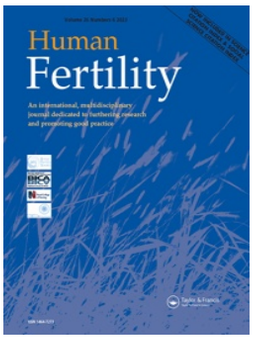

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Donor conception and psychosocial support provisions across jurisdictions – what's out there?

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ABSTRACT

As demand for donor conception (DC) rises the landscape is becoming increasingly complex. DC-linking now occurs through various means, including direct-to-consumer DNA testing, which may reveal DC where this has not been disclosed and make those genetically related known to each other, including earlier than is possible through identity-release provisions in many jurisdictions. Early contact between donors and recipient parents, as well as same-donor siblings is becoming more common. Large sibling groups within and across jurisdictions are increasingly being identified and there is also growing reliance on imported gametes and online donor recruitment platforms. These developments can be associated with challenges for donor-conceived people (DCP), parents, donors and their families, and have led to calls for more accessible and responsive psycho-social support services. This paper maps the DC context in ten Western countries, including the availability of psychosocial support and counselling. Given the growing complexity of DC and its lifelong impact on all involved, we pay particular attention to post-donation counselling support related to disclosure, long-term psychosocial wellbeing, and DC-linking. We identify key challenges in existing DC provisions and support systems and propose improvements that support DCP, donors, parents, siblings, and their families in managing the longer-term implications of DC.

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KEYWORDS
Donor conception; psychosocial support; counselling; post-donor conception; donor conception linking

Introduction

In this paper, we map the legislative and policy context of donor conception (DC) – including within gestational surrogacy using donor gametes - and the provision of psychosocial support across ten jurisdictions: Australia, New Zealand, Canada, United States of America, Belgium, the Netherlands, United Kingdom, Germany, Ireland and Sweden. While donor-assisted treatments were initially regarded primarily as medical interventions, there has been growing recognition that DC involves complex decision-making and emotionally-charged dilemmas for donors and recipients (Salazar et al., 2023) and longer-term implications for all parties, including DCP (Indekeu et al., 2022; Zadeh et al., 2024).

Historically, DC practice has been largely anonymous: donor identities were concealed, and parents were advised to keep the DC a secret (Crawshaw & Marshall, 2008). Increasingly however, the needs and rights of individuals to have knowledge of and access to their genetic background have been acknowledged (Dambach & Cantwell, 2024; Indekeu et al., 2025; Mulligan, 2022). While early disclosure and access to donor information have been found to support heathier identity development and positive family relationships (Golombok, 2021; Golombok et al., 2023; Ilioi et al., 2017; Indekeu et al., 2021), research on late disclosure has underscored the potentially negative impact on DCP wellbeing and family relationships (Allan, 2017; Frith et al., 2018; Grethel et al., 2023). Some research also suggests that the

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ability to have contact with donors, same-donor siblings and their families may also be important, although sometimes challenging, for DCP (Indekeu et al., 2021; Scheib et al., 2020; Widbom et al., 2024).

While anonymous (or non-identified) donation remains possible in several countries (such as Italy, Japan, Spain, Singapore, South Africa, China), many jurisdictions have enacted identity-release provisions: Sweden (1984), Austria (1992), Victoria, Australia (1998), Switzerland (2001), the Netherlands (2004), Western Australia (2004), New Zealand (2004), Norway (2005), the United Kingdom (UK) (2004), Finland (2007), New South Wales Australia (2008), Germany (2018), Portugal (2018), Ireland (2020), France (2022), Queensland, Australia (2024), South Australia (2025) and Colorado, the United States of America (USA) (2025) (Colorado Department of Public Health & Environment, 2025; Government of South Australia, 2025; Indekeu et al., 2021; Queensland Government, 2025). In some cases, provision has been made for retrospective lifting of anonymity (e.g. Victoria - Australia and South Australia) (Salazar et al., 2023).

Both in anonymous and in identity-release contexts however, challenges for DCP remain, including access to DC information, stigma, and navigating genetic relationships (Bolt et al., 2024; Hertz & Nelson, 2019; Indekeu et al., 2022, 2025; Lampic et al., 2022; Salazar et al., 2023; Scheib et al., 2017). Likewise, donors may face psychosocial challenges related to identity, around their access to information about DCP, boundaries in relationships, and family dynamics, particularly when DCP seek contact. While many may feel pride and fulfilment, they may also experience ambivalence, regret, or tension in navigating expectations, disclosure, and the long-term implications of their genetic contribution (Lampic et al., 2025; Mohr, 2015; Nordqvist & Gilman, 2022). Similarly, parents may grapple with disclosure decisions, feelings of parental legitimacy (especially for non-biological parents), and navigating complex family dynamics. They can also face boundary challenges around donor and sibling contact, alongside fears of stigma or judgment (Daniels et al., 2011; Duff & Goedeke, 2024; Indekeu et al., 2014; Widbom et al., 2021; Zadeh et al., 2016). The evidence base on gestational surrogacy using donor gametes is much smaller but suggests that parents may face particular challenges in being open about their use of a donor as well as a surrogate (D'Amore et al., 2025).

These challenges have become more apparent as information-seeking and contact between the different parties have become more common either with identity-release provisions coming into effect (Indekeu et al., 2021) or through the increasing use of commercial direct-to-consumer DNA testing. Testing can reveal DC to those previously unaware, expose same-donor relatives and donors to their families, and together with the exponential growth of social networking sites, enable early contact, sometimes before legal identity-release ages (Braverman, 2010; Crawshaw, 2018; Gilman et al., 2024; Harper et al., 2016; Kelly et al., 2023; Woodward, 2015). Furthermore, given that research has suggested that early disclosure of DC is in the best interests of DCP, early contact – before the legal age of access to information in identity-release jurisdictions – is also increasingly occurring, including among same-donor families (Kelly & Dempsey, 2016; Volks et al., 2015). It is thus important to further understand the needs that arise from the impact on the wider family and social and genetic networks involved, including where large numbers of genetically related 'siblings' are identified (Cahn, 2013; Hertz & Nelson, 2019; Indekeu et al., 2022; Nordqvist & Gilman, 2022).

Meanwhile, demand for DC treatments, including for gestational surrogacy with donor gametes, has continued to rise, including for single people and same sex couples (Human Fertility and Embryology Authority [HFEA], 2024), as well as global growth in commercial gamete provision (Attinger et al., 2024). The use of private international gamete banks, social media recruitment, and informal donation outside the clinic sector are increasingly common (Côté et al., 2025; Volks et al., 2025). Media coverage highlights concerns about serial donors (donors who repeatedly donate sperm or eggs, including potentially across multiple settings and/or through informal arrangements, resulting in a high number of offspring; Eriksen, 2022) and insemination fraud (the unauthorised use of gametes, typically involving a clinician or other party substituting their own sperm, or that of another individual, without the informed consent of the recipient; Zeghiche et al., 2023) and their impact on those involved. The use of gametes sourced internationally may raise challenges for access to donor identifying information and contact (Goedeke, 2025; Jackson et al., 2017). This evolving landscape underscores the need for accessible and responsive professional psycho-social support services to help parents, donors, DCP and their families navigate DC over time (Indekeu et al., 2025; Redhead et al., 2025; Zadeh et al., 2024). This position is supported by the International Infertility Counsellors' Organisation (IICO, 2024) (an umbrella organisation for

professional bodies providing fertility counselling) who argue for comprehensive psychosocial service provision, encompassing psychoeducation, decision-making support, implications counselling, and therapeutic counselling, both pretreatment for donors, gestational surrogates and recipients, and post donation for all parties, in particular for support with information release and the exchange of information and contact between those genetically related following DC.

To what extent policy, practice and support provisions have kept pace with these developments and complexities is unclear, however. In this paper, we map the context of DC in terms of legislation, policy and practice, including current provisions for psychosocial support and counselling across ten jurisdictions. Given the growing complexity of DC and its lifelong implications, we focus on provisions for donors and recipients before treatment, as well as post-treatment or donation support for disclosure, longer-term psychosocial wellbeing support, and DC-linking support for all parties. We highlight challenges in current provisions and offer suggestions to strengthen services to better meet the ongoing needs of DCP, donors, parents and their families.

