Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

A scoping review of publicly-funded services for donor-assisted human reproduction in selected countries

Publication Date: 21 May 2026

About the Health Information and Quality Authority

The Health Information and Quality Authority (HIQA) is an independent statutory body established to promote safety and quality in the provision of health and social care services for the benefit of the health and welfare of the public.

Reporting to the Minister for Health and engaging with relevant government Ministers and departments, HIQA has responsibility for the following:

- **Setting standards for health and social care services** — Developing person-centred standards and guidance, based on evidence and international best practice, for health and social care services in Ireland.
- **Regulating social care services** — The Chief Inspector of Social Services within HIQA is responsible for registering and inspecting residential services for older people and people with a disability, and children's special care units.
- **Regulating health services** — Regulating medical exposure to ionising radiation**.**
- **Monitoring services** — Monitoring the safety and quality of permanent international protection accommodation service centres, health services and children's social services against the national standards. Where necessary, HIQA investigates serious concerns about the health and welfare of people who use health services and children's social services.
- **Health technology assessment** — Evaluating the clinical and cost effectiveness of health programmes, policies, medicines, medical equipment, diagnostic and surgical techniques, health promotion and protection activities, and providing advice to enable the best use of resources and the best outcomes for people who use our health service.
- **Health information** — Advising on the efficient and secure collection and sharing of health information, setting standards, evaluating information resources and publishing information on the delivery and performance of Ireland's health and social care services.
- **National Care Experience Programme** — Carrying out national service-user experience surveys across a range of health and social care services, with the Department of Health and the HSE.

Visit www.hiqa.ie for more information.

Acknowledgements

HIQA would like to thank all members of the Expert Advisory Group (EAG) listed below who provided time, advice and information in support of this work.

The findings and conclusions of this report represent HIQA's assessment of the evidence and may not reflect the views of all members of the EAG. However, all perspectives were carefully considered in the preparation of this report.

HIQA would also like to thank all individuals and organisations who supported this work.

The membership of the EAG was as follows:

Dr Máirín Ryan (Chair)	Director, HTA Directorate, HIQA
Ms Anne Byrne	Chief Executive Officer, LGBT Ireland
Ms Cliona Carroll	Patient representative, Rare Diseases Ireland
Ms Pamela Carter	Principal Officer, Bioethics Unit, Department of Health
Dr Laura Comber	Deputy Director, HTA Directorate, HIQA
Ms Caitriona Fitzpatrick	National Infertility Support and Information Group (NISIG) Committee member and spokesperson (former NISIG Chairperson)
Dr Julie Kenneally	Assisted Human Reproduction Regulatory Authority Board Member and Assisted Human Reproduction (AHR) Programme Manager at Cork University Maternity Hospital
Dr Jean Long	Head of Evidence Centre, Health Research Board
Dr Ciara McCarthy	Irish College of General Practitioners and HSE Clinical Lead in Women's Health
Ms Julie McGinley	Project Manager, Public AHR Programme, HSE
Dr Karl Neff	National Clinical Lead, HSE Gender Healthcare Programme

Ms Amy Nolan	Director of Clinical Affairs, Irish Cancer Society
Ms Michelle O'Neill	Deputy Director, HTA Directorate, HIQA
Dr Nikhil Purandare*	Consultant Obstetrician & Gynaecologist and Honorary Treasurer (Office Role), Institute of Obstetricians and Gynaecologists
Dr John Sullivan	Consultant Urologist, St. James Hospital

*Dr Nikhil Purandare is the Medical Director and owner of Fertility & Fetal Health – Antenatal Care & Fertility Clinic in Galway.

Organisations that assisted HIQA in providing information, in writing or through meetings, included:

Merrion Fertility Clinic

Chief Nursing and Midwifery Officer Division, Australian Government Department of Health, Disability and Ageing

Danish Ministry of the Interior and Health

Federal Ministry of Education, Family, Senior Citizens, Women and Youth, Germany

Women, Children and Organ Donation Unit, Department of Health, Northern Ireland

Directorate for Chief Operating Office, NHS Scotland

NHS Wales Joint Commissioning Committee

Members of, or representatives on, the European Society of Human Reproduction and Embryology (ESHRE). This includes members of the European IVF Monitoring Programme (EIM) Steering Committee. Information was provided for the following countries:

- Germany
- Portugal
- Sweden.

Members of the Evaluation Team:

This report was led by staff in HIQA's HTA Directorate. The following individuals contributed to the management, technical writing or dissemination of this report:

Michelle Norris (Project Lead), Eavan Brennan, Marie Carrigan, Carolina Cunha Bassul, Laura Comber, Ellie Duggan, Dane Moriarty, Ruairi Murray, Michelle O'Neill, Michelle O' Shea, Máirín Ryan, Debra Spillane.

Conflicts of Interest

None reported.

Table of contents

Acknowledgements **3**
Foreword **7**
Key Points **8**
Plain Language Summary **11**
List of abbreviations used in this report **13**
1 Background **15**
2 Methods **16**
2.1 Terminology used in this report 17
3 Findings **18**
3.1 Identified resources 18
3.2 Summary of resource contents 27
4 Discussion **69**
4.1 DAHR interventions and eligible populations 70
4.2 Funding 71
4.3 Organisational aspects 72
4.4 Donor material management 73
4.5 Governance and legislation 75
4.6 Counselling, communication and information provision 76
4.7 Ethical and social considerations 77
4.8 Limitations 78
5 Conclusion **78**
References **80**
Appendices **105**
Appendix A – Database search results **105**
Appendix B – Excluded published literature **112**
Appendix C – Characteristics of included published literature **121**
Appendix D – Summary tables **125**

Foreword

Donor-assisted human reproduction (DAHR) is any procedure where the aim is for an embryo to be implanted in the womb of an individual and one or both of the gametes (the sperm or the egg) or the embryo has been provided by a donor. In some countries, if you need DAHR treatment, this is partially or fully publicly-funded within the national healthcare system. However, in Ireland, as of May 2026, there are no publicly-funded DAHR services and those wishing to undertake DAHR must self-fund services in a private or not-for-profit clinic.

