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RESEARCH ARTICLE

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Donor identity in Aotearoa New Zealand: early contact between parents and identity-release clinic donors, same-donor siblings and donors' raised children

Sonja Goedeke[a], Karyn Anderson[b], Solene Bertrand[b], Rebecca Hamilton[c], Jeanne Snelling[d], Annabel Ahuriri-Driscoll[e], Sarah Wakeman[f] and Cindy Farquhar[b,g]

[a]Department of Psychology and Neuroscience, School of Clinical Sciences, Auckland University of Technology, Auckland, New Zealand; [b]Department of Obstetrics & Gynaecology, University of Auckland, Auckland, New Zealand; [c]American University, Washington College of Law, Washington, DC, USA; [d]Faculty of Law, University of Otago, Dunedin, New Zealand; [e]School of Health Sciences, University of Canterbury, Christchurch, New Zealand; [f]Fertility Associates Limited, Christchurch, New Zealand; [g]Fertility Plus, Te Toka Tumai, Te Whatu Ora, Health New Zealand, Auckland, New Zealand

ABSTRACT

Contact among donor-conceived people (DCP), families and donors is increasing, but little is known about contact before DCP reach adulthood. Although DCP in New Zealand can access donor identifying information at 18, parents may request information earlier, enabling 'early' contact. This study reports findings from the Donor Identity Aotearoa New Zealand survey examining contact between 189 parents of DCP aged 7–18 and clinic-recruited donors, same-donor siblings, and donors' raised children. Quantitative data were analysed using Stata 17BE and qualitative responses were analysed thematically. Eighty-six parents (45.5%) had accessed donor identifying information, 42 (22.2%) had met the donor and 34 (18.0%) reported other contact. Among the 91 parents aware of same-donor siblings, 14 (15.4%) had met their parents; 16 (17.6%) had met a sibling. Twenty-two of 107 (20.8%) parents aware of donors' children had met them. Contact did not differ by family type, donation type, or child age. Qualitative findings suggested positive experiences, alongside parents' negotiation of donor-related families' roles, often with limited guidance. Forty-six parents (24.3%) wanted help with contact; 42 (22.2%) were unsure, and 7/57 (12.1%) already in contact wanted additional assistance. Findings indicate parents may benefit from support to initiate and maintain early contact in New Zealand.

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Introduction

Contact among those connected through donor conception, such as donors, donor-conceived people (DCP), same-donor siblings and parents is increasing (Hall et al., 2026; Volks et al., 2025). In part, this is as a result of identity-release provisions enacted in several jurisdictions coming into effect, allowing DCP to access identifying information about and possibly contact donors and genetic siblings (with consent). Contact may also be more common given growing awareness of the needs and rights of DCP to access identifying information, and their potential interest in connecting with those genetically related to them (Duff & Goedeke, 2024; Newton et al., 2024). Alongside this, the expansion of direct-to-consumer DNA testing services (e.g. 23andMe, Ancestry.com) and social media has markedly increased the likelihood of contact (Darroch & Smith, 2021; Harper et al., 2016; Pasch, 2018). This may occur even in contexts where parents have not disclosed donor conception (DC) to their children, donations occurred under anonymous arrangements, or legal frameworks restrict access to identifying information to particular parties (e.g. DCP only) (Harper et al., 2016; Pasch, 2018). Furthermore, voluntary information exchange services e.g. the US-based Donor Sibling Registry, have emerged to facilitate contact between DCP conceived with

CONTACT Sonja Goedeke sonja.goedeke@aut.ac.nz Department of Psychology and Neuroscience, School of Clinical Sciences, Auckland University of Technology, Private Bag 92006, Auckland, 1142, New Zealand.

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sperm from donors who were previously anonymous, but are now open to identification and contact (van Rooij et al., 2026).