Materials and method

Data were collected with respect to with three areas: (1) The context of donation in each country (i.e. regulations around DC, access to DC, identity-release provisions); (2) professional and other psychosocial support at the time of treatment or donation (e.g. mandated and/or optional, access to support); and (3) professional and other psychosocial support post-treatment or donation (e.g. mandated and/or optional). Information on the context e.g. if DC practice was legislated, including if anonymous/non-identified or identity-release, was collected as these practices may present a range of psychosocial challenges for the DC parties involved and carry implications for support provision.

Inclusion criteria for countries were that they needed to have a professional fertility counselling organisation (an established association or network that provides, regulates or supports fertility-related psychosocial services in line with recognised professional and ethical standards), and/or that research on DC in that country had been published in English. Ten countries were identified: Australia, New Zealand, Canada, United States of America, Belgium, the Netherlands, United Kingdom, Germany, Ireland and Sweden. Data were collected through collating publicly available information (e.g. government legislation, assisted reproductive technology policy documents, fertility counselling organisation policy/practice documents, support groups) provided by key researchers/psychosocial service providers or board members of the identified fertility counselling organisations, or sourced online. In some cases, those approached referred the authors to more appropriate or additional sources to access or confirm information. For example, the Canadian Counselling Special Interest Group referred the authors to the Law and Ethics Special Interest Group of the Canadian Fertility & Andrology Society (CA) to ensure the most current legal information was accessed. As it is only gestational surrogacy with donor gametes that is relevant for inclusion in this paper, we do not cover any provision for support with genetic surrogacy or gestational surrogacy using parents' own gametes. Data were correct at the time of publication.

The data from the ten countries were then extracted in two tables. Table 1 depicts the legal frameworks relevant to each country, including the types of donation allowed (e.g. sperm, egg, embryo; identity-release; known; anonymous/non-identified), laws that cover systems for recording and release of information, donor limits in place, and information rights by law for the various parties involved: (i) DCP, (ii) RP (recipient parent), (iii) Donor, (iv) Others, including the donors' 'own' children. (Note we use the term 'own' children here in recognition of the fact that donors may not necessarily be raising the children to whom they or their partners have given birth).

Table 2 depicts psychosocial support provisions for each country, including: the requirement for counselling provision at the time of treatment and any relevant professional guidelines for counselling that may apply; the requirement for counselling provision at identity-release/other life stages or any professional guidelines which may apply; the qualification requirements for counsellors; funding available for counselling; and any other support e.g. access to support groups, that may be available.

Table 1. Legal Frameworks.

Country	Laws that cover donor conception	Types of donation allowed: • identity (ID)-release, known, anonymous • altruistic or commercial • sperm, egg, embryo	Laws or guidelines that cover: • national system for recording information • ID-release	National donor limits in place	Information rights by law for: i. Donor Conceived People (DCP) ii. RPs iii. Donors, iv. Donors' 'own' children and others
Australia	No national framework. DC laws in: Victoria, South Australia, Western Australia, Queensland, Australian Capital Territory, New South Wales. Birth certificate addendums for DCP in Victoria (from 2028). DC recorded on birth certificate (from 2025) in South Australia. To be accredited providers, clinics must follow the Fertility Society of Australia and New Zealand Reproduction Technology Accreditation Committee (RTAC) Code of Practice.	• ID release or known • Altruistic • Sperm, egg, embryo and gestational surrogacy with donor • Available to heterosexual couples, single people and LGBTQ+ individuals and couples except in Western Australia where same sex male couples and single men are not eligible.	Central state registers in: Victoria, South Australia, Western Australia, Australian Capital Territory, and New South Wales. Fertility clinics maintain donor information In Tasmania and Northern Territory. National Health and Medical Research Council guidelines recommend that ART clinics retain records indefinitely.	No single Australian wide limit; some state-based limits apply (e.g. South Australia: 10 families plus donor's 'own' children; Victoria: 10 women worldwide; Western Australia: 5 family limit worldwide; New South Wales: 5 families including the donor's 'own' children).	i. DCP aged 18 (in some cases 16) can access identifying information about donors/donor-conceived siblings (where siblings have given consent). ii. In some states, RPs can approach clinics or their state DC register to access information about donors (with donor and/or DCP consent). Recent regulatory changes in the ACT may allow parents to access donor identities at birth, though this remains subject to change. iii. Donors cannot access identifying information about DCP without consent from the child's parents, or DCP if aged 18 or older. Donors can be informed about the number, gender, and year of birth of children born. iv. Donors' 'own' children do not have rights to information about DC siblings. v. The Queensland Assisted Reproductive Technology Act 2024 will allow direct descendants of DCP to apply for donor identifying information.
Belgium	Wet betreffende de medisch begeleide voortplanting en de bestemming van de overtallige embryo's en de gameten (6 Juli 2007 (Belgian Act of 6th July 2007 - Law on Assisted Reproduction and the Use of Surplus Embryos and Gametes). A government agreement on 31st January 2025 announced the abolition of donor anonymity. Het Afstammingscentruman (an Ancestry Centre) was established by the Flemish government in 2019 to provide information, a DNA database, and psychosocial support.	• (Pending law change) anonymous or known • Altruistic • Sperm, egg, embryo • Available to heterosexual couples, single parents and LGBTQ+ individuals and couples. • Gestational surrogacy with donor will be allowed legally when enacted (as per government agreement, January 2025).	Central register as of January 2024 (by Royal Decree of 17th December 2013 and based on Articles 35, § 2 and 64, § 2 of the 2007 Act) to exchange information between clinics and adhere to the national limit of 1 one donor for 6 women. Data must be kept for at least thirty years and a maximum of fifty years from its clinical use. It is not yet known for how long the data recorded in the Central Register will be retained.	The 2007 law stipulates that a donor should not be used to give birth to one or more children for more than six different women.	No parties currently have information rights. This may change with the enactment of a new law in 2027.
Canada	Assisted Human Reproduction Act of Canada (AHRA, S.C. 2004, c. 2) - although provincial legislation may apply. All donors must undergo assessment to identify any risk factors for infectious and genetic disease transmission.	• Anonymous or known • ID release donors may be accessed from international sperm and egg banks • Altruistic • Sperm, egg, embryo and gestational surrogacy with donor • Available to heterosexual couples, single parents and LGBTQ+ individuals and couples.	Quebec will create a registry with effect June 2025. Length of time records are to be retained is not specified legally but assumed to be indefinite.	No federal limits. Individual provinces may specify limits.	i. DCP cannot access donor identifying information without explicit donor consent. Non-identifying information may be obtained by DCP aged 14 or over. In Quebec: DCP aged 14 or older will be able to access donor identifying information from June 2025. ii. RPs cannot access identifying information about the donor (except with explicit donor consent). iii. Donors cannot access identifying information about DCP. iv. Donor's 'own' children cannot access identifying information about DC siblings.

(*continued*)

Table 1. Continued.