In 2015, the Children and Family Relationships Act was passed and provides the regulatory basis for DAHR services in Ireland. Following this, in 2024, the Assisted Human Reproduction Act 2024 outlined further the legislative regulatory framework regarding fertility services in Ireland. When fully commenced, this Act will regulate the provision of any treatment or procedure that involves the handling of gametes, embryos and or tissues for the purposes of establishing a pregnancy. With the legal basis now established and commencement of the 2024 Act underway, an understanding of which DAHR services are publicly funded internationally may inform the consideration of and development of a policy in relation to publicly-funded services for DAHR in Ireland. Therefore, this report contains a scoping review of publicly-funded services for DAHR in selected countries, and was conducted at the request of the Department of Health.

An Evaluation Team from the Health Technology Assessment Directorate in HIQA undertook this review. An Expert Advisory Group was convened to advise the Evaluation Team during the course of the review. HIQA would like to thank its Evaluation Team, the members of the Expert Advisory Group and all who contributed to the preparation of this report.

Dr Máirín Ryan

Deputy Chief Executive & Director of Health Technology Assessment

Health Information and Quality Authority

Key Points

- As of 2026, there are currently no publicly-funded services for donor-assisted human reproduction (DAHR) in Ireland. This report provides a summary of publicly-funded services for DAHR in selected countries. The findings of this scoping review will inform the consideration and development of a policy in relation to publicly-funded services for DAHR in Ireland, through supporting the work of the Department of Health. This review does not include surrogacy arrangements involving donated gametes or embryos.
- Grey literature and academic publications were identified for 10 selected countries: Australia, Denmark, England, France, Germany, Northern Ireland, Portugal, Scotland, Sweden, and Wales. These countries were selected as they are a combination of EU and non-EU countries, vary in terms of DAHR service provision, have a similar population size as Ireland, and or provide healthcare in a similar way to Ireland.
- A descriptive analysis of publicly-funded services for DAHR was undertaken. Information examined included DAHR interventions available and eligible populations; funding; organisational aspects; donor material management; governance; counselling, communication and information provision; ethical and social considerations; and legislation.
- Intrauterine insemination, in vitro fertilisation (IVF) and or intracytoplasmic injection that require donor materials (such as donor sperm, donor eggs, or both, which is termed 'double donation') were identified as having at least partial funding in nine of the selected countries. As of April 2026, Germany does not publicly fund any DAHR interventions, at a national level.
- Eligibility criteria for DAHR interventions were often the same as for other fertility interventions (such as IVF without donor materials) in the selected countries.
- The decision as to who to treat and the publicly-fund DAHR intervention provided was generally at the discretion of the treating healthcare professional. However, indications included:
  - in couples with infertility or where there is an identified risk of a child inheriting a genetic disease
  - being in a same-sex couple
  - being a single individual.

- The majority of DAHR interventions identified were fully funded through public healthcare or a statutory health insurance system. However, in some countries the person availing of the intervention may need to pay certain costs. For example, the person pays for:
  - partial treatment costs in Australia
  - subsidised medication in Denmark and Portugal
  - donor sperm in some regions in England.
- General practitioner or consultant referral is required for access to services in all nine countries which publicly fund DAHR. A stepwise model of care is often used with initial clinical assessment and preliminary investigations prior to referral to specialist fertility services. In France and Sweden additional psychological and social assessments are required before DAHR treatment can proceed.
- Information related to donor material management was identified for nine of the selected countries. In the majority of countries donor materials are primarily accessed through regulated fertility clinics or licensed gamete banks, with import from abroad permitted under regulatory approval in Australia, Sweden and the UK. In Denmark, France, and Sweden the treating healthcare professional is responsible for allocating donor materials to the recipient. Decisions on access and disposal of donor materials are guided by legal and ethical frameworks and linked to consent, life events (such as death or separation of a couple) and legal storage limits.
- The same governing bodies accountable for the delivery of publicly-funded fertility services without donor materials, were also accountable for DAHR services. This included national governments, ministers or ministries for health, and national state agencies. In Australia, Portugal and the UK, regulatory bodies are responsible for licensing, regulation and inspection of facilities providing DAHR services.
- Counselling and information provision was identified for all 10 selected countries. Counselling addresses social, psychological and ethical considerations of DAHR, for donors, recipients and donor-conceived people. This includes the disclosure of genetic origins to donor-conceived people. It was noted that accessible information should be provided to patients prior to DAHR treatment and should include comprehensive information on:
  - clinical success rates
  - risks and complications (including genetic and hereditary risks)

  - legal implications
  - practical aspects of treatment.

- Ethical and social considerations around DAHR services were identified for eight of the selected countries. These included obtaining informed consent, consideration of equity, non-discrimination and fair access, and guidance regarding donor anonymity, openness, and the right of the donor-conceived person to know their origins.

- Legislation governing, or related to, publicly-funded DAHR services was identified for all 10 selected countries. In Australia, Denmark, France, Portugal, Sweden and the UK, the number of times in which a donor can donate, the number of children that can be born, or the number of viable pregnancies and or families in which children are born from donor gametes and or embryos is legally regulated. It ranges from an egg donor being allowed to donate four times in their lifetime in Portugal, to a sperm donor being allowed to donate to 12 families in Denmark.

- Public funding for DAHR services removes or limits the associated financial burden that may be placed on those wishing to access these services. However, a number of factors including the availability of resources, the funding available, ethical considerations and any underpinning legislation may impact how, and what, services are provided.

Plain Language Summary

Donor-assisted human reproduction (DAHR) involves having a baby with help from someone who donates sperm, eggs, or embryos (donor materials). In some countries, if you need DAHR treatment, this is provided free of charge by the government (publicly funded). This report describes publicly-funded services for DAHR in 10 countries: Australia, Denmark, England, France, Germany, Northern Ireland, Portugal, Scotland, Sweden and Wales. Surrogacy, where a woman or birthing person (the surrogate) carries and gives birth to a baby for someone else, is not included within this report.