'Early' contact (before the legislated DCP age of access in identity-release jurisdictions) also appears to be becoming more common (Volks et al., 2025). Although identity-release provisions typically enable DCP to access donor identifying information in adulthood (usually at age 18), emerging research has challenged existing legal age thresholds, indicating that DCP may desire access to identifying information before reaching the age at which it becomes legally available (Bolt et al., 2024). Parents may thus attempt to initiate contact earlier, including to obtain medical or psychosocial information from the donor, facilitate future contact between their children and donors or same-donor siblings, or to develop supportive relationships with same-donor families (Gilman & Davis, 2026; Indekeu et al., 2021; Nordqvist & Gilman, 2024). Interest in searching for donors and same donor siblings may also be more common among lesbian-couple or single parents and seen as a way of cultivating a broader kinship network, with some research suggesting greater parental interest in contact with their child's same-donor siblings and families than with the donor (Freeman et al., 2009; Indekeu et al., 2021). In addition, early contact may be arranged between donors and intending parents prior to donation, for example, where recruitment of donors occurs through online platforms, and donors negotiate with recipients the expected nature and frequency of contact between donors, parents and children prior to donation in the belief that this is in the best interests of DCP (e.g. Volks, 2022; Volks et al., 2025). However, the extent to which this early contact occurs is unknown.

In New Zealand, the Human Assisted Reproductive Technology (HART) Act 2004 mandated the registration of donor identifying information and stated among its principles that DCP should have access to this information – which is legally possible at age 18 or earlier by request. However, the legislation stopped short of requiring parents to disclose, nor did it introduce mechanisms, such as birth certificate annotation, to ensure that DCP would be made aware of their DC. In practice, and as required under the HART Act, fertility clinics encourage parents to share information about their DC with their donor-conceived child (DCC), and from an early age. Donors may be recruited by parents i.e. known to parents prior to donation, such as family members or friends, or may be clinic-recruited donors, i.e. not known to parents prior to donation. It is however also possible for clinic-recruited donors and recipients to ask fertility clinics for identifying information about each other and, in some cases, to meet prior to donation (Goedeke et al., 2023).

The extent to which legislation and practice has influenced parents' disclosure patterns was explored as part of the Donor Identity in Aotearoa New Zealand (DIANZ) project. A total of 381 parents of DCP aged 7–18 years and conceived through DC completed an anonymous, online survey (Anderson et al., 2026). Among those using clinic-recruited donors i.e. donors not previously known to recipients/parents, 86% of parents had shared information about their children's DC with them, with two-parent gay or lesbian families disclosing at highest rates, followed by single parents and two-parent heterosexual couples. Most parents expressed a belief in the rights of children to access their genetic information, although they also reported concerns around stigma and the impact of DC on parent: child relationships. As part of the survey, data were also collected on contact between parents and donors, same-donor siblings/families, and donors' raised children. In this paper, we report on the frequency, form and nature of contact between parents of DCP aged 7–18 years (i.e. 'early' contact) and clinic-recruited donors, as well as their contact with same-donor siblings and their families. Parents using known donors already have pre-existing relationships, i.e. family or friendship relationships, with their donors prior to donation, thus potentially making DCP access to information about and contact with donors more likely. Parents of clinic-recruited donors do not know their donors prior to donation, and in this study, we aimed to explore to what extent contact occurs between parents and donors (and same-donor siblings/donors' raised children) in this context, and the nature and form of such contact. This is particularly relevant given the HART Act, which aims to ensure that all DCP have access to information.

Materials and methods

Parents with a DCC (including via egg, sperm, or embryo donation) aged between 7 and 18 years at the time of recruitment and whose details were on the donor register (a total of 1528 children) were eligible

to participate in the anonymous survey. Information about the study and invitations to participate were sent to parents by New Zealand fertility clinics, who are required to maintain records of births through DC. Where parents had more than one child born through DC and recorded on the register, a single invitation was sent, and they were asked to complete the survey questions with reference to their oldest child. The survey remained open for 6 weeks, with a repeat invitation sent 2 weeks following the initial invitation as a reminder.

The survey was undertaken using Qualtrics software, Version Qualtrics XM© (Qualtrics, Provo, UT). Most questions were asked as multiple choice, with some allowing free-text responses for further comment. Conditional logic was used to guide parents through a series of questions regarding access to identifying information; whether or not they had disclosed DC to their child and their experience of disclosure; awareness of legislative provisions; whether or not they had contact with the donor, donor's family and same-donor families, and if so, the form, frequency and experience of such contact. Questions were also asked about support services accessed or desired. Parents were able to provide additional free-text comment for questions related to disclosure, contact, and support services. The current paper focuses on data collected with respect to contact experiences. Questions were developed through a review of relevant literature and related surveys and piloted with a small group of respondents including parents, fertility counsellors and researchers.