Country	Laws that cover donor conception	Types of donation allowed: • identity (ID)-release, known, anonymous • altruistic or commercial • sperm, egg, embryo	Laws or guidelines that cover: • national system for recording information • ID-release	National donor limits in place	Information rights by law for: i. Donor Conceived People (DCP) ii. RPs iii. Donors, iv. Donors' 'own' children and others
Germany	Samenspenderregistergesetz (1/7/2018) (German Sperm Donor Register Act)	• ID release or known • Altruistic • Sperm donation is available to heterosexual, lesbian and single women. Egg donation is not allowed. • Embryo donation is not regulated by law but is accepted. • Domestic gestational surrogacy with donor is forbidden by law.	The German Sperm Donor Register Act established a *Central Sperm Donor Register.* Information must be retained for 110 years ("Gesetz zur Regelung des Rechts auf Kenntnis der Abstammung bei heterologer Verwendung von Samen" (SaRegG)	No legal limits, but the Association for Donor Treatment recommends a maximum of 15 DCP per donor.	i. DCP aged 16 and older born after July 2018 can request information from the Central Sperm Donor Register (BfArM - Samenspender-Register (SaReg). ii. As of July 2018, RP's may request identifying information on behalf of their child at any age, although to date requests from parents of DCP younger than 16 have been denied. iii. Donors have no legal rights to identifying information but may be informed about DCP birth. iv. Donors' 'own' children have no right to information about DC siblings.
Ireland	The Children and Family Relationships Act 2015 (CFRA 2015) sets out provisions regarding access to information, record-keeping, and parental rights. The Assisted Human Reproduction Regulatory Authority (AHRRA) established under the Health (Assisted Human Reproduction) Act 2024 (H(AHR) Act 2024) administers the National Donor-Conceived Person Register (NDCPsR).	• ID-release donors (since 2020); Known donors permissible for egg but not sperm donation • Altruistic • Sperm, egg, embryo • Available to heterosexual couples, single women and same-sex female couples. • Legislation to allow gestational surrogacy has been passed but the implementation date is still to be determined.	The National Donor-Conceived Person Register (NDCPsR). Records related to DC arrangements must be retained permanently.	H(AHR) Act 2024 stipulates that there should be no more than four families from the same donor.	i. DCP have the right to access donor identifying information upon reaching 18. They do not have automatic rights to information about DC siblings but may apply to access this information. ii. RP' have no rights to donor identifying information but can access non-identifying information. They have no rights to information about siblings. iii. The donor is entitled to information on the number of persons born, and the sex and year of birth. They may apply to the Department for the name, date of birth and contact details of a DCP over 18 but information release requires DCP consent. iv. Donors' 'own' children have no right to information about DC siblings.
The Netherlands	The Wet donorgegevens kunstmatige bevruchting (Wdkb) (Artificial Fertilisation Donor Information Act) https://wetten.overheid.nl/BWBR0013642/2021-07-01) 2004 From 1992–2004 a double-track system allowing a choice between anonymous or ID-release donors was available.	• ID release or known • Altruistic • Sperm, egg, embryo • Available to heterosexual couples, single parents and LGBTQ+ individuals and couples. • Domestic gestational surrogacy with donor is permitted but not regulated for heterosexual couples, single people and LGBTQ+ individuals and couples.	National government-funded register managed by the College Donorgegevens Kunstmatige Bevruchting (Cdkb) [the Donor Data Foundation -previously known as Sdkb) established under the Wdkb Act 2004. By law (Wdkb 2004), Cdkb must keep DC records for at least 80 years after the mother's treatment date. The Fiom KID-DNA database, funded by the Dutch Ministry of Health, Welfare and Sports, is a nation-wide voluntary register that facilitates exchange of information and contact between donor and DCP born through Dutch fertility clinics prior to the Wdkb 2004.	Since April 2025 there is a national legal limit of 12 families. The register records whether a pregnancy has resulted from donation, not whether a birth has resulted, and is dependent on information provided by the RP or clinic. Prior to the establishment of the central register in April 2025 there was a professional guideline of 25 children per donor from 1992 onwards. This professional guideline changed to 12 families per donor in 2018.	i. DCP may request non-identifying information about the donor from the age of 12. DCP have the right to know the identity of the donor from age 16 and they may request how many other pregnancies resulted from donations made by the donor. At 16 DCP may request information regarding same donor siblings. Information is exchanged with mutual agreement only. ii. RPs can request access to donor's non-identifying information from the child's birth until the child reaches the age of 12 years.Since 1 April 2025, mothers can ask the clinic how many other pregnancies resulted from the donations made by the donor that they used (if known).

(*continued*)

Table 1. Continued.

Country	Laws that cover donor conception	Types of donation allowed: • identity (ID)-release, known, anonymous • altruistic or commercial • sperm, egg, embryo	Laws or guidelines that cover: • national system for recording information • ID-release	National donor limits in place	Information rights by law for: i. Donor Conceived People (DCP) ii. RPs iii. Donors, iv. Donors' 'own' children and others
					i. Since 1 April 2025, donors can request the number of pregnancies that resulted from their donations (if known). (iii) Donors' 'own' children have no right to information.
New Zealand	Human Assisted Reproductive Technology (HART) Act 2004, which established the HART Register, and ACART (Advisory Committee on Assisted Reproductive Technology), which provides independent advice to the Minister of Health, issues guidelines to ECART, and advises on matters related to assisted reproductive procedures and human reproductive research and ECART (Ethics Committee on Assisted Reproductive Technology). which considers and determines applications from clinics for certain assisted reproductive procedures and research, based on ACART's guidelines and advice.	• ID release or known. Donors and recipients can meet before donation by request and with mutual consent. • Altruistic • Sperm, egg, embryo donation and gestational surrogacy with donor • Available to heterosexual couples, single parents and LGBTQ+ individuals and couples. • Embryo donation requires approval from ECART, and donors and recipients must have pre-donation joint counselling.	HART Act register - maintained by Births, Deaths and Marriages (BDM), a government department. The HART Act Register's records are retained indefinitely.	No legal limit exists for egg and sperm donation. However, clinics generally set limits of 5–7 families per donor. Embryo donation may result in full genetic siblings in no more than two families.	i. DCP can access identifying information from age 18 or earlier by parental request. If DCP are aged 16 or 17, DCP may ask the Family Court to get access to information held on the register. Same donor siblings may request information but only with DCP or parental consent. ii. RPs may, by request, access identifying information about the donor from birth of child from clinics or from 'Births Deaths and Marriages' (BDM). iii. Donors may request information about children born from their donations, but access only with explicit DCP consent. iv. Donors' 'own' children have no rights to access information about DC siblings. They may approach the clinics who may contact the other party on their behalf.
Sweden	Lag om genetisk Integritet (Swedish Genetic Integrity Act) (SFS 2006:351): all gamete donation treatments provided by Swedish health care must be ID-release. The Swedish government has recently commissioned the National Board of Health and Welfare to develop legislative proposals to enable the establishment of a national register for gamete donors with the responsible body being Socialstyrelsen [The National Board of Health and Welfare].	• ID release or known • Altruistic • Sperm, egg, embryo • Available to heterosexual couples, single women (not available to men or same sex male couples) • Gestational surrogacy with donor is not permitted. • RPs must undergo an assessment of their medical, psychological, and social circumstances prior to DC treatment being allowed.	No national donor register; each clinic maintains its own records. Parents report birth data to clinics, which are added to medical records and a national quality register. According to the 2006 Act, a "special record" with information about the donor must be kept for at least 70 years. The Health and Social Care Inspectorate (IVO) may also be involved in securing data and record keeping.	Gamete donation is limited to six families, and embryo donation to one additional family beyond the donors. Limits are not legally mandated but recommended by the Swedish National Board of Health and Welfare and endorsed by Vävnadsrådety (the Swedish National Council for Organs, Tissues, Cells and Blood), and by Svensk förening för Obstetrik och Gynekologi (SFOG) (Swedish Society for Obstetrics and Gynecology).	i. DCP have the right to obtain donor identifying information and/or same donor siblings on request 'at maturity' (usually 18). (Note that there have been no recorded requests to date from younger DCP). As of 2019, DCP may add their name and contact information in the donor's "special record" and obtain identifying information about same-donor siblings who have added information. ii. RPs have no rights to access information. iii. Donors can enquire at the clinic about the number of offspring but not about the year of birth. This is not specified in Swedish law (SFS) but is covered by clinical practice. iv. Donors' 'own' children have no right to information about DC siblings.
UK	Human Fertilisation and Embryology Act 1990 Act and Human Fertilisation and Embryology Act 2008. Human Fertilisation and Embryology Authority (HFEA) licences clinics, manages the central Register of Information and produces a Code of Practice. It also manages the Donor	• ID release or known • Altruistic • Sperm, egg, embryo donation and gestational surrogacy with donor • Available to heterosexual couples, single parents and LGBTQ+ individuals and couples.	HFEA Register of Information records information about all treatment cycles, RPs and donors from August 1991. Register records are retained indefinitely. The HFE Act also sets requirements for clinics to retain records for full traceability.	No specific law setting a national donor limit, but HFEA-licensed clinics must adhere to the HFEA's regulatory limit of creating no more than 10 families per donor for UK-based treatments.	i. DCP conceived after 1st April 2005 can request donor identifying information at 18 and non-identifying information (number, sex and birth year) of siblings from 16. From 16, DCP may check if a potential partner was conceived with the same donor.

(*continued*)

Table 1. Continued.

