and applied in practice; how decisions about eligibility, access, and allocation are made in real-world settings; and perceived ethical tensions and practical challenges in provision (Supplementary File 1).

Data analysis

Interviews were analysed using inductive content analysis (Vears & Gillam 2022). Transcripts were read iteratively and coded line-by-line to identify concepts, practices, and decision-making processes. Initial codes were developed directly from the data and grouped into higher-order categories through comparison across interviews and jurisdictions. The authors discussed the categories; where discrepancies arose, these were resolved through discussion and re-classified if necessary.

Document analysis findings provided the regulatory context against which interview accounts were interpreted, with the two data sources integrated through a thematic comparative framework organised around four domains: donor eligibility, recipient access, matching and allocation, and the rationales underpinning practice.

Findings are presented in two parts: Part 1 reports the regulatory frameworks, and Part 2 draws on interview data to examine how egg donation is operationalised in clinical practice across our four specified domains.

Results

Part 1: Regulation of egg donation

The included jurisdictions varied in their regulatory approaches to egg donation, spanning quite prescriptive statutory acts (e.g. Israel, Czech Republic, Spain), hybrid systems combining broad parent legislation with enforceable guidelines produced by delegated statutory authorities (e.g. United Kingdom, New Zealand, Denmark, Australia) and professional self-regulated models (e.g. United States). Two professionals were interviewed separately from the United States and Australia in an attempt to capture diversity between two different models operating within the same governance framework (Table II).

Table II: Legal and regulatory requirements for access to egg donation across eight jurisdictions

Jurisdiction	Primary governance	Donor eligibility*	Recipient eligibility*	Donor-Recipient Matching and allocation*
Australia	● "Patchwork" of Legislation** ● NHMRC Ethical Guidelines on the use of Assisted Reproductive Technology 2017 ● Reproductive Technology Accreditation Committee (RTAC) Code of Practice 2025	Providers must consider the physical, psychological and social wellbeing of each party when accepting and allocating gamete donations		
		● Donor gametes must be deemed 'safe' for use; minimise possible risks including from infectious diseases and health risks associated with donor age; ● Donors and their partners, must have received counselling and comply with relevant family limits	Recipients have received counselling	None identified
Czech Republic	Czech National Legislation, (Act No. 373/2011 and 227/2006)	● Aged between 18 and 35 years ● Be in good health and mental condition (Sanchez et al 2024) ● Maximum of six egg retrievals (Sanchez et al 2024)	● Upper age limit of 49 years ● 'Stable' heterosexual couples (Slepičková 2022) ● Medical need for egg donation (Sanchez et al 2024)	Phenotypic matching. Matched based on several criteria including blood type, hair and eye colour, weight, skin tone, height (Slepičková 2022; Wiecki 2026)
Denmark	● Lov om assisteret reproduktion i forbindelse med behandling, diagnostik og forskning m.v. (LBK nr. 902 af 23/08/2019) [Consolidated Act on Assisted Reproduction in	● Aged between 18 and 35 years ● Pass biological screening requirements (e.g. infectious	● Upper age limit of 45 years ● Pass psychological and parental	None identified

* Unless otherwise stated, information is drawn from the primary governance source/s listed

**Assisted reproduction is subject to over 40 pieces of legislation across nine jurisdictions within Australia (Hunt & Swift 2024)

Jurisdiction	Primary governance	Donor eligibility*	Recipient eligibility*	Donor-Recipient Matching and allocation*
	Connection with Treatment, Diagnostics, and Research etc.] ● Bekendtgørelse om assisteret reproduktion (BEK nr. 1452 af 01/12/2025) [Executive Order on Assisted Reproduction] ● Bekendtgørelse om kvalitet og sikkerhed ved håndtering af humane væv og celler (Vævsbekendtgørelsen) [Executive Order on Quality and Safety in the Handling of Human Tissues and Cells]	diseases, hereditary conditions) ● Maximum of six egg retrievals	fitness evaluation	
Israel	Egg Donation Law (5770 – 2010),	● Aged between 21 and 35 years ● Egg retrieval must be performed in Israel ● Unmarried (Preisler et al 2024) ● Maximum of three egg retrievals	● Aged between 18 and 54 years ● Medical need for egg donation ● Resident of Israel	● Donor and recipient must be of the same religion ● Eggs allocated to up to three women (Ministry of Health 2026). IVF Units receive financial subsidies from the government only when eggs from one donor are distributed to three recipients (Preisler et al 2024)

* Unless otherwise stated, information is drawn from the primary governance source/s listed

**Assisted reproduction is subject to over 40 pieces of legislation across nine jurisdictions within Australia (Hunt & Swift 2024)