Quantitative data were analysed using descriptive statistics. Frequencies and percentages were calculated for identifying information received before or after donation, contact with donors, same-donor siblings and donors' raised children, and the frequency and form of such contact. Chi-squared tests were used to test for differences in contact with donors, same donor siblings, or the donors' raised children by donation type (egg, sperm, embryo), family type (same sex two-parent family, heterosexual two-parent family, single parent family) and DCC age. The DCC's age at survey completion was treated as a categorical variable (<7, 7–12, 13–18 years). All statistical analyses were conducted using Stata 17 BE©.

Responses to questions/comments related to experiences of contact and support desired or accessed were analysed by the first author and reviewed by the second author using Braun and Clarke (2006) thematic analytical steps. This method was chosen to identify and interpret patterns of meaning within parents' accounts of contact with donors and same-donor families, and support accessed/desired. Analysis involved familiarisation with the data, coding of responses, development and refinement of themes, and the production of a thematic account of parents' experiences.

There were 1528 DCP births recorded on the HART Act register within the study period. Thirteen hundred and seventeen survey invitations were sent as 211 individuals/families had more than one DCC. Three hundred and seventy-four responses were eligible for inclusion - an overall response rate of 28.4%. Half of the respondents (189/374, 50.5%) to the initial DIANZ survey had used a clinic-recruited donor and form the study population for this analysis.

The demographic characteristics of the 189 respondents who used clinic-recruited donors are summarised in Table 1. Most respondents were two-parent heterosexual families (44.4%), 36.5% were single parents, 13.2% were two-parent lesbian families, and 5.8% were two parent gay families. The majority had a DCC through sperm donation (85.7%) with only 4 respondents using embryo donation. The average age of the DCC was 10.9 years at the time of survey completion with a median of 10 years.

Ethics approval for this study was granted by the Auckland Health Research Ethics Committee (AHREC) [Project ID: AH26445, 14/09/2023], and the Auckland University of Technology Ethics Committee (AUTEC) [Project ID: 23/290, 21/09/2023].

Results

Access to information and contact with donor before donation

27% of parents (51/189) had received/obtained identifying information about the donor prior to donation. Of these, 47% (24/51) had met the donors prior to donation (12.7% (24/189) overall), with most of these meetings facilitated at the clinic by request of the parents or donors, and only 1 meeting occurring outside the clinic setting. A further 2.1% (4/189) had other forms of contact - online, via social media, email or written contact – prior to donation. Thus, 14.8% of parents (28/189)) had some form of

Table 1. Demographic factors of parents who conceived using clinic donors ($N = 189$).

	N	%
Donation type		
Egg	22	11.6
Sperm	162	85.7
Embryo	4	2.1
Did not answer	1	0.5
Family type		
Two-parent heterosexual	84	44.4
Single parent	69	36.5
Two parent gay or lesbian	25	13.2
Other family make up[a]	11	5.8
Age range		
<35	0	0.0
35–39	14	7.4
40–44	26	13.8
45–49	62	32.8
50–54	59	31.2
55–59	15	7.9
60+	0	0.0
Did not answer	13	6.9
Gender identity		
Male	4	2.1
Female	182	96.3
Non-binary	0	0.0
Prefer not to say	2	1.1
Did not answer	1	0.5
Respondents prioritised ethnicity[b]		
Māori	9	4.8
Pacific Island	2	1.1
Asian	5	2.6
MELAA	0	0.0
NZ European/other European	173	91.5
Religious Identity		
Christian	46	24.3
Muslim	0	0.0
Hindu	0	0.0
Buddhist	0	0.0
Other	6	3.2
None/atheist/agnostic	135	71.4
Did not answer	2	1.1
Highest education level		
Secondary school or lower	21	11.1
Technical college/Institute	34	18.0
University undergraduate	58	30.7
University postgraduate	66	34.9
Other	10	5.3
Partner's prioritised ethnicity[b] ($N = 114$)		
Māori	5	4.4
Pacific Island	0	0.0
Asian	2	1.8
MELAA	1	0.9
NZ European/other European	106	93.0

[a]Other family make up includes parents who did not identify with the other family categories.
[b]By Level 1 by HISO ethnicity reporting protocols. MELAA is a composite ethnicity grouping including Middle Eastern, Latin American, and African ethnicities.

contact with donors prior to donation (Table 2). Parents using egg donation were more likely to have met the donor prior to donation ($\chi^2(2, n = 189) = 133.62$, $p = <0.001$) as were two parent heterosexual parents ($\chi^2(3, n = 189) = 12.64$, $p = 0.005$). No significant differences were found by the child's age ($\chi^2(2, n = 189) = 3.05$, $p = =05,$).