Country	Laws that cover donor conception	Types of donation allowed: • identity (ID)-release, known, anonymous • altruistic or commercial • sperm, egg, embryo	Laws or guidelines that cover: • national system for recording information • ID-release	National donor limits in place	Information rights by law for: i. Donor Conceived People (DCP) ii. RPs iii. Donors, iv. Donors' 'own' children and others
	Sibling Register set up under the 2008 Act.				ii. RPs of those conceived after August 1991 have the right to request non-identifying donor information and the number of children conceived from the same donor, year of birth and gender. iii. Donors who donated from 1st August 1991 have the right to information about the number of DCP born, their year of birth and gender. iv. Donor's 'own' children have no right to information.
USA	No federal laws. The Food and Drug Administration (FDA) requires that records pertaining to each donor (screening and test results) be maintained for 10 years. SEEDS (Society for Ethics for Egg Donation and Surrogacy) and The US Donor Conceived Council work set standards for donor conception and surrogacy.	• Anonymous, known ('directed') or ID release • Compensation beyond reimbursement i.e. payment constituting financial reward, allowed • Sperm, egg, embryo • Available to heterosexual couples, single parents and LGBTQ+ individuals and couples. • Gestational surrogacy with donor is available to heterosexual couples, single parents and LGBTQ+ individuals and couples, although some states require one intended parent to have a genetic connection to the embryo.	No national legislation on donor information access, although Colorado's (2022) Act prohibits anonymous donation, and Washington requires gamete banks to release identifying information to adult DCP. Record retention varies by state, typically 7 years. The Food and Drug Administration (FDA) requires that donor screening records be maintained for 10 years, while the American Society for Reproductive Medicine (ASRM) recommends indefinite retention.	Limits vary according to gamete banks, but most restrict to 25 families per donor in the US. For egg donation, ASRM recommends a maximum of 6 cycles per donor.	i. DCP have no rights with the exception of Colorado, where DCP can access donor information at age 18. ii. RPs' access to information is state dependent or dependent on the gamete bank. iii. Donors have no rights to information about DCP. iv. Donors' 'own' children have no legal rights to access information.

Acronyms: ART = assisted reproduction treatment; DC = donor conception; DCP = donor conceived person/s; ID-release donors = donors whose identity must be released; RPs = recipient parents of DC treatment, including gestational surrogacy with donor; 'donors' 'own' children' refers to their genetic/legal children who may or may not be raised by them.

Table 2. Psychosocial Support Provisions.

Country	Requirement for counselling provision at treatment	Professional Guidelines re counselling at treatment	Requirement for counselling provision at ID release/ other life stages	Professional Guidelines re counselling at ID release / other life stages	Qualification requirements for counsellors pre and post DC	Funding for counselling at treatment and post DC	Other support
Australia	The Australian and New Zealand Code of Practice stipulates that donors and recipients have two sessions provided by Australian and New Zealand Infertility Counsellors' Association (ANZICA) registered counsellors prior to proceeding with DC. In New South Wales the Assisted Reproductive Technology Act 2007 mandates counselling for donors and recipients.	ANZICA Professional Standards of Practice (2023) and ANZICA Guidelines for Donation (and Surrogacy) 2023 requirements include that: i. Donors, RP surrogates/ IP and their partners be seen for a minimum of 2 sessions pre-donation. ii. For known donation arrangements/ surrogacy/ embryo donation, a third group/joint meeting with donors, RP/IP and partners is required.	No uniform post DC support, including for information release. Support is at clinic discretion. Queensland's ART Act 2024 provides for free counselling for DCP seeking register information. South Australia's DCR Support Service (DCRSS) and Western Australia's Donor Conception Information Service (DCIS) provide support at information release/help facilitating contact. In Victoria, the Victorian Assisted Reproductive Treatment Authority's psychosocial/ linking services ended in December 2024, with the Department of Health now offering an information service.	ANZICA's *Donor Conception Linking Guidelines* (2024) provide principles and a protocol to facilitate information exchange and linking between the various parties.	ANZICA registered-counsellors must hold a 4-year tertiary qualification; registration as a psychologist, social worker, psychiatrist or equivalent; have at least 200 hours of supervised fertility/reproductive counselling experience; demonstrate current knowledge of infertility and ART; and engage in ongoing professional development. Provisionally registered members may provide implications counselling under supervision if deemed competent by their supervisor	At treatment: Varies between clinics. Some include pre-donation counselling in Donor Programme fees, others require RPs to pay. Medicare rebates cover at least one free counselling session per cycle. Post DC Support is generally unfunded, though Queensland will offer free counselling to DCP's, and Victoria one free information/ support session to register applicants.	Donor Conceived Australia (DCA) is a consumer-led support and advocacy group for DCP, providing resources and support for RPs, DCP and health professionals. VANISH is a Victorian-based not-for-profit organisation for adults affected by adoption but also assisting DCP.
Belgium	All accredited clinics are legally required to offer counselling pre- and during treatment (Belgian Act of 6 July 2007, art. 6).	POINT, a professional organisation for Belgian and Dutch fertility counsellors was established in 2020 but has not yet issued professional guidelines.	No legislative requirement. However, the Flemish Decree (26/04/2019) established 'Het Afstammingscentrum', a Flemish Ancestry Centre and DNA database. The Centre provides information, psychosocial support, advocacy and expertise on ancestry questions. DNA searches are limited to parent-child (first degree) relationships.	None available	Counselling is only required to be offered and no standard 'fertility counselling' training exists. POINT requires a Bachelor in Psychosocial Sciences; peer supervision hours, and continuing professional development. 'Het Afstammingscentrum' must have a multidisciplinary team including legal, psychological or pedagogic expertise related to adoption.	At treatment Clinics determine funding for counselling. Some costs may be reimbursed through health insurance but most counselling is privately funded. Post DC 'Het Afstammingscentrum' offers free, unlimited, government-funded support.	Donorfamilies [DC families] is a parent-led group offering informal support. Donorkinderen is a DCP-led support group. Alote provides a platform for donors.
Canada	None prescribed by federal law. Quebec law requires RPs and surrogates to attend an information session.	The Canadian Fertility and Andrology Society (CFAS) Counselling Special Interest Group (CSIG) Assisted Human Reproductive Counselling Practice Guidelines (Revised September 2023) specify counselling should be available for anyone considering donation, and that patients may need support following treatment.	None prescribed by federal law.	CFAS Guidelines do not address post donation support for RPs or donors but note that DCP may require psychosocial support at various developmental stages.	CFAS Guidelines require counsellors to have training and experience in reproductive and mental health; a post-graduate degree in mental health; belong to a recognised regulatory body; have several years of clinical experience; and undertake professional development and supervision.	At treatment and post DC No public funding; costs may be high without insurance. Some clinics provide in-house counsellors included in treatment fees.	Donor Conception Canada offers volunteer-led peer support for RPs, DCP and family. The Donor Conceived Alliance of Canada is an advocacy group. Centre ESPER (Quebec) offers support for people facing reproductive challenges.
Germany	No legal requirements for counselling although The German Medical Chamber [national medical association] recommend counselling prior to DC treatment.	Beratungsnetzwerk kinderwunsch Deutschland (BKiD), (the German professional counselling association) guidelines recommend pre-treatment counselling by a qualified BKID counsellor.	No legal requirements. The Central Register recommends counselling to DCP (but not donors) prior to donor-linking.	BKiD guidelines encourage counselling prior to contact/ information-exchange. BKiD plan to develop guidelines.	BKiD provides certification for infertility counselling, DC counselling and DC linking counselling.	At treatment and post DC No public funding; free counselling may be available through public associations. Few clinic-based counsellors available; most work privately.	Spenderkinder [DCP Support Group]. Di-Netz [Family Association for Donor Insemination]. FE-Netz [Family Association for Families built through Egg Donation].

(*continued*)

Table 2. Continued.