Jurisdiction	Primary governance	Donor eligibility*	Recipient eligibility*	Donor-Recipient Matching and allocation*
New Zealand	● The Human Assisted Reproductive Technology (HART) Act 2004 ● The Status of Children Amendment Act 1987 ● Guidelines produced by the Advisory Committee on Assisted Reproductive Technology [ACART], 2020 ● Reproductive Technology Accreditation Committee (RTAC) Code of Practice 2025	● Lower age limit of 18 years ● Pass medical and genetic screening ● Donors have received counselling	Recipients have received counselling	None identified
Spain	Law 14/2006, of May 26 on Assisted Reproduction Techniques, and one Royal Decree 9/2014	● Aged between 18 and 35 years. ● Good physical and psychological health. ● Not suffer from genetic, hereditary or communicable infectious diseases. ● Has not been legally adopted ● Maximum of six children born.	● Lower age limit of 18 years ● Reasonable chance of treatment success ● No severe risk to physical health of recipient or future child	Phenotypic and immunological matching
United Kingdom	● The Human Fertilisation and Embryology Act 1990 ● The Human Fertilisation and Embryology Authority's Code of Practice	● Aged between 18 and 35 years ● Pass medical and genetic screenings ● Pose no risk of serious physical,	Consideration of the welfare of the future child, including medical and psychological assessment	None identified
* Unless otherwise stated, information is drawn from the primary governance source/s listed				
**Assisted reproduction is subject to over 40 pieces of legislation across nine jurisdictions within Australia (Hunt & Swift 2024)				

Jurisdiction	Primary governance	Donor eligibility*	Recipient eligibility*	Donor-Recipient Matching and allocation*
		psychological or medical harm to a recipient or child born as a result of treatment ● Maximum of 10 families		
United States	● 21 CFR Part 1271 (Human Cells, Tissues, and Cellular and Tissue-Based Products) ● American Society for Reproductive Medicine (2021) (non-binding standards on gamete donation)	● Aged between 21 and 34 years ● Pass medical and genetic screening ● Maximum of six egg retrievals	Pass medical screening	None identified
* Unless otherwise stated, information is drawn from the primary governance source/s listed				
**Assisted reproduction is subject to over 40 pieces of legislation across nine jurisdictions within Australia (Hunt & Swift 2024)				

Part 2: Practice of egg donation

Thirteen professionals were interviewed to provide insights into the operation of egg donation in their respective jurisdictions. For three jurisdictions, Denmark, the Czech Republic and Israel, two participants were jointly interviewed upon the request of the participants (Table III). In what follows, we present the main findings as per our pre-specified domains.

Table III: Key Informants by jurisdiction and profession (n = 13)

Participant ID	Country	Primary profession*
P1	United States (commercial egg bank)	ART professional
P2	United States (ART provider)	ART professional
P3,P3A	Israel	ART professionals
P4	Australia (public clinic)	ART professional
P5	Australia (private clinic)	ART professional
P6	Spain	Academic
P7	United Kingdom	Academic
P8	New Zealand	Academic
P9, P9A	Czech Republic	Academics
P10, P10A	Denmark	ART professionals

**To reduce the chance of identification, we have used broad professional categories. ART professionals included clinicians and donor coordinators; Academics worked across fields of sociology, anthropology, bioethics and psychology.*

Domain 1: Donor eligibility

Participants explained that donor eligibility was not determined solely by formal regulatory requirements, but was shaped in practice through additional criteria and provider discretion.

1.1 Variation and clinical discretion in practice Although laws and guidelines established broad parameters for donor eligibility, participants described substantial variation in how these criteria were interpreted and applied between and within clinics.

'We decline very few donors, but when we do, there's nothing stopping them from going down the road to another provider… there are differences between clinics, for example, age cut-offs may vary… so there's a level of subjectivity that goes with it.' P8

'For egg donation, our age range is 21 to before the 38th birthday… however, we can make exemptions through our medical advisory committee… there are quite a number of people in that 38 to 40 range, so we do try to make exemptions where we can.' P5

One participant described eligibility assessments as necessarily flexible, reflecting the reality that the same condition does not automatically have the same implications for every donor:

'… we don't provide a standard information sheet about what would include or exclude someone, because it's so variable. A condition can mean very different things depending on whether it affects the donor, a

parent, or a more distant relative, you couldn't keep up with that in a fixed guideline.' P4

Participants from Denmark explained that screening expectations were evolving, and practices were implemented across clinics despite uncertainty about whether they were formally required by law.