This report found that DAHR treatments which involve placing sperm into the womb (called 'IUI') or creating embryos in a lab (called 'IVF' or 'ICSI'), using donor eggs, sperm or both, are at least partly funded by the government in nine of the selected countries. Germany does not publicly fund any DAHR treatments. The rules for who can access DAHR treatments are often the same as the rules for who can access other fertility treatments. Each country has different rules about funding the use of donor eggs, sperm, and or embryos. Usually the treating healthcare professional decides who to treat and the DAHR treatment that is provided. Some situations where donor materials might be used include:

- in couples, if there is a risk of passing a genetic disease to a child, or if someone in the couple is infertile
- in same-sex couples
- in single people.

We found that most DAHR treatments are fully paid for by public healthcare or national health insurance systems in two countries. However, in seven countries people still pay some of the cost. For example, patients pay for some treatment costs in Australia, some medication costs in Denmark and Portugal, and for donor sperm in some parts of England. In 9 of the 10 countries, access to DAHR services is through the person's family doctor or consultant.

Donor materials mainly come from licensed fertility clinics or regulated sperm or egg banks. Often, donor materials come from other countries if that is approved by the relevant authorities. In Denmark, France, and Sweden, when unknown donors are used, the doctor is responsible for assigning donor materials to the person receiving treatment. Decisions on accessing and destroying donor materials are guided by national laws and ethical rules, and often depend on consent, changes in personal circumstances (such as the breaking up of a couple undergoing treatment) and how long materials can be stored.

In most of the countries, the national government, or department of health has overall responsibility for DAHR services. In some countries, there are laws that say how many times a donor can donate, how many children can be born from their donations, or how many families can have children using their donor materials. It ranges from an egg donor being allowed to donate four times in their lifetime in Portugal, to a sperm donor being allowed to donate to 12 families in Denmark.

Many countries considered the principles that guide decision-making and behaviour around DAHR treatment. This includes making sure the person receiving treatment has enough information to understand and agree to treatment and explaining that DAHR does not guarantee the ability to get pregnant. These principles also focused on fair access to DAHR treatment and that ensuring that people conceived using donor material have the right to know where they came from.

This report describes publicly-funded services for DAHR in 10 selected countries. The findings of this report will inform the consideration of and development of a policy for DAHR services in Ireland.

List of abbreviations used in this report

ACU	Assisted Conception Unit (Scotland)
AHR	assisted human reproduction
ART	assisted reproductive technology
CCG	Clinical Commissioning Group (in context of the NHS England)
CNPMA	National Council for Medically Assisted Reproduction (Portugal)
DAHR	donor-assisted human reproduction
DI	donor insemination
EAG	expert advisory group
ESHRE	European Society of Human Reproduction and Embryology
HFEA	Human Fertilisation and Embryology Authority (UK)
HIQA	Health Information and Quality Authority
HSC	Health and Social Care (Northern Ireland)
HSE	Health Service Executive (Ireland)
ICB	Integrated Care Board (England)
ICS	Integrated Care System (England)
ICSI	intracytoplasmic sperm injection
IFR	Individual Funding Request (England)
IUI	intrauterine insemination

IVF	in vitro fertilisation
NBHW	National Board of Health and Welfare (Sweden)
NHMRC	National Health and Medical Research Council (Australia)
NHS	National Health Service (UK)
NICE	National Institute for Health and Care Excellence (UK)
PGD	pre-implantation genetic diagnosis
PGT	pre-implantation genetic testing
ROPA	Reception of Oocytes from Partner
SALAR	Swedish Association of Local Authorities and Regions
SNS	*Serviço Nacional de Saúde,* National Health Service (Portugal)

1 Background

In Ireland, the Children and Family Relationships Act 2015 defines a donor-assisted human reproduction (DAHR) procedure as "any procedure performed in the State with the objective of it resulting in the implantation of an embryo in the womb of the woman on whose request the procedure is performed, where -

(a) one of the gametes from which the embryo has been or will be formed has been provided by a donor,
(b) each gamete from which the embryo has been or will be formed has been provided by a donor, or
(c) the embryo has been provided by a donor".[1]

People may elect to undergo DAHR for a number of reasons including if they have a fertility issue, a medical condition that makes pregnancy or childbirth with their own gametes impossible or dangerous, or are a LGBTQI+ couple or single individual wanting to have children.[2]

In Ireland, as of May 2026, there are no publicly-funded DAHR services.[3] Those wishing to undertake DAHR in Ireland must self-fund services in a private or not-for-profit clinic. The process of undertaking DAHR in Ireland includes, where appropriate consultations and investigations (such as blood tests and semen analysis); the purchasing and transfer of donor gametes from an international gamete bank (such as Cyros International Sperm and Egg Bank in Denmark[4]); the cost of the intervention itself (such as intrauterine insemination (IUI), in vitro fertilisation (IVF) and or intracytoplasmic sperm injection (ICSI)); and the storage of surplus gametes or embryos following the DAHR intervention.[5, 6] All of these elements contribute to the overall cost of DAHR, which can reach up to an estimated €10,000 per round.[7-10] Affordability is therefore often identified as a major barrier to accessing DAHR services.[11]

In recent years, a number of countries, including Armenia, France, Ireland and Norway, have expanded access to assisted reproductive technology (ART) (which 'includes all fertility treatments or procedures in which either eggs or embryos are handled to help achieve a pregnancy')[12] and IUI through increased public funding coverage.[13-15] However, the use of donor gametes may not be covered within these publicly-funded schemes. In 2025, the International Federation of Gynaecology and Obstetrics provided recommendations to ensure safe, equitable, and ethically responsible practices for all those involved in gamete donation (donors, recipients and offspring).[16] One of these key recommendations in regards to access and equity was to 'promote inclusive services with policies addressing financial barriers and supporting insurance or government funding'.[16]

To ensure access and equity to ART services nationally, there is a need for national policy to provide direction on the use of public funding to support the provision of DAHR services. This review aims to highlight the different approaches taken in a select number of EU and non-EU countries. The information contained in the report will inform the consideration of and development of a policy in relation to publicly-funded services for DAHR in Ireland, through supporting the work of the Department of Health.

2 Methods

A detailed summary of the methods used to conduct this review is provided in the *Protocol for a scoping review of publicly-funded services for donor-assisted human reproduction in selected countries*. In brief, this report presents the findings of a scoping review conducted to identify and summarise available information on publicly-funded services for DAHR in 10 selected countries.