Country	Requirement for counselling provision at treatment	Professional Guidelines re counselling at treatment	Requirement for counselling provision at ID release/ other life stages	Professional Guidelines re counselling at ID release / other life stages	Qualification requirements for counsellors pre and post DC	Funding for counselling at treatment and post DC	Other support
Ireland	The Health (Assisted Human Reproduction) Act 2024 (H(AHR) Act 2024) stipulates a minimum of one implications counselling session by a specialist fertility counsellor for donors and RPs before proceeding with DC or surrogacy arrangements.	There are currently no professional counselling guidelines. The Irish Fertility Counsellors Association (IFCA)—a professional body of trained counsellors—support implications counselling.	No legal requirement. Some clinics and organisations offer voluntary support. Pending legislation (AHR Bill) post-treatment support services may expand. The 2024 Act acknowledges, but does not mandate, the need for psychosocial support.	There are currently no professional guidelines.	Fertility counsellors must be qualified (e.g., members of the Irish Fertility Counsellors Association) and trained in reproductive counselling.	Pre-treatment Counselling is largely privately funded although some clinics include counselling in treatment costs. Post DC Counselling is mostly privately funded.	National Infertility Support and Information Group (NISIG) for RPs.
The Netherlands	No legal requirements for counselling	The Nederlandse Vereniging voor Obstetrie en Gynaecologie (NVOG) (Dutch Society of Obstetricians and Gynecologists) (NVOG/KLEM, 2018) position statement recommends counselling for donors and RPs prior to DC and the completion of a "donor passport" or donor profile.	The College van Donorgegegevens Kunstmatige Bevruchting (Cdkb) (Donor Data Foundation, previously known as Sdkb) maintains information about donors and provides guidance on identity release through collaborations with Fiom, a Dutch centre of expertise on questions about ancestry. Its optional services include educational webinars and counselling for DCP, donors and family members regarding identity release and contact.	No legal or professional guidelines exist for counselling DC children or adults. Fiom has donor-linking guidelines and refers to other counsellors for services such as disclosure. Fiom maintains a list of professionals and peers experienced in DC.	At treatment: NVOG recommends counselling by psychosocial counsellors with expertise in reproductive medicine and donor assessment by psychologists, social workers or physicians with ART expertise. Post treatment: Fiom provides counselling and donor linking by qualified social workers and may refer to specialist counsellors for therapeutic services.	Pre-treatment: Some clinics use private insurance to cover limited counselling; otherwise counselling is self-funded. Post DC: Cdkb provides free guidance on identity information and Fiom provides free government-funded services. Specialist counselling is privately funded.	Stichting Donorkind (Foundation Donor-conceived people) is a DCP organisation. Landelijk informatiepunt donorconceptie (National Information Point Donor conception) is a national government funded information website. Priamos is a platform for donors.
New Zealand	The Australian and New Zealand Code stipulates that donors and recipients have two sessions provided by Australian and New Zealand Infertility Counsellors' Association (ANZICA) registered counsellors prior to proceeding with DC. For known donation arrangements/surrogacy/ embryo donation, all participants and partners must also be seen for a third session in a group/ joint meeting. Approval from the Ethics Committee on ART (ECART) is needed for embryo donation and surrogacy.	ANZICA Professional Standards of Practice (2023) and Guidelines for Donation (and Surrogacy) 2023 require that: donors and RPs; surrogates, and their partners be seen for a minimum of 2 sessions. For known donation arrangements/surrogacy/ embryo donation, all participants and partners must also be seen for a third session in a group/joint meeting.	Counselling is not legally required but is recommended and is at the discretion of clinics – this could include support for DC children and adults, donors, recipients and for information-exchange and DC linking.	ANZICA *Donor Conception Linking Guidelines* (2024) provide principles and a protocol to facilitate information exchange and DC linking. Births, Deaths and Marriages (BDM), manage the DC register, but do not provide counselling. DCP and RPs can request support from clinic donor coordinator teams and counsellors for same donor family linking and support.	At treatment and post DC, including DC linking: ANZICA registered counsellors must hold a 4-year academic qualification; registration as a psychologist, social worker, psychiatrist or equivalent; have at least 200 hours of supervised fertility/ reproductive counselling experience; demonstrate current knowledge of infertility and ART; and engage in ongoing professional development. Provisionally registered members may provide implications counselling under supervision if deemed competent by their supervisor.	At treatment: Two sessions prior to treatment are required; these may be included in treatment costs or additional costs to the recipients. Post DC, including DC linking: Post donation support is not funded.	Donor Conceived Aotearoa (DCA) is a consumer-led support and advocacy group providing resources and support for parents, DCP and health professionals. FertilityNZ is a charitable organisation providing education, support and advocacy for those affected by fertility issues.
Sweden	Swedish legislationdoes not specify requirements for professional psychosocial support, However Swedish law (SFS 2006:351) stipulates a medical, psychological and	No professional guidelines regarding counselling. The Swedish National Board of Health and Welfare has regulations (SOSFS 2009:32) and guidance (Nationellt	No legal, professional or practice guidelines.	The Svensk förening för Obstetrik och Gynekologi (SFOG) (Swedish Society for Obstetrics and Gynaecology)	At treatment: Clinics determine their own counselling policies. Licensed counsellors or psychologists may provide support at clinics but this is	At treatment and post DC Clinics determine their own counselling funding policies. Sweden's tax-funded health system provides subsidised counselling via primary care	Socialstyrelsen (The National Board of Health and Welfare) provides some online information and advice about disclosure and post-DC issues.

(*continued*)

Table 2. Continued.

Country	Requirement for counselling provision at treatment	Professional Guidelines re counselling at treatment	Requirement for counselling provision at ID release/ other life stages	Professional Guidelines re counselling at ID release / other life stages	Qualification requirements for counsellors pre and post DC	Funding for counselling at treatment and post DC	Other support
	social evaluation of RPs to ensure 'suitable conditions for the upbringing of a child'.	kunskapsstöd 2016-12-36) for mandatory RP evaluation, including that a behavioural science health professional conduct this evaluation.		recommends that psychosocial support be offered to DCP and donors when a request for donor identifying information is made.	not required by Swedish legislation, regulations or guidelines. Post DC No information is available on the qualifications for professionals providing psycho-social support.	though wait times may be long. Privately funded services are available.	
UK	The HFE Act 1990 (as amended) refers to the need to offer 'a suitable opportunity to receive counselling', although this is not mandatory. Requirements prior to surrogacy were recently strengthened in the HFEA Code of Practice.	The British Infertility Counselling Association (BICA) has counselling Guidelines for Good Practice in Infertility Counselling, and produces Practice Guides, including on the implications of DC for RPs. Guidelines recommend at least two free counselling sessions for those considering DC or for donors, but this is not enforceable.	Until September 2024, the HFEA offered time-limited, free counselling services when identifying information requests were made to the HFEA or Donor Sibling Register or when pre-91 donors were considering re-registering to become identifiable. This service has been disbanded and replaced with online pages. Some time-limited counselling is available in relation to those using the pre-1991, HFEA-funded Donor Conceived Register.	BICA's Guidelines for Good Practice in Infertility Counselling do not address post treatment, ID release or DC linking. However BICA runs an online Donation Forum on DC issues and is developing training, accreditation and professional resources for DC linking and implications counselling.	At treatment: The HFEA Code of Practice requires counsellors to have specialist infertility competence; a recognised counselling, psychology, psychology or psychotherapy qualification; British Infertility Counselling Association (BICA) (or equivalent) accreditation and membership in a professional counselling body. Post DC There are no current requirements.	At treatment: Clinics decide their own funding policies for counselling. Some include it in the treatment package costs for RPs. Counselling for donors in HFEA-licensed clinics should typically not incur a charge. Privately funded fertility counselling is also available.	Donor Conception Network (DCN) provide resources and workshops mainly for RPs and DC families. Donor Conceived UK (DCUK) offers support mainly for DCP.
USA	There is no legal requirement for psychosocial support at treatment stages.	ASRM Mental Health Professional Group (MHPG) has guidelines for fertility counsellors which recommend counselling for donors and RPs pre-DC or surrogacy. For known (directed) donation or surrogacy, single individual sessions for the donor and recipient(s) surrogate and IPs and additional joint sessions are recommended.	There are no federal laws or regulations about post-donation services including when information is released.	MHPG guidelines suggest counselling but there are no formal services.	At treatment: MHPG recommends licensed mental health professionals with training in third-party reproduction infertility, holding a Masters or PhD in a counselling-related field and a license to practice. No official accreditation exists and membership is open regardless of training.	At treatment and post DC: No funding available; privately funded.	RESOLVE is a national infertility association providing advocacy around infertility. Donor Sibling Registry is a service to connect DCP and donors and same donor siblings, RPs. Donor Conceived Community (DCC) provides support to DCP and professionals.Some gamete banks provide donor registries to connect DC families and at times the donor.

Acronyms: ART = assisted reproduction treatment; DC = donor conception; DCP = donor conceived persons; ID release donors = donors whose identity must be released; RPs = recipient parents of DC treatment, including gestational surrogacy with donor; donors' 'own' children' to their genetic/legal children who may or may not be raised by them.

Once the tables had been developed the previously-contacted people from each country were asked to check the information for their countries, and the information was also cross-checked with reference to online sources where possible. The authors then analysed the tabled data for general trends, commonalities and differences across the countries in terms of legislative frameworks for DC, pre-treatment/donation and post-treatment/donation psychosocial support.

Results

Legislative provisions for DC

Legislative provisions with respect to ART and DC vary widely, even across such a small sample (See Table 1). For example, while in Australia and Canada, state/provincial laws may regulate ART and DC there is no overarching country-wide legislation. In Australia, however, government Health and Medical Research Council ethical guidelines apply, and clinics cannot be accredited as service providers unless they comply with Reproduction Technology Accreditation Committee guidelines. In the USA, no formal country-wide legislation applies with respect to ARTs/DC, and only Colorado has legislative provisions. In contrast, in Belgium, Ireland, Germany, the Netherlands, New Zealand, Sweden and the UK, ART legislative frameworks are in place to regulate DC.