'There's been a lot of new policies… but the guidelines haven't yet been updated… so we're in a kind of triangle. We discussed a lot whether [genetic screening] was in the law or not… but right now everyone has to do it.' P10, P10A

1.2 Eligibility criteria expanded in practice Participants consistently described clinics adding more detailed screening and assessment practices, such as expanded genetic screening and mental health assessments, than what was explicitly required by regulation.

'Many of these practices [genetic screening, psychological assessment] are not stated in the law. The law simply requires that the donor is in good physical and psychological health, it is very broad. What I am describing reflects how clinics actually operate in practice, rather than detailed legal requirements.' P6

'If they have a history of psychological disease of any kind… It's very strict. Sometimes too strict… even ADHD… we have to say you cannot do it. If it's been a hard depression, then no.' P10, P10A

'Our egg donors go through a one-hour appointment with a social worker, and they also complete a personality inventory, the [Personality Assessment Inventory]. It's screening for psychopathology, to identify whether there are any significant concerns [to proceed as a donor].' P2

1.3 Implicit criteria and informal assessment Participants also described how counselling could function as a form of assessment, with concerns raised during counselling sometimes influencing whether a donor was considered suitable to proceed.

'Some clinics might say you have to go and see the counsellor first as part of this process… others might say they get further down the process and then get sent back if something comes up… and then, of course, there are clinics now saying you can be offered it, but you don't need to have it and some won't let donors proceed unless they've had a session with the counsellor, because that in itself, for some clinics, is a red flag.' P7

Related to this, a few participants reflected on the ambiguity of counselling within donor eligibility processes, describing ongoing uncertainty about whether it should function primarily as support, informed consent, or assessment.

'I wish this were more clear-cut, but it isn't. Fertility counsellors are intended to provide implications counselling rather than assessment; however, in practice, an assessment component does emerge. Where concerns arise during counselling, these may be escalated to the treating clinician or medical director, for example, concerns about safety or the person's ability to give informed consent. So, while counselling is not formally designed as an assessment, it effectively becomes one in practice.' P8

In some settings, implicit assessment extended to subjective judgements about donor appearance and anticipated recipient preferences, as illustrated by the following account:

'Just yesterday, I received a donor profile… I could see that she hadn't been fully truthful… her BMI was higher than stated… They asked her to remove her makeup, and she still didn't present well. I had to cancel her. I said, I'm so sorry, but I knew that none of the patients, either in Australia or in Israel, would choose her.' P3,P3A

One participant also suggested that donor reliability is a factor in determining whether a would-be donor is deemed suitable to proceed.

'There is also an assessment of how reliable the donor will be throughout the process. Clinics look at aspects of her life, such as whether she has what they perceive as a stable situation, in order to feel confident that she will not withdraw partway through treatment. If a donor is seen as having an unstable life, or being potentially unreliable, that may influence whether she proceeds.' P6

While the focus of these conversations was on outlining what happens in practice, some participants also described the outcomes of these decisions, and observed that donor responses to being excluded were sometimes experienced as distressing or discriminatory.

'We do sometimes rule out donors based on their history or screening, and they can become upset and keep calling, asking for an explanation… It can feel discriminatory, but we explain the criteria and why they were disqualified.' P2 'We have had donors who are quite upset, for example, a donor with autism. While we understand it's a spectrum, we know inheritance can vary significantly, and some children can be severely affected even if the parent is less affected. Some donors don't understand why they can't proceed, and that can be difficult. Others ask upfront, 'I have autism, can I donate?' so there is some awareness. But when people are excluded, they can be very distressed… one donor told us, 'don't ever call me again, you guys are horrible." P5 'Some donors felt that counselling was unnecessary, while others valued it as a space to think about things they hadn't considered. However, some also felt they were being screened through the counselling, that they were being judged or evaluated.' P7

1.4 Institutional decision-making processes Although donor eligibility decisions were often discretionary, participants described a range of formal clinical processes, including committee review, psychologist assessments and multidisciplinary teams through which decisions were reviewed and authorised.

'Donors complete a very detailed profile, including multiple generations of family history. A genetic counsellor reviews this in detail and may construct a pedigree to determine whether the donor can proceed.' P1

'We've recently started police vetting… that's not a regulatory requirement, it was a clinic decision… the information is reviewed by the medical director, and if needed escalated to the group medical directors, based on the severity of what is identified.' P8

'If there were significant health concerns, we would manage that on an individual basis and bring it to a clinical review committee.' P4

'We have a psychologist who is part of the team… that's not the law, it's something we chose. If she does not approve the donor, then the donor cannot proceed.' P3,P3A

While these processes represent an attempt to introduce structure and oversight, they remain largely internal to clinics rather than externally governed or publicly articulated.