Five EU countries were included (Denmark, France, Germany, Portugal and Sweden) as well as all UK countries (England, Northern Ireland, Scotland, and Wales) and Australia. The countries included were selected to include a combination of EU and non-EU countries, combined with other factors such as geographical proximity to Ireland, similar population size and or organisation of health services, and availability of published information on national DAHR policies.

Information was included from peer-reviewed publications, reports and evaluations, as well as grey literature sources such as policies and procedures, press releases, legislation and other legal documents. Within the identified documents, relevant information included, but was not limited to, the following elements:

- eligibility and or criteria for access (for example, information on age thresholds)
- interventions provided (for example, artificial insemination with donor sperm, and or IVF with donor eggs, sperm and or embryos)
- organisational aspects (for example, timelines to access services)
- donor material management by the clinic intending to conduct fertility treatment (for example, storage of received donated gametes and or embryos by a fertility clinic)
- governance (for example, organisational structures and governance arrangements)
- funding (for example, aspects of services that are fully or partially funded)
- counselling, communication, and information (for example, availability of appropriate information on DAHR options for relevant populations)
- ethical and social considerations (for example, potential benefits and harms of DAHR services)

- supporting legislation (for example, relevant primary and or secondary legislation that provides a legal basis for the provision and or funding of DAHR services)

When identifying relevant resources, documents and or information in documents focused on the following were deemed out of scope:

- DAHR services within private healthcare, not in receipt of public funding
- the initial donation and storage of gametes and or embryos, such as that performed at international gamete banks, for example Cryos Denmark[4] and Ovumia, Finland[17]
- surrogacy using donor gametes or embryos
- publicly-funded DAHR services occurring in a different country from the funding source, such as cross-border services.

Representatives from national-level organisations were contacted for confirmation of key documents and additional resources, as appropriate. Information identified up until 02 March 2026 was included for analysis within this scoping review. Any additional relevant information identified up until 16 April 2026 was noted in the discussion, where appropriate.

2.1 Terminology used in this report

Using inclusive and accurate language is a key consideration within this report, and it is acknowledged that there are a range of sexual orientations and gender identities. To ensure respect, clarity and readability, the following terminology is used:

- couple: may refer to opposite-sex, same-sex or LGBTQI+ couples, one of whom must have a womb and the potential to sustain a pregnancy
- individual: refers to a person who has a womb and the potential to sustain a pregnancy.

In instances where further clarification is required the following will be used:

- opposite-sex couple: may refer to heterosexual couples and couples where one person was assigned the gender female at birth and one person was assigned the gender male at birth
- same-sex couple: may refer to lesbian couples and couples where both partners were assigned the gender female at birth.

As surrogacy is not within scope for the current review, within this report an individual does not refer to a man or person with male reproductive organs, and a

same-sex couple does not include a couple consisting of two men or a couple where both partners were assigned the gender male at birth.

Additionally, as many of the included resources did not define their terminology used in regard to sexual orientation and or gender identity, best efforts were made to interpret this correctly within the report. However, the terminology used within Appendix E is directly as extracted from the included resources.

The term Assisted Human Reproduction (AHR) will be used to describe all fertility treatments intended to assist reproduction, and will represent terminology including ART, assisted fertilisation, medically-assisted procreation and medically-assisted reproduction.

3 Findings

The findings of the scoping review are presented in two main sections, as follows:

- Section 3.1 Identified resources: presents a descriptive summary of the relevant identified published and grey literature.
- Section 3.2 Summary of resource contents: presents a summary of the information identified for the selected countries with respect to their publicly-funded services for DAHR.

3.1 Identified resources

3.1.1 Published literature search results

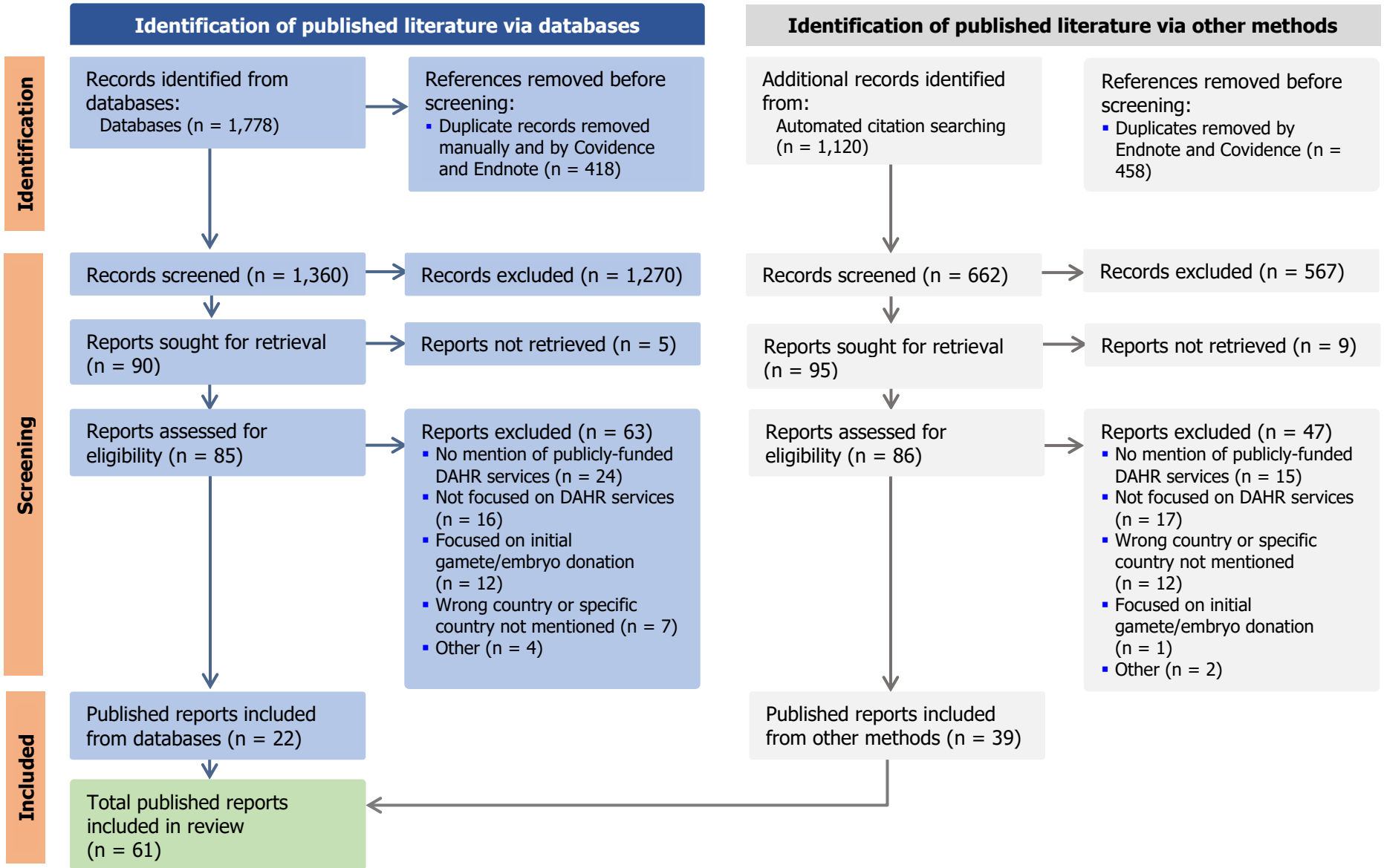
Overall search results are presented in Appendix A and the PRISMA flow diagram in Figure 3.1 below. The collective search, up until 22 January 2026 resulted in 2,502 potentially relevant records.