Access to information and contact with donor subsequent to donation

Of the 138 parents who did not already have identifying information, 25.35% (35/138) had requested and accessed identifying information about the donor subsequent to donation. 51.4% (18/35) of these parents had in-person contact with donors subsequent to donation, with 6/18 having met a few times in the child's life, and a further 6/18 meeting 3–6 monthly. A greater number had non-face-to-face

Table 2. Parents' access to identifying information and contact with the donor prior to donation.

	N	%
Identifying information about donor prior to donation ($N = 189$)		
Yes	51	27
No	138	73
Among those with identifying information about donor prior to donation ($N = 51$)		
Met with donor in person prior to donation		
Yes	24	47
No	26	51
Other forms of contact with donor prior to donation		
Online/social media/email/written	10	5

contact with donors (24/35) i.e. with 1/3 having contact 1–3 monthly (see Table 3). No significant differences were found by family type ($\chi^2(3, n = 189) = 3.67$, $p = 0.299$), donor type ($\chi^2(2, n = 189) = 2.58$, $p = 0.275$), or child's age ($\chi^2(2, n = 189) = 2.31$, $p = 0.315$), in those who had any form of contact with the donor after donation.

Overall, 45.5% (86/189) of parents had access to donor identifying information at the time of the study. 22.2% (42/189) of parents had in-person contact with the donors, and 18% (34/189) of parents had some form of other contact with the donors. Thus, over half of all parents with donor identifying information had no early contact with donors.

Same-donor sibling contact

48.1% of parents (91/189) were aware of other DCC born from the same donor. 15.4% (14/91) had met the parents of same donor siblings, with 35.7% (5/14) having met a few times in their DCC's life (Table 3). 17.6% of parents (16/91) had met at least one of the same-donor siblings, with 25% of these having met the siblings once only to date and 31.3% having met a few times in their DCC's life. No significant differences were found by family type ($\chi^2(3, n = 91) = 1.26$, $p = 0.738$), donor type ($\chi^2(1, n = 91) = 2.08$, $p = 0.150$), or child's age ($\chi^2(2, n = 91) = 1.87$, $p = 0.392$) in those who had any form of contact with same-donor siblings.

Contact with donors' raised children

More than half of parents (56.9%, 107/189) were aware of the existence of donors' 'own' or raised children. Of these, 20.8% (22/107) had met the children raised by the donor with approximately 1/5 having met the children once only, 1/5 on a 3–6 monthly basis, and 1/4 a few times in their child/children's lives (Table 3). Only 6 had been in other forms of contact e.g. via social media with the donors' children. Note that parents were more likely to have met the children raised by the donor if they had used embryo donation to build their families, although only 4/107 parents were embryo recipients. Parents were least likely to have had contact with donors' raised children if they had used sperm donation to conceive ($\chi^2(3, n = 107) = 12.15$, $p = 0.002$). No differences were noted by family type ($\chi^2(3, n = 107) = 6.18$, $p = 0.103$), or child's age ($\chi^2(2, n = 107) = 1.09$, $p = 0.598$) in those who had any form of contact with donors' raised siblings.

Support for contact with donors

Overall, 24% of all parents (46/189) reported that they would want assistance with contact with donors, while a further 22.2% (42/189) were unsure if they would like assistance. This could include parents who already had access to identifying information obtained prior or subsequent to donation, but had not had contact, and those who did not have access to identifying information. 26.5% (50/189) reported that they were already in some form of contact and did not feel they needed additional assistance. However, 12.1% (7/57) of the parents already in contact with donors reported wanting additional assistance (Table 4).

Table 3. Parents' contact with donor, other children from the same donor and their parents, and children being raised by the donor following the birth of their child.