Sperm donation is possible in all countries surveyed. Egg donation and embryo donation are possible in all except for Germany, where egg donation is prohibited, and the status of embryo donation is unclear. In New Zealand, embryo donation requires approval from the Ethics Committee for Assisted Reproductive Technologies (ECART). In Germany and Sweden, gestational surrogacy with donor gametes is either illegal, clinics are not allowed to offer it and/or there is no route for legal parenthood to be assigned to the parents who commissioned the arrangement, and in Ireland legislation has been introduced but not yet enacted. In the UK, gestational surrogacy is possible, providing that one of the intending parents has a genetic link to the child. Known donation is possible in all jurisdictions. While seven of the 10 countries surveyed require identity-release donation where the identifying information about donors can be released to DCP at a certain age, anonymous (or non-identified) donation is still possible in the USA, in most of Canada, and in Belgium, although the Belgian government has agreed that donor anonymity will be abolished as of 30 June 2027; in Quebec Canada, identity-release donation came into effect in June 2025.

All jurisdictions except for the USA, where commercial donation is common, state that altruistic donation is required, however, how this is interpreted appears to vary widely and, in some cases, e.g. Canada, the UK and Belgium, it is possible to source donor gametes through commercial banks. DC is generally available to heterosexual couples, single people, and same sex couples across jurisdictions, however Western Australia prohibits access to single men and gay couples, and in Sweden and Germany access is complicated given surrogacy restrictions.

Registers that enable donor identifying information be made available to DCP are available in most states/territories of Australia, Germany, Ireland, the Netherlands, New Zealand and the UK, with the age of access to identifying donor information for DCP generally 18 or, in some cases 16 (e.g. Western Australia, Germany, the Netherlands). In Sweden, DCP can access information from clinics who retain records, as there is currently no national register - although the National Board of Health and Welfare has been commissioned to adapt the law to establish a central register. In the US, only Colorado has a register; in Canada, Quebec has had a register from June 2025. Currently, DCP can thus generally not access identifying information about their donors in Belgium, the US, and Canada (with the recent exception of Quebec, and in cases where the donor explicitly consents). With the exception of the Australian states of Victoria and South Australia, donors are also not recorded on birth certificates or birth certificate addenda.

While 7 of the 10 countries (Australia, Germany, Ireland, the Netherlands, New Zealand, the UK and Sweden) allow access to DCP about the identifying information of their donors, access by parents to donor identifying information is more limited. Parents do not have automatic access to identifying information before or after their child reaches adulthood in Ireland, Sweden, the Netherlands, and the UK. In

the UK, parents have access only to non-identifying information, and in the Netherlands, parents can access only non-identifying information up until the child is twelve years old.

In contrast, most states in Australia allow parents to approach clinics or registers to access donor identifying information, and in New Zealand and the Australian Capital Territory, parents can apply to access identifying information about donors from birth or approach clinics for this information. Although this is theoretically also possible in Germany, requests by parents of DCP younger than 16 have to date been denied access to identifying information, given that the law stipulates that the child needs to understand the concept of DC and genetic ancestry when a request is made. In Canada, access by parents to identifying information is generally not possible unless the donor explicitly consents.

DCP are generally also restricted from accessing identifying information about their same donor siblings - although in Australia, New Zealand, Ireland, the Netherlands and Sweden, where these same donor siblings (aged over 18) or, in some cases, where DCP are younger, their parents, have given consent, this may be possible. In the UK, DCP can ask to join the HFEA Voluntary Donor Sibling Register from age 18, and if their DC siblings also join, they can be connected. Similarly, connection with donor siblings tends to be voluntary and through informal registries in the USA.

Donors typically have even fewer rights and generally cannot access identifying information about DCP. In most of Australia and New Zealand, donors may, however, access such information with consent from the child's parents, or the DCP if they are 18 or older (and are aware they are DC). Similarly, in Ireland, donors may apply for identifying information about DCP over the age of 18, but the consent of the DCP is requested prior to the release of information to the donor. Donors' 'own' children typically have no rights, and do not have the right to access information about donor-conceived siblings in most jurisdictions surveyed. In New Zealand, donors' children, while having no legal rights to information, can approach clinics who may contact the other party on their behalf. Similarly, the rights of other parties, such as the descendants of DCP, appear to fall outside of provisions across the jurisdictions surveyed. The exceptions here are Queensland, Australia, where under the Assisted Reproductive Technology Act 2024, direct descendants of DCP will be able to apply for identifying information about the donor, and Quebec Canada, where descendants can apply for information and, if the other person has consented, contact information will be provided. Note that there are also significant variations in terms of the length of time records are expected to be kept either by clinics or central registries, with some countries having no specifications around time limits. There is also a lack of legislation and inconsistency in terms of donor limits (restrictions on the number of children that can be born from one donor, or the number of families that may be created). In most countries surveyed, there are no legal limits imposed by law, with the exceptions being Ireland (where no more than four families should be built from the same donor); Belgium (where no more than six women can give birth to children from the same donor); and New Zealand (where embryo donation cannot result in full genetic siblings in more than two families). In other cases, guidelines may apply e.g. In Sweden the Swedish National Board of Health and Welfare recommends a maximum of 6 families for egg and sperm donation, and for embryo donation, one family besides the donors'. In the UK, the HFEA specifies 10 families for UK-based treatments, and in the US, limits vary according to different donor banks, but most restrict donations to 25 families per donor. Note however that there are currently only limited ways of enforcing limits in some jurisdictions, and no way of enforcing these internationally.

Psychosocial support provisions: pre-treatment/donation and during treatment

Across the ten countries, there was marked inconsistency in how psychosocial support services were integrated within DC pre-treatment (e.g. if regulated by law or recommended in guidelines, with the content of counselling specified, funding availability for counselling) and how the quality of counselling is guaranteed (e.g. through training, or membership of, or accreditation by a professional organisation).

Ireland, Quebec in Canada, Sweden, Australia and New Zealand have some form of mandatory counselling, either as specified by law, or due to guidelines that must be met by clinics as a condition of accreditation. For example, in terms of legislative requirements, only Quebec in Canada and Ireland specify attending mandatory pre-donation counselling. In Quebec, this is in the form of an informational session which intended/recipient parents are required to attend. In Ireland, a minimum of one

implications counselling session with a specialist fertility counsellor is required for donors and RPs before proceeding with DC or gestational surrogacy arrangements. In Sweden, while there are no legal requirements for professional psychosocial support, all recipients and donors undergo a mandatory medical and psychosocial evaluation by a counsellor/psychologist, and through this they may have access to counselling services pre- and during treatment or donation, either at the clinic or through referral.

In contrast, in the UK and Belgium, while the law specifies that counselling must be offered to intending parents and donors for donor conception, attendance is not mandatory. In other jurisdictions, such as Australia and New Zealand, clinics must comply with the Australian and New Zealand Code of Practice to be accredited as service providers. The Code of Practice stipulates the provision of two counselling sessions for both donors and recipients prior to proceeding with DC, so while counselling may not be legally required, clinics cannot be accredited if counselling is not provided, and donors and recipients cannot proceed with donation without having attended counselling, making it effectively mandatory.

In other cases, professional or practice guidelines contain recommendations as to counselling availability, content and included parties. For example, in Germany, the Bundesärztekammer (the German medical chamber) recommends counselling prior to donor treatment, as does BKiD (the German professional counselling association). In Australia and NZ, the Australian and New Zealand Infertility Counsellors' Association - ANZICA Professional Standards of Practice (2023) and ANZICA Guidelines for Donation 2023 - specify that donors and recipients and their partners be seen for a minimum of two sessions, and specify the nature of the implications counselling offered to both parties. In Canada, the Canadian Fertility and Andrology Society (CFAS) Counselling Special Interest Group (CSIG) Assisted Human Reproductive Counselling Practice Guidelines (Revised September 2023) specify that counselling for anyone considering third party reproduction should be available. In the Netherlands, the Dutch Society of Obstetricians and Gynecologists (NVOG) (NVOG/KLEM, 2018) position statement recommends donor and recipient counselling prior to DC as well as the completion of a 'donor passport' or donor profile. In the UK, the British Infertility Counselling Association (BICA) recommends at least two free counselling sessions for those considering DC. Finally in the USA, the American Society of Reproductive Medicine (ASRM) recommends counselling for donors and recipients pre-DC and surrogacy. Given that these are guidelines only, the extent to which clinics comply with such recommendations and offer counselling by professional trained psychosocial experts may vary.