1.5 Challenges to oversight

One of the challenges to donor eligibility was actually applying and managing criteria in practice. Several participants commented that the absence of national or international donor registries is a significant gap in oversight, with implications for monitoring donation frequency and enforcing donor limits. Together, the accounts below suggest that oversight is dependent on donor self-disclosure and clinic-level compliance.

'There is no central way to check how many times someone has donated, that's one of the biggest problems…At the moment, if someone donates 15 times, they can do it and nobody will stop them. Clinics may know a donor has already donated multiple times, but they will still proceed, partly because there is such high demand for egg donors.'P9,P9A

'In the United States, the limit [to the number of donations] is typically around 25 families, and that's our clinic policy as well. But there's no central registry, so if a donor goes to another jurisdiction to donate again, there's currently no mechanism to track that'.' P1

'Right now it's based on trust. We ask them how many times they've donated, but we don't actually know. There isn't a register or anything we can check, so we just have to rely on what they tell us.' P10, P10A

Oversight gaps extended beyond donation frequency to questions about the transparency and reliability of screening practices in cross-border donation arrangements.

'For egg donation, some countries like Spain are used because it is relatively inexpensive. Eggs are also being shipped into the United States, but that raises questions about how well donors have been screened, and whether clinics can fully trust the screening processes in those countries. P1

Domain 2: Recipient access

Recipient access was described as being shaped by clinic policy and clinical judgement, donor availability, and resource constraints, as outlined below.

2.1 Clinical assessment and eligibility

Participants described recipient access to egg donation as dependent on clinical assessment and clinic-based interpretation of suitability.

'Recipients here can access donor eggs up until their 51st birthday. Beyond that, there aren't really other fixed eligibility criteria. They do implications counselling, and if anything comes up, it's up to the counsellor's discretion whether to seek further information.' P4

'…there is no official age at which you cannot provide fertility treatment. It's not stated anywhere in the law… But some clinics claim that they have their own ethics… so some would say that beyond, say, 55, they would not do it… but it's not really stated anywhere, so it's not an official cut-off.' P6

In some settings, participants explained that whether recipients gain access to treatment is ultimately a matter of clinician discretion

'Everything is really up to the doctors in Israel. If I have a patient who is 82, and I call the doctor and say, 'Did you see his age? He's 82,' they might say, 'Okay, what's the problem?' Or you see they have mental health issues or all kinds of other problems… it's still up to the doctor. If the doctor says yes, then you have to treat them.' P3,P3A

2.2 Supply constraints and waiting lists

Participants consistently identified donor scarcity as a central factor shaping access to treatment. Donor shortages were frequently described as contributing to significant delays, with demand outpacing supply in many settings.

'There's a long waitlist at the moment. Being a public service, and only using Australian donors, the demand far outweighs the number of donors.' P4

'What I am seeing is a significantly growing number of people requiring egg donation or sitting on waiting lists for egg donation, and a much smaller group of people coming forward to become egg donors.' P8

2.3 Variability and inequity in access to donor eggs

Supply constraints did not affect all prospective recipients equally; access to timely treatment is shaped by various factors, with scarcity driving broader inequities in access. In some settings, a gap between law and practice allowed more permissive access than formal regulation would have suggested.

'One of the reasons people come here is that access is not very restricted. A woman can receive donor eggs up to around age 49…and in practice, even though the law only permits [access to egg donation for] a heterosexual couple, clinics don't always strictly verify this… people can present as a couple without much scrutiny.' P9

Within jurisdictions, participants described significant inequities between public and privately funded systems, including differences in age thresholds, donor availability, and waiting times.

‘In some NHS clinics, they might only do a handful of egg donation cycles a year due to limited resources. So patients are pushed into the private sector or overseas, whereas in well-resourced private clinics, there’s a much wider choice of donors and shorter wait times…’P7

‘In the public sector we’re only allowed to treat until the woman turns 41… in private they can continue until 46.’ P10, P10A

Beyond system differences, participants described the composition of the donor pool, specifically the lack of donor diversity, as a limiting factor for prospective recipients. One participant questioned the reliance on altruistic donation systems, arguing that the absence of donor diversity in these settings disproportionately affects recipients from minority backgrounds and carries long-term consequences for donor-conceived identity.