	Contact		Monthly		1–3 monthly		3–6 monthly		Yearly		On special occasions		A few times only		Only once		Did not answer[a]		No contact	
	N	%	*N*	%	*N*	%	*N*	%	*N*	%	*N*	%	*N*	%	*N*	%	*N*	%	*N*	%
Parents' who requested identifying information about donor after birth of their child (*N* = 35)																				
Parent met donor in person after birth of their child	18	51.4	1	2.9	1	2.9	6	17.1	2	5.7	0	0	6	17.1	1	2.9	1	2.9	17	48.6
Parent been in other forms of contact with donor after birth of their child	24	68.6	1	2.9	8	22.9	4	11.4	1	2.9	0	0	4	11.4	5	14.3	1	2.9	11	31.4
Parents' aware of other donor conceived children from the same donor (*N* = 91)																				
Parent met other children from same donor	16	17.6	2	2.2	2	2.2	2	2.2	1	1.1	0	0	5	5.5	4	4.4	0	0	75	82.4
Parent been in other forms of contact with children from same donor (i.e.. social media)	8	8.8	1	1.1	2	2.2	0	0	0	0	0	0	2	2.2	2	2.2	1	1.1	83	91.2
Parent met parent(s) of other children from the same donor	14	15.4	1	1.1	2	2.2	1	1.1	1	1.1	0	0	5	5.5	4	4.4	0	0	77	84.6
Parent been in other forms of contact with parent(s) of children from same donor	16	17.6	1	1.1	1	1.1	1	1.1	3	3.3	0	0	7	7.7	3	3.3	0	0	75	82.4
Parents' aware of children being raised by donor (*N* = 107)																				
Parent met children raised by donor	23	21.5	1	0.9	2	1.9	4	3.7	4	3.7	0	0	6	5.6	5	4.7	1	0.9	84	79.3
Parent been in other forms of contact with children raised by donor	6	5.6	1	0.9	0	0	2	1.9	2	1.9	0	0	1	0.9	0	0	0	0	101	94.4

[a]Participant answered that they had contact but did not provide a frequency of this contact.

Table 4. Parents' who used clinic donors desire for assistance with donor linking ($N = 189$).

Would want assistance with donor linking	*N*	%
Yes	46	24.0
No	40	21.2
Unsure	42	22.2
Already in contact and do not need help	50	26.5
Already in contact but would like assistance	7	3.7
Missing	4	2.1

Thematic analysis

Responses to the free-text questions were aggregated and analysed thematically, with particular attention to experiences of contact. Three main themes related to contact were identified.

1. Finding an appropriate place for donors within family life – from 'not too involved' to being family, from occasional to regular contact

Parents generally described contact with donors as a positive experience, although the nature and frequency of contact varied. Parents emphasised the importance of developing relationships that felt appropriate and comfortable for all parties involved. For some parents, this involved close and ongoing relationships in which donors and their families became integrated into family life:

> We have a wonderful relationship with the donor and his wife and two kids. They feel like cousins. Related but not in each other's lives all the time. The kids got on so well right from the start. I'm excited that they will know each other growing up and through adulthood. (107, two-parent heterosexual parent family, sperm donation)

> It's been an awesome experience. We contacted our donor early on through the clinic. We get on incredibly well and our kids and us hang out all the time. They are a part of our family, and our donor is a big part of our son's life. We chat most days online. (50, two-parent heterosexual parent family, sperm donation)

For other parents, the contact was more occasional and/or via social media but equally described as positive. These parents often described relationships characterised by flexibility, mutual respect and an absence of pressure regarding the level of involvement expected from either party:

> Our experience has been positive. The egg donor was given the option of meeting us which she initially rejected but later changed her mind. I think both parties found it beneficial to meet. It gave closure to both parties. Since meeting at the clinic, we have maintained occasional contact on birthdays and Christmas mainly. (172, two-parent heterosexual parent family, egg donation)

> It's great. We have met the donor and still keep in touch with him. (151, two-parent same-sex parent family)

> Things that have worked well is that the donor family allowed us to be the ones to initiate contact if we wanted to. There was no pressure from them at all. They have always made us feel like the parents (which of course we are). We only make contact once or twice a year through email. This works well to ensure that we are not too involved in each other's lives. I have kept each email in a scrapbook for our children to read later on too. (206, two-parent heterosexual parent family, embryo donation)

For some parents, contact between themselves and the donors was seen as creating opportunities for future relationships between their DCC and the donors. Contact was therefore viewed as a way of preserving future choice for their DCC:

> We have had contact with our donor since my girls were about 1 year old and have met 3–4 times. I think it is important for my children to have the ability to meet with their donor when they are older if they wish to do so. (30, single parent family, sperm donation)

2. Negotiating boundaries and donor involvement

While most parents wrote positively about their contact experiences, challenges were also noted in establishing and maintaining relationships with donors. Central was the need to negotiate boundaries and define the donor's role in the lives of their children. Parents often emphasised the importance of ensuring that contact enhanced, rather than disrupted, family relationships and parental roles.