Searching of electronic databases resulted in 1,778 records. Following removal of duplicates, 1,360 records were screened for relevance, with 85 full texts assessed for eligibility and 22 reports subsequently included.

Automated backward and forward citation searching of all included articles was conducted via CitationChaser with 609 backward and 511 forward citation results identified. Following removal of duplicates and citations published before 2016, 662 records were screened and 86 additional records were identified and retrieved. Following eligibility assessment, 39 reports were subsequently included.

Reasons for exclusion of all reports which underwent full-text review were documented and summarised (see Appendix B).

Figure 3.1 PRISMA flow diagram



Characteristics of the included published literature

Sixty-one published literature reports were included in the review. A summary of the characteristics of the included published literature can be found in Appendix C. Of the 61 included resources, 56 were journal articles and the remainder were either commentary or opinions pieces, book chapters, or conference abstracts. Twelve studies included information related to publicly-funded DAHR services in Sweden, 10 in the UK, eight in Australia, seven in Germany, four each in Denmark and France, three in Portugal, and one in England. The remaining 12 studies included information relevant to multiple countries. The included studies were published between 2016 and 2025.

3.1.2 Grey literature

Multiple documents and or website resources were identified for all of the selected countries. These included government websites or the websites of government-mandated bodies, legislation, guidelines and policy documents. This resulted in information for an individual country identified from either:

- multiple resources published by a single government or a government mandated body, such as the legislation identified for Denmark[18-24]
- multiple resources published by a mixture of government, and or government-mandated bodies, such as for France[25-29] and Sweden.[30-36]

Additionally, documents containing information related to publicly-funded DAHR services at a UK level (while not specific to any individual UK country) were also included. As outlined in a *Protocol for a scoping review of publicly-funded services for donor-assisted human reproduction in selected countries*, in countries such as Australia that operate regionally, information on publicly-funded DAHR services specific to an individual state or territory was excluded. In England, National Health Service (NHS) AHR policies can vary across the seven NHS regions:

- East of England
- London
- Midlands
- North East and Yorkshire
- North West
- South East
- South West.

Within each region, a number of Integrated Care Systems (ICS) are in place, which act as partnerships between organisations to meet the health and care needs of those in the area. Within each ICS a single Integrated Care Board (ICB) is responsible for planning health services for the local population. In the absence of a

single national policy in England, a sample ICB policy from one ICS was selected at random from each of the seven NHS regions. Where a consolidated policy was not identified for the randomly selected ICS (that is, previous NHS Clinical Commissioning Group (CCG) policies were still in place), an alternative ICS in the same region was selected.

Similarly, Scotland has 14 territorial Health Boards that there are responsible for the protection and the improvement of their population's health. Across these 14 Health Boards there are four NHS Assisted Conception Units (ACUs), the Edinburgh Fertility Centre (NHS Lothian),[37] the Glasgow Royal Infirmary Assisted Conception Service (NHS Greater Glasgow and Clyde),[38] the Aberdeen Fertility Centre (NHS Grampian)[39] and the Ninewells Dundee ACU.[40] These four ACUs were included for extraction.

Table 3.1 Identified grey literature documents or resources related to publicly-funded services for DAHR in the selected countries

Country	Policy	Legislation	Other (for example, websites or guidelines)
EU countries			
Denmark	1. New agreement to help involuntarily childless people get pregnant[41] (and implementation agreement[42]) 2. New agreement provides twice as many fertility attempts for child number two[43] (and implementation agreement[44])	1. LBK no. 902 of 23/08/2019: Executive Order on the Act on Assisted Reproduction in Connection with Treatment, Diagnostics and Research, etc.[19] and all associated and relevant executive order and circulars including: ▪ BEK No. 316 of 27/03/2019[20] ▪ LAW No. 129 of 30/01/2021[21] ▪ ACT No. 1212 of 26/11/2024[22] ▪ ACT No. 1213 of 26/11/2024[23] ▪ BEK No. 1452 of 01/12/2025[24] 2. ROAD no 9351 of 26/05/2015: Guidance on the activities and obligations of healthcare professionals and tissue establishments in the field of assisted reproduction[45]	1. Trianglen Fertility Clinic: Fertility Treatment via a public health referral at Trianglen[46] 2. LGBT Familie: Access to assisted reproduction[47, 48] 3. Fertility Clinic Skive: Fertility Treatment[48] 4. Rigshospitalet: The Fertility Clinic[49]
France	N/A	1. Public Health Code: Title IV: Medically assisted procreation (Articles L2141-1 to L2143-9)[28] 2. Public Health Code: Chapter IV: Donation and use of gametes (Articles L1244-1 to L1244-9)[29]	1. Service Public: Medically assisted genetic procreation 2025[25] 2. L'Assurance Maladie: Assisted Reproductive Technology (ART)[26] 3. Biomedicine Agency: Procreation-medical.fr[27] and associated webpages.