‘It is possible to access donor eggs here, but one of the main limitations is the lack of donor diversity. We don’t have Black, Asian, or Mexican donors…for those who do want a Black or Mexican donor, they usually have to go to Spain.’ P9, P9A

‘I feel that in much of Europe, Australia, and Canada, this model of volunteerism is discriminatory… if you’re from a minority background, say Southeast Asian, you can’t easily find a donor from that background. So instead, they might use a Hispanic donor. And then donor-conceived children may later discover, through ancestry testing, that their origins don’t match how they were raised.’ P1

Domain 3: Matching and Allocation in Practice

Participants described matching and allocation as practice-based processes operating largely through clinical discretion. In some settings, matching was not a formal process; no regulatory framework or clinic policy governed how donors and recipients were paired, and selection was left entirely to individual recipients. In settings where matching was mediated, this often occurred through various mechanisms. As one participant observed: *‘Matching happens at multiple levels… shaped by regulation… but also by clinic culture… practices vary significantly within the same regulatory environment.’ P7*

3.1 Matching criteria and processes

In some jurisdictions, matching between donors and recipients was based on resemblance such as physical or religious, with clinics playing a central mediating role in determining what constituted an appropriate match.

‘ … you can send a clinic your picture, and the clinic identifies a donor with similar physical characteristics… the patient receives a written description… but no photo… matching is based on trust that the clinic will find the best possible fit.’ P9, P9A

‘There are no catalogues, and intending parents can never see anything about the egg donor, so it's all in the hands of the clinics to select the most appropriate match… the aim is to ensure the donor resembles the recipient… some characteristics are non-negotiable.’ P6,

'It's anonymous donation, anonymous. The recipient will get information about age, height, weight, eye color, and hair color… they must be from the same religious, Jewish to Jewish, Muslim to Muslim, Christian to Christian.' P3,P3A

Some participants described matching as shaped by implicit assumptions about appearance, social acceptability, or perceived compatibility.

'But at the end of the day, people are looking for someone who looks similar. If she has very distinct ethnic features, it can be a problem. I need her to look more like what patients expect, Israeli, Greek, Italian, Spanish, so that the match feels acceptable for the patient.' P3,P3A,

Cultural considerations also shaped matching decisions, with some jurisdictions actively developing frameworks to govern cross-cultural donation, particularly in relation to indigenous communities.

'There are no set policies as such around who can donate to whom, from an ethnicity perspective or cultural perspective. Our donors all have the ability to place directions on their donation… we would usually encourage further counselling… particularly around cultural safety… for Māori… we are not offering donors to non-Māori recipients… but this has to be balanced against donor autonomy…' P8

3.2 Allocation mechanisms

Participants described the allocation of donor eggs as pragmatic and variable, driven by availability, timing, and financial structures rather than consistent principles. Across jurisdictions, several distinct allocation models were identified.

In Australia, participants described queue-based systems where the time of entry determined access.

'It's essentially first come, first served.' P4

'At the moment, allocation is based on when a patient was added to the waitlist… we require them to check in every 6 months… to keep it fair…' P5

In other settings, allocation operated through market-based systems where financial means determined access. While eggs were often allocated in fixed batches at set prices (usually around six to eight eggs), in some settings, recipients could reserve further eggs by paying more.

'To reserve that allocation, it requires a considerable amount of money. So access can depend on whether someone is able to secure that allocation financially.' P8

'Demand is very high. We give recipients access to a database of donors, and they go in and select their own donor. We don't allocate donors ourselves; we wait for them to choose. So whoever is first to select a donor and pay effectively secures the eggs.' P2

'In clinics moving towards an egg bank model, you can see different pricing structures depending on the number of eggs. If you want to reserve all of the eggs from a donor, you pay more, whereas if you only want

a smaller number, you pay less. So allocation is tied to how many eggs you select and what you're willing to pay.' P7

Several participants identified difficulties in accessing the same donor for subsequent treatment cycles or sibling pregnancies, reflecting a broader absence of continuity planning within allocation systems.

'It's almost impossible to access the same donor again…' P4

'Sometimes there are no eggs left from that donor…' P6

Within jurisdictions, allocation systems varied substantially between clinics, producing inconsistent and at times inequitable outcomes.

'Allocation looks quite different across clinics. In some settings, a single donor may be shared between recipients, while others use egg bank models with different pricing depending on how many eggs are selected. This creates a kind of patchwork, where some clinics operate smaller, known-donor models, and others have more catalogue-based, commercialised systems where recipients can select and reserve donors online.' P7

3.3 Clinic discretion and constrained choice

The way donor eggs were matched and allocated also shaped how much say recipients had in the process. Some participants described systems that offered recipients considerable choice:

'We give patients access to all available donors once they reach the top of the list. We're not selecting one or two… we send all of the available donors to each patient who reaches the top of that list.' P5

More commonly though, recipient choice was constrained by donor availability, clinic oversight and the information available to recipients.