For some, challenges arose when donors were perceived as overstepping boundaries or seeking a level of involvement that parents regarded as inappropriate. Such experiences underscored the importance of clear expectations regarding the donor's role:

> Met donor after my child was born. Initially a good experience. Donor then became controlling and thought he had a say in decisions about my child. He started contacting my workplace, friends, neighbours. I cut off contact as I found this behaviour distressing. (83, single parent family, sperm donation)

Similarly, some parents highlighted the importance of maintaining clear boundaries, even when contact was otherwise welcomed:

> Boundaries are important! (111, two-parent same-sex parent family, sperm donation)

Other parents described uncertainty about how DCC would understand and navigate the donor relationship as they matured. In these accounts, concerns centred less on donor behaviour and more on children's developing understanding of the distinction between a donor and a parent:

> We have met him a few times when (our children) were younger. Once (they) are ready then we might meet him again, but I will be led by my children on this and their ability to process the concept of and being able to differentiate between the donor being a birth father rather than a dad. That is a hard concept for them right now and the lines could be easily blurred. (30, two-parent same-sex parent family, sperm donation)

Not all concerns related to excessive donor involvement. For some families, the challenge was the donor's limited engagement, particularly when this had implications for their DCC's sense of connection and understanding of their origins:

> We are very happy with that connection however my son still has a lot of conflicting feelings about the donor's decision not to stay in touch with him for the first twelve years of his life. (308, single parent family, sperm donation).

3. Navigating donor contact without guidance or support

Parents commented on the lack of structured support post donation, particularly in relation to initiating and sustaining contact with donors and other donor-linked families. Families were described as needing to manage complex relational and practical decisions with minimal guidance from fertility clinics or formal systems. For some parents, this absence of ongoing support was described as part of a broader sense of being left to navigate the DC journey alone once pregnancy had been achieved:

> Once you are pregnant, that was the end of communication from the Clinic. It would be really nice, to have check in points along the way (i.e. phone call). This experience is a roller coaster, and making the decision of having a donor child, is only the start. (165, two-parent heterosexual parent family, sperm donation)

Others noted the lack of support more specifically for initiating contact with donors and uncertainty about appropriate processes, timing, and etiquette.

> I think a bit more guidance around how to make contact would have been useful - we keep talking about making contact but I'm a bit nervous about how to do it right. (262, two-parent heterosexual parent family, sperm donation)

Some parents also described difficulties in connecting with other donor families, expressing frustration at the lack of facilitation for peer or shared-donor contact. In these accounts, clinics were seen as gatekeepers to potentially valuable relationships that were not actively supported:

> I also asked if the clinic could connect me to other Mums who had used a donor, but no information was received. I also left my contact details with the clinic and asked them to be passed on to any Mums who were keen to connect, with no success. I have since found 2 other Mums living in the same city as me who had the same experience, so it would seem that the clinic prevented connection rather than facilitating it. (343, single parent family, sperm donation)

Beyond initial contact, some parents also expressed a need for guidance on maintaining donor relationships over time and managing potential difficulties if relationships broke down. These accounts point

to uncertainty not only about how to begin contact, but also about how to sustain and structure it in ways that support all parties involved:

> (Support for) how to structure contact so that the parents of the donor children still feel like the parents. And what to do if the relationship between the parents and the donors breaks down. (206, two-parent heterosexual parent family, embryo donation)

Discussion

The aim of our study was to explore experiences of contact between parents of DCP and clinic-recruited donors (and their families), as well as between parents and same-donor siblings (and their families) in the context of New Zealand's identity-release provisions, which allow for the possibility of 'early' contact i.e. before DCP reach the age of 18. Previous research has suggested that DCP may have an interest in forming connections with donors to obtain up-to-date medical or genetic information, explore shared traits relevant to their identity development, or build ongoing relationships with donors and their families (Indekeu et al., 2021; Macmillan et al., 2021; Newton et al., 2024; van Rooij et al., 2026).