Country	Policy	Legislation	Other (for example, websites or guidelines)
Germany	1. Federal Republic of Germany: Apply for cost coverage for measures to induce pregnancy[50] 2. Federal Ministry for Education, Family Affairs, Senior Citizens, Women and Youth: Fertility Information Portal[51]	1. Social Code Book 5: Statutory Health Insurance: Section 27a – Artificial insemination[52] 2. Act for the Protection of Embryos (Embryo Protection Act - ESchG)[53]	1. Guideline of the Federal Ministry for Education, Family Affairs, Senior Citizens, Women and Youth on the granting of subsidies for the promotion of ART measures[54] 2. D.I.R (Deutsches in vitro fertilisation (IVF) Register) Annual 2023 – The German IVF-Registry[55]
Portugal	N/A	1. Law No.32/2006: Medically assisted procreation (Consolidated Legislation currently in force)[56] 2. Law No. 12/2009: Establishes the legal framework for quality and safety relating to the donation, collection, analysis, processing, preservation, storage, distribution and application of tissues and cells of human origin, transposing into national law (Consolidated Legislation currently in force)[57] 3. Ordinance No. 300/2024/1, of 25 November: Reimbursement of medicines intended for the treatment of infertility.[58] 4. Regulatory Decree No. 6/2016, of 29 December: Regulates medically assisted procreation[59]	1. National Council for Medically Assisted Reproduction[60]
Sweden	N/A	1. Act (2006:351) on Genetic Integrity, etc.[30] 2. SOSFS 2009:32 Use of tissues and cells in healthcare and clinical research etc.,[31] and amendment[61]	1. National Board of Health and Welfare: Assisted fertilisation with donated gametes guidelines[33] 2. Recommendations for homogeneity in county councils' and regions'

Country	Policy	Legislation	Other (for example, websites or guidelines)
			publicly funded assisted reproduction offers[35]
Non-EU countries			
Australia	1. Medicare Benefits Schedule[62] 2. Services Australia: ○ ART services[63] ○ Item numbers for billing Assisted Reproductive Technology services[64]	N/A	1. National Health and Medical Research Council: Ethical guidelines on the use of assisted reproductive technology in clinical practice and research[65] 2. ART Storage Funding Program and Guidelines[66] 3. Parliament of Australia: Regulation of donor conception practices[67]
UK	N/A	Human Fertilisation and Embryology Act 2008[68]	1. National Institute for Health and Care Excellence (CG156) Fertility problems: assessment and treatment[69]* 2. Human Fertilisation and Embryology Authority[70] 3. Fertility Network UK[71] 4. General Debate: IVF provision[72]
England	Integrated Care Board (ICB) polices by National Health Service (NHS) Region and Integrated Care System: 1. East of England Region ▪ NHS Cambridgeshire & Peterborough: Assisted Conception[73] 2. London Region	N/A	Guidance: NHS-funded IVF in England[80]

Country	Policy	Legislation	Other (for example, websites or guidelines)
	▪ North East London: Fertility Policy[74] 3. Midlands Region ▪ NHS Staffordshire and Stoke on Trent ICB Commissioning Policy Assisted Conception for Infertility[75] 4. North East and Yorkshire Region ▪ Yorkshire and Humber Access to Infertility Treatment Commissioning Policy Document[76] 5. North West Region ▪ NHS Lancashire and South Cumbria ICB Policy for Assisted Conception Services[77] 6. South East Region ▪ Schedule of policy statements for ART for Kent and Medway ICB[78] 7. South West Region ▪ NHS Devon Assisted Conception Commissioning Policy[79]		
Northern Ireland	Eligibility for HSC (Health and Social Care Trust) funded IVF and related treatments effective from 1st June 2019[81]	N/A	Belfast HSC Trust. Regional Fertility Centre[82]

Country	Policy	Legislation	Other (for example, websites or guidelines)
Scotland	1. Access Criteria for: ▪ NHS IVF Treatment in Scotland[83] ▪ NHS-Funded Donor Insemination[84]	N/A	1. Fertility Scotland (NHS Scotland) National Strategic Network[85] 2. NHS Scotland: Right Decision Service: Infertility[86] 3. National Infertility Group Report (March 2016)[87] 4. NHS Scotland Assisted Conception Units (ACUs): ▪ Edinburgh Fertility Centre – NHS Lothian[88] ▪ Glasgow Royal Infirmary Assisted Conception Service[38] ▪ Aberdeen Fertility Centre[39] ▪ Assisted Conception Unit | Ninewells Dundee | Dundee ACU[40]
Wales	NHS Wales. Specialised Services Commissioning Policy: CP38 Specialist Fertility Services[89]	N/A	Wales Fertility Institute[90]

Key: ACU = Assisted Conception Unit; ART = assisted reproductive technology; HSC = Health and Social Care Trust (Northern Ireland); ICB = Integrated Care Board (England); IVF = in vitro fertilisation; LGBT = lesbian, gay, bisexual and transgender; NHS = National Health Service (UK); UK = United Kingdom.
*NICE Guideline CG156 was updated and replaced by NICE guideline NG257 Fertility problems: assessment and treatment,[91] published on 31 March 2026. The updated guideline was not included for analysis, however relevant information is discussed in Section 4, Discussion.

3.2 Summary of resource contents

The data extracted from both published and grey literature for each of the selected countries is summarised in the following sections:

- DAHR interventions available and eligible populations
- funding
- organisational aspects
- donor material management
- governance
- counselling, communication, and information provision
- ethical and social considerations
- legislation.

Due to the variability observed across the selected countries in the DAHR interventions available and the eligible populations, detailed information is outlined for each country individually in Section 3.2.1. However, for the remaining sections (3.2.2, Funding to 3.2.8, Legislation) a high-level summary approach is taken.

When summarising the information extracted it was noted that, across the selected countries, AHR and DAHR are closely linked, particularly in relation to eligibility criteria, access pathways, funding sources, governance structures, and legislative frameworks. For example, many of the selected countries apply very similar eligibility criteria for both AHR and DAHR interventions, with the use of donor material then incorporated into existing AHR pathways where required or clinically indicated and publicly funded. As a result, throughout Sections 3.2.1 to 3.2.8 broader AHR policies and services arrangements are often described, with information specific to donor-related components of fertility care then highlighted.