Indeed, the requirements for those offering counselling vary significantly across jurisdictions and depending on whether there is an accrediting body for counsellors working in the field, or whether counselling is required for clinic accreditation. In Australia, New Zealand, Belgium, Ireland, the UK and Canada professional fertility counselling associations or organisations (or in some instances, regulators) specify particular requirements for counsellors in the area which may include that they are registered mental health practitioners, hold relevant academic qualifications, have specified hours of supervised counselling experience in fertility/reproductive medicine and are engaged in ongoing professional development. Whether or not these requirements are applied by clinics employing counsellors, with the exception of Australia and New Zealand where clinics cannot be accredited as providers without meeting counselling requirements, remains unclear. The ASRM similarly recommends such qualifications but has no official accreditation, and anyone can join the Mental Health Professional Group (MHPG) regardless of training. Finally, in the Netherlands, the NVOG position statement only recommends that counselling for recipients be provided by a psychosocial counsellor with expertise in reproductive medicine, but does not set clear conditions for the qualifications or experience of counsellors. There are thus differences in how the quality of counselling may be ensured across jurisdictions.

In Australia, New Zealand, Belgium, Canada, Ireland, the Netherlands, Sweden and the UK, clinics can typically decide themselves how they organise payment for counselling, and there is thus often limited access to funded counselling. In some cases, counselling is included in the donor treatment plan, or patients may have some reimbursement via their health care insurance. In Germany, while there is no public funding for pre-donation or treatment counselling, counselling may be offered by some clinics and can also be accessed through public counselling associations (e.g. Pro Familia organisations) and is usually free of charge. Similarly, while waiting lists may be long, individuals in Sweden can access tax-

funded mental health care - although this may not be by practitioners experienced in and knowledgeable about the psychosocial considerations involved in DC.

Psychosocial support provisions: post DC support

In comparison to pre-DC psychosocial support provision, post-DC psychosocial support provision is rarely specified in legislative provisions. The exceptions here are the Netherlands, Quebec in Canada, and some Australian states, and are usually with respect to counselling around identity-release and/or donor-linking services (rather than wider support following DC). In the Netherlands, counselling must be *offered* at the time of donor-linking/request for information, and services are provided by Fiom, a Dutch organisation that has provided independent information and support in the search for biological origins since 1930. Fiom offers government-funded counselling to both DCP and donors (and potentially their families) regarding the provision of identifying donor information and any contact that may result. In the Australian states of Queensland, New South Wales and South Australia recently enacted provisions include that counselling will be made available to DCP applying for information. However, Australia has also seen the dissolution of psychosocial/DC-linking services in other states e.g. in Victoria, where the Victorian Assisted Reproductive Treatment Authority (VARTA), offering services such as counselling around identity-release and donor-linking, was dissolved on 31st December 2024. Similarly, while the HFEA in the UK previously offered time-limited counselling services when identifying information requests were made to the HFEA Register or Donor Sibling Register, this service was disestablished in September 2024 and replaced solely by online information pages. On the other hand, while Belgium has no legislative requirement for donor-linking counselling given the existing donor anonymity, the donor-linking service provided by 'Het Afstammingscentrum', a service that helps with different kinds of ancestry questions such as those of DCP, receives limited funding from the Flemish government, with no restrictions on the number of sessions provided although waitlists are common.

Where psychosocial support is available post-treatment or donation, including for donor-linking, across the other jurisdictions reported in this paper, it is mainly specified in professional guidelines as a recommendation, rather than requirement, and is generally not publicly funded. For example, in both Australia and New Zealand, ANZICA Donor Conception Linking Guidelines (2024) provide principles and a protocol to facilitate information exchange and linking between the various parties, but while clinics generally have donor coordinator teams who may assist with information provision and call on counsellors to offer counselling around identity-release and donor-linking support, such support (with the exception of Australian States listed above) is at the discretion of clinics and is largely unfunded.

In Canada, in the Assisted Human Reproductive Counselling Practice Guidelines no specific mention is made of post-treatment or donation support provision, although guidelines do state that implications of DC may vary for individuals and that DCP and their families *may* require support at different life stages. In Ireland, while the H(AHR) Act 2024 does not explicitly mandate ongoing counselling, it similarly acknowledges the need for psychosocial support, particularly during significant events such as the release of identifying information. Likewise in Sweden, the Society for Obstetrics and Gynecology (SFOG) practice guidelines recommend that psychosocial support be offered to DCP and donors in connection with a request for donor identifying information. In the USA, the ASRM suggests that counselling be available post donation, but it is not required. In the UK, BICA's Guidelines for Good Practice in Infertility Counselling do not currently have a section about post-treatment interventions, nor about identity-release and donor-linking. BICA does, however, run an online (peer) Donation Forum for its members where the specific focus is on DC-related matters, and is also developing training for, and accreditation of DC-linking counselling.

Two special instances of support, are the Landelijke Informatiepunt Donorconceptie (LIDC) (national information point donor conception) in the Netherlands, which is an online platform funded by the Dutch government providing information for parents, DCP and donors at different stages, and a Swedish version, which also provides mainly informational support e.g., how to disclose/talk to a child about DC, donor-linking and legal aspects, and is available via the National Board of Health and Welfare. Overall, however, there is a lack of funded provision of later life professional support across countries, and limited reference to the need for support from specialist counsellors.

Other forms of psychosocial support

While government post-treatment or donation psychosocial services appear to be limited, several largely not-for-profit organisations have emerged offering support, mainly for DCP, and some for parents and families, with little available to support donors. These groups include support groups for DCP, parents and health professionals such as Donor Conceived Australia (DCA) and VANISH in Australia; 'Donorfamilies' (Donor-conceived families), and 'Donorkinderen' (DCP) in Belgium; Donor Conception Canada in Canada; 'Spenderkinder' (DCP Support Group) and 'Di-Netz' (the Family Association for Donor Insemination) and 'FE-Netz' (Family Association for Families built through Egg Donation) in Germany; the National Infertility Support and Information Group (NISIG) in Ireland; 'Stichting Donorkind (DCP organisation) in the Netherlands, the Donor Conception Network (DCN) and Donor Conceived UK (DCUK) in the UK, Donor Conceived Aotearoa (New Zealand) and the Donor Sibling Registry and Donor Conceived Community (DCC) in the USA. Some commercial egg and sperm banks also offer support in the form of sibling connection sites. While the list provided here may not be exhaustive, the only support groups identified by respondents specifically for donors was Alote in Belgium and Priamos in the Netherlands. It is important to note that these support services are mainly advocacy or peer-support services, generally with no access to funded support from professional counsellors and often with little or no funding for their work.

Discussion

In this mapping exercise, provisions with respect to DC across countries surveyed varied significantly in terms of legislation regulating DC and surrogacy with donor arrangements, including the type (e.g., egg, sperm, embryo) and form (anonymous, identity-release) permitted, eligibility of recipients, donor limits, counselling provisions, and – in identity-release contexts – record-keeping and access to donor registers. Many of these different provisions and practices lack vision in terms of the longer-term effects and implications of DC and fail to address technological and societal developments such as DTC-DNA testing and the use of online platforms in recruitment. Inconsistent or absent donor limits – the number of children permitted to be born or families permitted to be built from a single donor – reflect limited understanding of the impact of sibling numbers on the wellbeing of DCP and their families (Blyth, 2012; Indekeu et al., 2022). Access to information remains uneven and often fails to consider the network of individuals created though DC and their needs and rights to information and contact. While identity-release contexts allow DCP to access identifying information about donors, other parties – such as parents, donors, and in particular, donors' own children - often have far more limited rights in spite of their potential interest. Further, there are significant differences in record-keeping, and generally no clear specifications on how long records should be kept, implying that the potential intergenerational effect of DC is seldom considered. Finally, none of the provisions in jurisdictions surveyed explicitly address DC which occurs outside the jurisdiction (e.g. through cross border reproductive care) or outside the formal medical sector i.e. DC which occurs in home settings. Collectively, these shortcomings suggest that DC is still too often framed as a (short-term) treatment for infertility and involuntary childlessness rather than a family-building practice with enduring psychosocial consequences for DCP, parents, donors and their families.