Our findings indicate that parents may similarly have an interest in contact with clinic-recruited donors, including prior to their child turning 18, often motivated by concerns about their child's well-being or needs. This aligns with emerging international research (Andreassen, 2023; Gilman & Davis, 2026; Goldberg & Scheib, 2015). In our sample, 45% of parents had access to identifying information. Approximately one-fifth had engaged in in-person contact with clinic-recruited donors either prior to or following donation, and a similar proportion reported other forms of 'early' contact, including via social media. This suggests that, in addition to formal information access, a substantial proportion of parents actively establish relational connections with donors during the child's early life. Such early contact may establish relational foundations that facilitate later connections between DCP and donors. Interestingly, parents through egg donation were most likely to have met the donor prior to donation, perhaps reflecting egg donors' tendency to view donation as a relational act (Goedeke et al., 2023; Volks et al., 2025).

These findings of early contact interest contrast with earlier research by the first author, in which parents positioned contact with clinic-recruited donors as primarily DCP-led and viewed themselves as facilitators of their children's future decisions (Duff & Goedeke, 2025). A key contextual difference, however, is that donations in the earlier research had occurred under anonymous systems, whereas the current sample involves identity-release arrangements in which identifying information is more readily available, and information exchange is encouraged. In identity-release contexts, parents may perceive having a more active role in initiating and facilitating contact, reflecting a potential shift in how parental responsibility is conceptualised in DC. While over half of our sample had not accessed donors' identifying information, it is possible that these parents had not done so because they were not aware of how and when they could obtain this, a concern reflected in our previous research (Anderson et al., 2026), where 33% of parents who did not have access to identifying information were not aware, and 26% were unsure, of where and when to access this information.

Contact in our study also extended to same-donor siblings, their parents, and donors' raised children, although less frequently than contact with donors themselves. Among parents aware of same-donor siblings, over 15% had met other parents and 17.6% had met same-donor siblings. Of those aware of donors' raised children, over 20% had met them. Previous research suggests that such connections may support identity development, reduce the risk of consanguinity, provide mutual support and contribute to the formation of extended family networks (Indekeu et al., 2021; Scheib et al., 2020).

Although our sample size limited subgroup analysis, and we found no differences in contact with donors or same-donor siblings by family type, existing literature suggests that single mothers and same-sex female couples may be particularly motivated to establish early connections with donors or same-donor siblings as a way of cultivating broader kinship networks (Freeman et al., 2009; Indekeu et al., 2021). Some may prioritise relationships with same-donor families over donors themselves, balancing

the creation of kinship ties with the preservation of parental autonomy (Freeman et al., 2009; Goldberg & Scheib, 2015; Kelly et al., 2019).

This study is limited in its ability to examine differences by donor type, due to very few parents using embryo donation responding to the survey, except for contact with donors' raised children, where analysis suggested that parents were least likely to have had contact with donors' raised children if they had used sperm donation to conceive. While our survey did not explore the reasons for this, it is possible that sperm donation is more often framed in organisational practice as a dyadic genetic contribution, with fewer embedded opportunities or expectations for wider familial connection (Johnson, 2013). On the other hand, Halcomb (2020) has argued that sperm donors have more freedom to create relationships with recipient families than egg donors. This warrants further exploration. Furthermore, while the limited number of parents using embryo donation to conceive in this study makes comparisons difficult, it is important to note that in New Zealand, embryo donation involves mandatory pre-donation meetings between donors and recipients, during which expectations regarding contact and the rights of DCP are discussed (ACART, 2020). All embryo donor and recipient families in this study had thus met prior to donation, and most reported ongoing contact. These structured sessions may facilitate early relationship-building, including contact with donors' children.

Contact frequency varied and did not necessarily involve regular interaction yet was generally described positively. Similar patterns have been reported internationally, particularly where donors are receptive and supportive and the number of same-donor siblings is manageable (Blyth et al., 2019; Davis et al., 2020; Frith et al., 2017; Goldberg & Scheib, 2015; Hertz & Mattes, 2011). Contact also occurred through non–face-to-face contact, such as through social media, which may enable the maintenance of low-intensity connections over time (Hertz & Mattes, 2011). In the New Zealand context, identity-release provisions and the preparatory counselling may contribute to donor openness to contact, including early engagement. Although there are no legislated limits on the number of children that may be conceived from a single donor, the Ngā Paerewa Standards require the clinics to set limits, which they tend to set at 5–7 families per donor (Goedeke et al., 2026), which may help to address concerns related to the discovery of large sibling groups.