3.2.1 DAHR interventions available and eligible populations

Donor-assisted human reproduction interventions which require donor sperm, donor eggs, or donor sperm and donor eggs (double donation) were identified as having at least part-funding in nine of the selected countries (see Table 3.2). Embryo donation is not legally permitted in Denmark,[19] and egg donation is not legally permitted in Germany.[53] In Germany, there is no financial support from federal and state funds for DAHR services; however, some states have specific funding initiatives which same-sex couples can apply for (such as Bremen).[51] Further, detailed information related to the DAHR interventions available, and the eligible populations is provided (see Appendix D, Table D 1) and by individual country below.

Table 3.2 Donor-assisted human reproduction interventions that are publicly-funded in selected countries

	Is there some public-funding for IUI, IVF and or ICSI with donor gametes?						Is there some public-funding for IVF and or ICSI with donor embryos?	
	With donated sperm?		With donated eggs?		With donated sperm plus donated eggs (double donation)?		Couples	Individuals
Country	**Couples**	**Individuals**	**Couples**	**Individuals**	**Couples**	**Individuals**		
Australia	Yes[a]	Yes[a]	Yes[a]	Yes[a]	Yes[a]	Yes[a]	Yes[a]	Yes[a]
Denmark	Yes	Yes	Yes	Yes	Yes	Yes	Embryo donation is not legally permitted for AHR	
France	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Germany	No[b]	No[b]	Egg donation is not legally permitted				Unregulated and unclear	
Portugal	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Sweden	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
UK								
England	Varies depending on the ICB and or region.							
Northern Ireland	Yes[c]	Unclear	Yes[c,d]	Unclear	Yes[c,d]	Unclear	Unclear	
Scotland	Yes	No	Yes	No	Yes	No	Unclear	
Wales	Yes[e]	Yes[e]	Yes[f]	Yes[f]	Yes[e,f]	Yes[e,f]	Unclear	

Key: ICB = Integrated Care Board (England); ICSI = intracytoplasmic sperm injection; IUI = intrauterine insemination; IVF = in vitro fertilisation; UK = United Kingdom.
[a]Medicare reimbursement is provided for specific fertility treatment use for DAHR. The cost of donor gametes and or embryos **is not** publicly-funded.
[b]Under the healthcare system, financial support from statutory health insurance is currently only available for married couples, in which the egg and sperm cells of the partners are used. Some states however do offer subsidies for unmarried and same-sex couples, but that is the exception rather than the rule.
[c]Same-sex couples are eligible if they meet the same eligibility criteria as opposite-sex couples.
[d]The Regional Fertility Centre does not have a bank of donor eggs but will advise eligible recipients how they can attempt to identify someone who may be able to donate an egg.
[e]For donor insemination, the procedure is funded by the Health Board, and the donor sperm is funded by the Welsh Health Specialised Services Committee (WHSSC). While IVF and ICSI are funded in Wales, it is unclear if the donor sperm for these procedures is funded.
[f]Egg donation may be available to those who meet certain criteria; however the patient must be able to identify and provide a donor, either through altruistic egg donation or through an individual agreement. WHSSC will not fund IVF for patients participating in the egg sharing schemes.

Australia

Artificial insemination, IVF and or ICSI

Artificial insemination, IVF and or ICSI using donor gametes or embryos are partially publicly funded through the Medicare reimbursement system for couples and individuals in Australia (see Section 3.2.2, Funding). To be eligible for Medicare rebates for DAHR services the patient must permanently reside in Australia.

Medicare rebate is restricted to treatments that are clinically relevant. As a result, access to publicly-funded DAHR services is limited to individuals with an identified medical need, such as infertility, and a referral from a general practitioner (GP) or specialist gynaecologist and or obstetrician.[63] As of 2024 the definition of infertility was broadened to 'the inability to achieve a successful pregnancy based on a patient's medical, sexual, and reproductive history, age, physical findings, diagnostic testing, or any combinations of these factors' and 'the need for medical intervention to achieve a successful pregnancy'.[92] Medicare rebate does not extend to elective fertility treatment.[62]

Following this, at national level there are no further eligibility criteria for access to rebates for DAHR treatment. At state level, jurisdictions may apply their own eligibility criteria for AHR or DAHR treatment, for example in Victoria the woman or birthing person must be under 46 years old to access IVF for the first time, and under 51 years old for embryo transfers.[93] Ultimately, however, the decision as to who to treat, and the intervention provided, lies with the treating clinician.[94] There is no limit to the number of cycles or rounds of DAHR services which someone can be reimbursed for through Medicare.[95]

Further interventions and or services

In Australia, pre-implantation genetic diagnosis (PGD) is covered by a Medicare rebate for couples with a high risk of having a child affected by a genetic disorder.[96] Eligibility for Medicare PGD items is restricted to patients and a reproductive partner (where appropriate) with a recognised risk of having a child affected by a Mendelian or mitochondrial disorder, autosomal dominant disorder, or chromosome disorder for which there is no curative treatment and there is a severe limitation of quality of life despite contemporary management.[96] Reception of oocytes from partners (ROPA) (or reciprocal IVF) is legally permitted in Australia; however, it was unclear from the included resources if it is publicly-funded.

Denmark

Artificial insemination, IVF and or ICSI

Artificial insemination, IVF and or ICSI, using donor gametes are partially publicly funded for couples and individuals in Denmark. Examination and treatment are free of charge; however, patients are required to pay for medication needed during treatment at subsidised rates.[47] Embryo donation is only legally permitted in Denmark for research purposes.[24] To be eligible for publicly-funded AHR and or DAHR services, the following eligibility criteria must be met:[19]

- There must be a treatment indication. Generally, it is required that there is attempted pregnancy for at least 12 months if the person is under 35 years old and there are no obvious causes of infertility. This does not apply to individuals who want to be pregnant, same-sex couples, and those where there may be one or more significant fertility-reducing biological factors in the couple or in the individual (including advanced age in the individual).
- In public clinics, treatment is only offered if the woman or birthing person is referred before they are 40 years old, and treatment is not provided after the age of 41 years. A woman or birthing person between 41 and 45 years old can still receive a referral for fertility evaluation; however, if fertility treatment such as IVF is initiated, it will be self-funded, and the woman or birthing person cannot be older than 45 years.
- Regionally, hospitals may only provide AHR to individuals who do not have children and couples who do not have children together. An individual or a couple who has had a child through AHR and who, after the end of treatment, still has frozen eggs, are, however, offered egg freezing in the public hospital system with a view to the couple or individual being able to have more children.[19]

Following this, clinical investigations (such as a gynaecological examination, and or semen analysis) must be carried out to clarify the cause of possible conception difficulties.[45] These examinations will not necessarily be relevant to perform for individuals or same-sex couples.