'Matching is very limited… patients may wait a long time if they decline donors… clinics may require counselling… some go abroad for more choice.' P7

'In the public sector we have no pictures [of donors] at all… in private they can pay to get more details.' P10, P10A

Where recipients sought to express preferences, including, for example, around the ethnicity or race of donors, clinics retained discretion over whether those requests would be accommodated.

'Matching around ethnicity and race is an area with a great deal of clinical discretion… patients can make requests… clinics decide whether that request is legitimate… categories are very elastic…' P7

Clinic discretion extended further to deciding whether to accommodate or in some instances, override donor preferences regarding recipient selection, particularly where there were perceived concerns about the long-term implications of donor preferences and the welfare of donor-conceived individuals.

'Even where a donor says they are happy to donate to anyone, there can still be concerns about whether recipients will be able to support the child's cultural identity and understanding of … and ancestry. Donors can specify who they are willing to donate to… there has been occasion where we've had concerns around the directions that the donor has specified… and ultimately, they were declined as a clinic donor out of concern about the long-term implications.' P8

Domain 4: Basis for decision-making

Across jurisdictions, decisions about donor eligibility, recipient access, matching and allocation were commonly justified in terms of protecting future children, safeguarding donor wellbeing, honouring professional duties and responding to market pressures and practical constraints.

4.1 Protecting future children Participants often justified policy and practice in terms of protecting the future welfare and interests of donor-conceived children. Decisions about donor or recipient eligibility were underpinned by assessments of risk and consideration of a child's best interests.

'If it was a life-limiting condition, the risk would be quite significant for the donor-conceived offspring, for example, something like cystic fibrosis. But conditions like ADHD vary so much, so that wouldn't necessarily restrict a donor. It's more about a high risk of passing on a severe condition'. P4

'There may be circumstances where our counsellors can't sign off on it. They consider any concerns that arise, and we have to keep the best interests of the child at the forefront of our thinking. If there's anything concerning, whether that relates to the donor or the situation more broadly, that will influence whether we proceed'. P5

'If there are concerns about the patient, for example, their health or the safety of the future child, the case is reviewed internally and may be escalated to a committee… and fertility specialists must determine that this is the appropriate pathway for the patient.' P8

4.2 Donor welfare

Decisions were also commonly justified in terms of safeguarding donor wellbeing, often through counselling and psychological assessment.

'If any member of staff identifies 'red flags', for example, concerns about a donor's motivations or behaviour, this may trigger further review or referral for counselling…to assessing whether the donor is acting for appropriate reasons and is not vulnerable.' P7

'We had a donor experiencing significant personal distress… including past sexual abuse and a parent with a terminal illness. That wasn't an immediate exclusion, but from a duty of care perspective, we decided not to proceed at that point.' P5

'If a donor has a confirmed diagnosis of depression or anxiety, the counsellor may seek a letter of support from their treating psychologist, just to make sure they're well supported and that going through the

donation process isn't likely to negatively impact their mental health.' P4

However, one participant also reflected on the ethical tension embedded in these decisions, noting the difficulty of balancing donor protection against paternalistic assumptions about donor capacity and autonomy.

'There's a difficult balance between protecting donors from harm or exploitation and avoiding overly paternalistic assumptions… particularly about young women. There's a long-standing concern about exploitation, but also a question about whether women are being seen as unable to make their own decisions.' P7

4.3. Professional duties

In some settings, participants suggested that decisions about acceptable risk are part of the clinic or professionals' duty of care to donors, future children and /or recipients.

'It's quite common that people say, 'I don't really care, I just want this donor,' and we do our best to support that. But there is still a duty of care where we may not be able to proceed, for example, if it could be harmful for the donor's mental health. In other cases, where a [disorder] is managed and not an immediate risk, we may explore other options.' P5

'Recipients would accept some … criteria, like anxiety, but we still have to say no. And sometimes the recipient will say it's okay, but we have to say we're not allowed to do it. It's very strict, sometimes too strict … there shouldn't be any known potentially genetic disease.' P10, P10A

4.4 Market pressures and practical considerations

In some settings, decisions were influenced by market pressures and practical considerations, where demand for egg donors influenced decisions about suitability.