Despite overall positive experiences, some parents expressed concerns regarding donor involvement, boundaries, and the potential impact of early contact on family dynamics. These concerns are consistent with prior research highlighting challenges such as mismatched expectations of contact (Goldberg & Scheib, 2015), lack of parental security in their role (Kelly et al., 2019) or discomfort with the role of the donor and the perceived threat to their parental autonomy, especially for non-genetic parents (e.g. Andreassen, 2016; 2023; Frith et al., 2018; Widbom et al., 2021). Notably, such concerns may arise even when contact occurs primarily between DCP and same-donor siblings (Andreassen, 2017).

Nonetheless, most parents who were already in contact (86.2%) did not report a need for additional support. However, a notable minority (12.1%) of those already in contact indicated that they wanted additional assistance, indicating that challenges may still arise. Among those not yet in contact, one in four parents indicated they would want support, and a further 22.2% were unsure. These findings suggest that a substantial proportion of parents may be interested in contact, and benefit from guidance in initiating and maintaining contact.

Taken together, these findings highlight the need for accessible psychosocial support for parents navigating contact with donors and same-donor families, echoing recommendations in previous research (Bolt et al., 2023; Goldberg & Scheib, 2015; Indekeu et al., 2022). However, this is challenging in practice, given the international lack of post-donation and donor-conception linking support reported in the literature (Bolt et al., 2024; Goedeke et al., 2026). In New Zealand, while pre-donation implications counselling for donors and recipients is mandated, post-donation support is discretionary and largely unfunded. The importance of such support is emphasised in the Australia and New Zealand Infertility Counsellors Association (ANZICA) Donor Conception Linking Guidelines (2024), which outline principles and protocols for facilitating contact. Nonetheless, questions remain regarding responsibility, accessibility, and funding of these specialised services (Goedeke et al., 2026).

This study has several limitations. First, the DIANZ survey response rate was 28%, suggesting potential response bias. Parents who had not disclosed DC to their children, or who held less favourable views

about donor contact, may have been less likely to participate in research on disclosure and contact practices. As a result, findings may not be fully representative of donor-conceived families in New Zealand, and caution is needed when generalising to other jurisdictions, particularly those where DCP have differing access to identifying donor information. Second, the cross-sectional design limits causal inference, including regarding changes in contact over time. Next, while age of DCP at the time of survey was collected, data on DCP age when contact was initiated were not collected. Further, although free-text survey responses provided useful insights, their brevity and variability limit interpretive depth compared with in-depth qualitative methods. Finally, the sample size also constrained subgroup analyses (e.g. by family or donation type), potentially obscuring important within-group differences. Further qualitative research by the first author is underway using in-depth interviews with parents to explore motivations for, and experiences of, contact with donors and donor-linked families.

Despite its limitations, this study provides evidence that some parents in New Zealand are actively engaging in contact with donors and same-donor families, including prior to donation and during early childhood. These practices may shape future contact pathways for DCP. While experiences are generally positive, the findings underscore the importance of developing structured, accessible support systems to assist families in navigating these relationships.

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Author contributions

CRediT: **Sonja Goedeke**: Conceptualisation, Formal analysis, Investigation, Methodology, Supervision, Validation, Writing – original draft, Writing – review & editing; **Karyn Anderson**: Data curation, Formal analysis, Investigation, Project administration, Validation, Writing – original draft, Writing – review & editing; **Solene Bertrand**: Data curation, Formal analysis, Investigation, Project administration; **Rebecca Hamilton**: Methodology, Writing – review & editing; **Jeanne Snelling**: Methodology, Writing – review & editing; **Annabel Ahuriri-Driscoll**: Methodology, Writing – review & editing; **Sarah Wakeman**: Methodology, Writing – review & editing; **Cindy Farquhar**: Conceptualisation, Funding acquisition, Investigation, Methodology, Resources, Supervision, Validation, Writing – review & editing.

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Data availability statement

Data will be made available upon request.

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