This is also evident in that legislative provisions rarely underscore the importance of offering and attending counselling: organisations and entities involved in DC - such as international sperm and egg banks - are not necessarily required to follow national health law regulations and/or guidelines, and there is inconsistency around the provision of 'professional' counselling services. For example, there are only a few countries where there are legal provisions for counselling *prior* to DC and usually the counselling is only required to be offered (rather than attendance mandated) e.g., as in Belgium and the UK, or is in the form of psychosocial assessment, such as in Sweden, rather than implications and/or supportive counselling. In contrast in Australia and New Zealand, while counselling is not prescribed by law, clinics need to adhere to a Code of Practice (COP) if they are to be accredited as providers of ART services. The COP stipulates the provision of a minimum of two free implications counselling sessions from qualified counsellors specifically trained in the psychosocial implications of DC for both donors and recipients, which at least underscores the importance of counselling and provides opportunity for

exploration of each party's motivations and needs, alongside considerations of the needs and rights of DCP to access their genetic knowledge (Reproductive Technology Accreditation Committee - Fertility Society of Australia & New Zealand, 2024).

In other jurisdictions with counselling provisions, these are in the form of professional guidelines rather than required by law, which may signal the relative consideration of psychosocial issues and importance given to counselling, both supportive and implications. Clinics in these contexts are also often free to determine their own counselling provisions. Moreover, given the increased use of imported gametes from commercial sperm and egg banks, it is unclear as to whether existing local provisions are applied and whether donors are receiving counselling in these contexts. Further, although several countries have professional organisations that outline the qualifications, training and experience counsellors should have to work in the field, and sometimes the content and form of counselling, these are not always required or applied in practice. Indeed, there is significant variation in the background of counsellors employed by and consulting to fertility clinics, something that would be unusual in other members of the multi-disciplinary team working in ART clinics.

While the requirement for and access to pre-DC counselling seems to be variable and differ in content, the situation with respect to post-donation psychosocial support e.g. with disclosure, with processing the implications of DC, and with DC-linking, is even worse. An earlier paper that drew on information from experienced psychosocial practitioners, academics and those with lived experience of DC across the USA, Europe and Australasia showed that services for DC-linking were patchy, and models were diverse where any existed (Crawshaw et al., 2015). Little appears to have changed since, in that there is very limited professional psychosocial and institutionally-required support available across jurisdictions, with the exception of the Netherlands and some Australian states where support may be provided post DC - though mainly on identity-release and with DC-linking. Some countries, however, have also seen the minimising of psychosocial support with respect to DC-linking counselling. For example, the Victoria Assisted Reproductive Treatment Authority, VARTA, which offered free counselling and donor-linking, has been disbanded, with responsibilities shifted to the Department of Health (Clayton, 2024). Similarly, in the UK, the HFEA has withdrawn funded counselling support for those seeking information or donor-linking (Crawshaw et al., 2024).

This decreased investment in counselling and donor-linking support may necessitate a move towards referring individuals requiring support post DC to private practitioners, and at the individuals' own cost, and/or to not-for-profit peer support networks (which should be seen as a complementary form of support rather than an alternative to professional support). As well as the equity issue involved, in that counselling access may be limited to those who have the funds, this may be particularly problematic given that such practitioners may have limited knowledge, experience and training to equip them to understand the DC context. Although there are some international guidelines e.g. ESHRE/ASRM/ANZICA with respect to fertility counselling and DC counselling *pre*-donation, guidelines with respect to *post*-DC (with the exception of ANZICA DC-linking guidelines in Australia and New Zealand) are rare, and most practitioners have to 'learn by experience'. While there is debate as to whether post-DC counselling goes beyond the remit and skill of 'fertility' counsellors whose sole experience is during the treatment stages, the need is clear for post-DC support for disclosure, to support the psychosocial wellbeing of DCP, parents, donors and their families as they grapple with the possible implications of DC for identity and family functioning, and to facilitate and support successful DC-linking (Duff & Goedeke, 2024; Goedeke & Rodino, 2023; Isaksson et al., 2014; Schrijvers et al., 2019; Skoog Svanberg et al., 2020; Söderström-Anttila et al., 2016; Visser et al., 2016). Such counselling is increasingly seen as highly specialised and complex (Blyth, 2012; Crawshaw et al., 2022) and may include therapeutic counselling, mediation and facilitation (Goedeke & Gamble, 2024). Counsellors providing such services need to be well-trained and experienced in the field, and ideally draw on knowledge from developmental, grief and loss, trauma and family systems theory. The qualifications and experiences of those providing counselling with respect to DC differ widely across jurisdictions, and some (such as those trained in family work) may be better positioned than others to offer post DC support. While support groups such as the ones outlined may offer invaluable assistance to those affected by DC, they are generally managed by those with lived experience themselves, tend to be unfunded and should be seen as a complementary (or separate) form of support, rather than a substitute for professional support where this is needed.

Our study has several limitations, including that the data are drawn from a select number of countries where research has been published in the area and/or counselling organisations exist, and thus may not be generalisable. While our mapping exercise was not intended to be exhaustive, even in the included countries, it is clear that DC provisions and support provisions varied significantly - in jurisdictions without identity-release practices, it is likely that psychosocial support has even less emphasis. Further, legislative and practice provisions are under review in several jurisdictions, and undergo continuous development, including in some of the countries we have included in this study. Publicly available data may not yet reflect these changes, and thus may not be captured by this paper. Further, the practices of individual clinics within jurisdictions, especially those without formal legislation or guidelines, may also vary and not have been captured by our data collection. Similarly, online searches or information provided by fertility counselling organisations may not always have identified available other forms of support e.g. support groups. Finally, our paper has collected data on DC practices as facilitated by local/domestic clinics – many people are accessing DC through alternative means such as home insemination or through travelling overseas. In these cases, there may be little legislative protection or counselling support.

It is clear however that there is an urgent need to lobby for appropriate provisions and support frameworks for DC pre-, during and post-DC for all parties, especially given the increase in DC as a means to build a family, the growth in the international trade in donor gametes and in gestational surrogacy using them, and the increase in those connected through DC wanting information about, and to connect with each other. Support is also called for given the increased complexity of DC, with DC-linking occurring across a range of contexts e.g. through DTC-DNA testing (where individuals may be unaware of the DC nature of their conception, and unprepared for outreach and contact, or where donors' past involvement may be identified to their family members); the increase in early DC-linking; the increasing reliance on imported gametes and the increase in cross border reproductive care (with associated issues such as potential lack of access to donor identifying information and complexities in DC-linking across borders, languages and cultures); the lack of international donor limits (and associated challenges such as large sibling networks); the increase in informal and unregulated DC (such as through home insemination); the increasing use of online platforms to recruit donors; and the changing nature of families accessing DC potentially raising additional issues to consider. If laws and regulations and/or health care providers across jurisdictions are making it possible for DC to be used as a way in which to build a family, then they also have a concomitant duty of care and a responsibility to ensure that those affected are appropriately supported (Nuffield Council on Bioethics, 2013), including through 'best practice', and not 'least practice' professional psychosocial support provision. Such provision could entail:

- Legislative frameworks that mandate the availability of funded professional psychosocial support pre-, during and post-DC, including for DC-linking
- Professional guidelines that clearly delineate the nature of counselling roles, including psychoeducation, decision-making, implications, supportive, therapeutic, relationship facilitation and mediation work
- Clear directives as to the qualifications, knowledge and experience of those providing counselling and psychosocial support at different stages and in different contexts alongside a need to ensure ongoing professional development
- Better support for peer support organisations, given their complementary value

Alongside this, psychosocial practitioners in the field need to continue to advocate for DC practice (including legislative frameworks) that supports the wellbeing of all parties - DCP, parents, donors and their families - concerned. In addition to access to specialised counselling support, such practice includes mechanisms to encourage parental disclosure of DC, provisions that respect the rights of DCP and others connected to each other through DC to be able to access identifying information, acknowledgment of, and support for the right to contact, and uniform limits on the number of children born or families created from each donation (Goedeke, 2025).

Conclusion

Medical interventions concerning DC are only the start of the human experiences of those affected – including donors, recipients, DCP, gestational surrogates and their families - which are dynamic and unfold over their lifetimes. The state and ART providers should consider the psychosocial challenges associated with DC and share responsibility for the provision of high quality professional psychosocial support services. While this field is ever evolving, the present study has identified barriers to responding organically throughout the life stages with appropriate psychosocial skills and knowledge, including a lack of financial structures, policies and legislative provisions, as well as a limited research and practice evidence base and limited availability of training, in particular for work at later life stages following DC.

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Author contributions

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Data availability statement

The data that support the findings of this study are available on request from the corresponding author.

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