'There is also a commercial element. If we collect eggs from a donor and no one selects them, because of a genetic condition, for example, then we may have spent thousands on a donor that nobody wants.' P5

'I think it's also a commercial issue, … there's not a big incentive…

It's not a formal thing for doctors to spend a lot of effort interviewing all these potential donors. You don't know who's going to come…in my opinion it's also commercial.' P3,P3A

Discussion

This study sought to examine how access-related decisions in egg donation are regulated, governed, and operationalised across eight jurisdictions. Our findings reveal a considerable and consistent gap between regulation and practice. While laws and guidelines establish the parameters within which egg donation is provided, these frameworks are often limited in scope, and it is clinical discretion that more often shapes who can participate in egg donation and in what form this participation takes. The

outcome of this is significant variation in practice both between and within jurisdictions. The decisions made about donor suitability, recipient access, and the allocation of scarce eggs carry significant implications for fairness, equity, and the welfare of donors, recipients, and donor-conceived people. Yet these decisions are rarely transparent or consistently applied.

The eight jurisdictions represented a spectrum of regulatory approaches, from nationally legislated frameworks with centralised oversight, to partially regulated systems, to settings where professional guidelines carry significant weight. This variation is consistent with what has been reported by others (Deng et al. 2025; Calhaz-Jorge et al 2020; Pennings et al 2014), demonstrating that the governance of egg donation differs substantially across countries according to legal, cultural, religious, social and economic contexts. Our study extends this work by demonstrating that the regulatory model does not reliably predict practice. Across all jurisdictions, how egg donation is operationalised is often determined at the institutional level, guided by in-house policy or, more commonly, provider discretion. Such discrepancies between formal policy and clinical practice in ART have been documented for over two decades (Stern et al., 2001; Gurmankin et al., 2005). Our findings suggest that despite this awareness, such gaps persist and that their consequences extend beyond inconsistency to produce what we argue is inequitable and largely invisible variation in access to egg donation.

Laws and regulations provide a broad framework for egg donation, but they cannot anticipate or prescribe how every individual decision that arises in practice should be made. This leaves many decisions to clinics and individual professionals. Making treatment decisions for both donors and recipients is both necessary and appropriate, particularly where decisions require clinical expertise, such as assessing medical suitability for egg retrieval or treatment, managing treatment-related risks, and determining appropriate clinical care. However, our data suggest that decisions about access to egg donation do not rest solely on clinical considerations. Instead, assessments and evaluations made by a variety of professionals span genetic and health-related factors, psychosocial considerations, and aesthetic and social judgements, and are being used to determine who can participate in donor conception and under what conditions.

Such decision-making practices in egg donation indicate that ART providers function not only as treatment providers but also as gatekeepers, shaping access to and participation in ART, an observation also reported in previous studies of fertility care (Tammi & Homanen 2025; Tsafrir et al 2025; Egeland et al 2023; Kool et al 2019; Lee et al 2014; Peterson 2005). Our participants described this gatekeeping in a range of clinic practices that influenced who could participate in egg donation and under what conditions, for example, upper age limits that effectively limit the pool of eligible recipients, preferential selection of donors perceived as more likely to be chosen by recipients, and the matching of donors and recipients based on features such as physical resemblance or cultural identity. Clinic discretion extended further to decisions about whether to accommodate or override both donors' and recipients' preferences, giving clinics considerable influence over how participation in egg donation was managed. Donor scarcity may further complicate these decisions, requiring clinics to make difficult judgements about how limited donor eggs should be allocated (Kool et al 2019).

Our participants described access-related decisions as underpinned by perceived professional obligations to protect donor wellbeing, ensure recipient suitability, and safeguard child welfare. These broadly construed 'welfare considerations' are commonly invoked in decisions about access to treatment (Kool et al 2018), and there is some evidence to suggest they are also supported in principle by ART patients and providers (Egeland et al 2023; Lind 2020; Kool et al 2019; de Lacey et al 2015; Lee et al 2014; Steinberg 1997). In some jurisdictions, welfare considerations are required by law. For example, in the Australian states of Victoria, Western Australia and South Australia, statutes require that providers must consider the interests of any child who may be born from an ART procedure (de Lacey et al 2015). Similarly, in the UK, providers must take account of the welfare of any child who may be born before offering treatment (Human Fertilisation and Embryology Act 1990, s.13(5)). However, such requirements do not necessarily specify what constitutes a threat to a future child's welfare, which factors should be considered, or how they should be weighed. This leaves considerable scope for providers to determine what is relevant to child welfare and when those concerns are sufficient to affect access to treatment. The use of welfare considerations to determine access to treatment, particularly where they involve judgements about the suitability of prospective parents and the welfare of the future child, has been criticised as potentially discriminatory and incoherent (Tonkens 2018; Thorpe et al 2012; Solberg 2009; Jackson 2002). Limited guidance also exists on how welfare considerations should be applied in practice, or which factors are relevant (Braverman 2015; de Lacey et al 2015; Pennings 1999; Blyth and Cameron 1998). Welfare considerations also raise tensions between patient autonomy and protection, as reflected in our data and reported previously (Peterson 2005). It remains unclear whether, and how, welfare considerations should inform access-related decisions, including in the context of donor conception.

Market pressures also seemed to, in part, inform decisions about which donors to accept. Providers bear the costs of donor workup regardless of whether a donor is ultimately selected, creating an institutional incentive to prioritise "reliable" donors and screen out those unlikely to be chosen by recipients before investing significant resources. Almeling (2009) describes how commercial gamete banks in the US target "sellable donors" with socially desirable characteristics. Similarly, in the non-commercial Finnish context, disability and impairment are treated as defects to avoid, positioning certain donors as undesirable investments (Tammi & Homanan 2025). These practices indicate that access-related decisions encompass more than clinical considerations and are vulnerable to social and commercial influences in both commercial and non-commercial settings.

Our findings revealed an apparent asymmetry in the scrutiny applied to donors and recipients. Prospective egg donors were subject to extensive assessment of their genetic, medical and family history, with findings in these areas potentially determining whether they could donate. While recipients were also assessed, the intensity and focus of scrutiny appeared different. This raises questions about the relative weight given to risks associated with the donor's biological contribution, compared with the broader range of medical, social and environmental factors that may shape the health and wellbeing of a future child. It also raises a broader ethical question about which risks are considered sufficiently important to justify restricting a person's participation in egg donation, and why.

While formal regulation sets the parameters for who is theoretically able to donate and receive eggs, how this is applied in practice remains somewhat opaque. This opacity has consequences for those involved. People excluded from donating or receiving eggs from their preferred donors may perceive these decisions as unfair, discriminatory, or difficult to understand, as described by our participants and reported elsewhere (Tammi & Homanen 2025; Pennings et al 2025). Variation in how criteria are applied, both between and within jurisdictions and clinics, may also contribute to inequity of access to donor conception. This can fuel reproductive travel to other locations where conditions are more compatible, which raises its own clinical, ethical, and legal complexities (Whittaker et al 2019).

Providers, too, are affected by the complexity of access-related decisions. Our participants described navigating significant ethical discomfort, role ambiguity, and uncertainty in making some decisions about access to egg donation. Language like "grey area," "sometimes too strict," and "doctor decides" reflected a field managing complex decisions without clear guidance or evidence. Together, these findings suggest scope for greater transparency, consistency, and evidence to support ethically significant decisions and the professionals responsible for making them

This study's primary strength lies in its integration of regulatory analysis with key informant interviews. This enabled the examination of both the formal governance frameworks shaping egg donation and how these are applied and experienced in practice. The inclusion of eight selected jurisdictions generated insight into the spectrum of ways egg donation is operationalised internationally, allowing us to identify meaningful areas of convergence and divergence across different models of provision. The descriptive nature of this study does introduce limitations, however. Regulatory documents varied in accessibility and completeness across jurisdictions, and English-language sources were limited in some settings. This may have affected the comprehensiveness of our regulatory analysis. Where gaps or uncertainties arose, we sought clarification from participants to mitigate this. While jurisdictions were selected to reflect regulatory diversity, they do not represent the full global range of egg donation practice, and other relevant considerations and experiences may exist beyond those captured here. Participants also varied in professional background, which likely influenced their accounts and assessments of practice. Finally, the perspectives of donors, recipients, and donor-conceived people are absent from this analysis. Our future research seeks to investigate how these groups experience and understand the governance of egg donation, and will meaningfully strengthen the assessment of practice.

In conclusion, our findings suggest that formal and informal regulation shape egg donation, with ART providers often serving as gatekeepers, intermediaries, and arbiters who determine who can participate. As a result, the provision of egg donation varies both between and within jurisdictions. Importantly, we do not suggest that all aspects of egg donation can or should be rigidly legislated, or that there should be no variation in practice. As egg donation can involve deeply personal, culturally sensitive and clinically unique scenarios, variation in decisional outcomes is arguably inevitable, and some provider discretion is necessary and clinically appropriate. However, the uncertainty and lack of transparency identified in our study does raise important concerns about equity, accountability and procedural fairness. Future research should examine the appropriate limits of provider discretion, including which factors should be

considered in access-related decisions and when they should justify limiting access, as well as the principles needed to support more transparent and consistent decision-making.

Declarations

Author contributions

Both authors conceptualised and designed the study. GF conducted the interviews and led the data analysis. Both authors interpreted the data, drafted the article, and approved the final version for submission.

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Data Availability

The data underlying this article cannot be shared publicly to protect the privacy of individuals that participated in the study. The data will be shared on reasonable request to the corresponding author.

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