A health assessment of the individual who will potentially undergo AHR and or DAHR is then undertaken, to inform them of any risk associated with the treatment, pregnancy and or childbirth.[45] The couple or individual's fitness to be a parent must then be assessed, and includes evaluations of:[20]

- any substance abuse problems in the individual or couple
- the mental state of the individual or couple, which may affect their ability to care for a future child
- circumstances that may result in the child being placed outside the home or that one or both prospective parents already have a child who is placed outside the home because of family circumstances.[20]

Once the initial eligibility is met and the above assessments are completed, the couple or individual will then be publicly-funded for a:

- first child: up to three IUI treatments, and or six cycles of IVF and or ICSI[41]
- second child: up to six cycles of IVF and or ICSI.[43]

However, fewer attempts may be offered if the chances of success are deemed very low. Additionally, the transfer of frozen embryos is not counted as a new cycle. Where donor gametes are required these are also publicly funded. These are ordered by the fertility clinic in the public hospital free of charge using a set selection criteria outlined within the agreement between the fertility clinic and the gamete bank (the standard offering).[97] If an individual wishes to add additional criteria (such as reservations for donor sperm, selecting a donor from the USA, or seeing photos of the sperm donor as an adult) during gamete selection, then they must purchase the gamete themselves.[97] Where a known sperm donor is used, individuals and couples must pay for all costs associated with screening, and storage of the donor sperm.[24]

Further interventions and or services

In Denmark, PGD is permitted and publicly funded where there is a known and significantly increased risk of giving birth to a child with a serious hereditary disease.[19] Counselling and examination must first be provided at a clinical genetics department. Examples of chromosomal abnormalities that would be covered include:[45]

- Trisomy-21 (Down syndrome)
- Trisomy-18
- Trisomy-13
- or XXY (Klinefelter)
- any chromosomal change that is not compatible with long-term survival is included.[45]

ROPA is legally permitted in Denmark, however it is not publicly funded and is offered at private fertility clinics for a fee.[46]

France

Artificial insemination, IVF and or ICSI

Artificial insemination, IVF and or ICSI using donor gametes or embryos are fully publicly funded for couples and individuals in France. To be eligible for publicly-funded AHR and or DAHR services in France, firstly (where appropriate):[25, 26]

- egg retrieval must be conducted before the woman or birthing person is 43 years old, and sperm collection must be conducted before the man or person producing sperm cells is 60 years old
- use of gametes and embryos must be undertaken before the woman or birthing person is 45 years old and before the other member of the couple is 60 years old.[25, 26]

Couples are not required to be married or provide proof of living together for a defined time period.[27]

To be eligible for AHR and or DAHR services, a medical evaluation must then be undertaken by a team at an AHR centre. This allows the doctor in the AHR centre to choose the most suitable solution for the couple or individual.[27] French law also requires that the implementation of AHR be preceded by several private meetings between the couple or individual, and the members of the centre's multidisciplinary team. Factors considered within these meetings include:[28]

- the motivation of both members of the couple (or of the individual)
- informing both members of the couple (or the individual) of the possibilities of success or failure of AHR techniques, their side effects, their short and long-term risks, and their challenges and constraints
- specifically in the case of DAHR, informing both members of the couple (or the individual) of the terms and conditions of access to non-identifying data and the identity of the third-party donor by the donor-conceived person.[28]

The couple or individual then has a reflection period of one month, after which they confirm in writing their consent to a notary for undergoing DAHR services.[28]

Following this, up to six inseminations and four cycles of IVF and or ICSI are fully publicly funded.[25] The use of donor gametes and or embryos are fully publicly-funded, with indications for either and or both including risk of transmitting a genetic disease to the child, infertility in either member of the applicant couple (where appropriate), or AHR in an individual.[25] Double donation is also allowed and funded, where necessary.[25, 27]

Further interventions and or services

In France, PGD is publicly funded and offered to couples with "a high probability of giving birth to a child with a genetic disease of particular seriousness recognised as incurable at the time of diagnosis".[26] Each request for PGD is studied by the multidisciplinary centre for prenatal diagnosis in each region, which must validate the indication for PGD. The intervention is only performed in one of five centres in France.[26] ROPA is not legally permitted in France.[27] This is based on the fact that

egg retrieval (except for use in IVF for the person from which the egg is retrieved, and or self-preservation) cannot have any other purpose than an anonymous donation.[27]

Germany

Artificial insemination, IVF and or ICSI

Artificial insemination, IVF and or ICSI, using donor gametes and or embryos are not publicly funded in Germany. This is because the main requirements for accessing publicly-funded AHR treatment in Germany are:[52]

- the couple cannot become pregnant naturally
- from a medical point of view, artificial insemination measures are suitable for bringing about a pregnancy
- the couple are married and use their own egg and sperm cells
- the woman or birthing person must be 25 to 39 years old, and the man or person producing sperm cells must be 25 to 49 years old.[52]

At state level there may be subsidies for unmarried couples and same-sex couples, but that is the exception rather than the rule.[51]

Further interventions and or services

In Germany, PGD is legally allowed if parents have a predisposition to a serious genetic illness. However, even in cases in which artificial insemination is allowed and publicly reimbursed (see above), PGD is not publicly funded.[98] ROPA is not legally permitted in Germany.

Portugal

Artificial insemination, IVF and or ICSI

Artificial insemination, IVF and or ICSI using donor gametes or embryos are partially publicly funded for couples and individuals in Portugal. Patients are required to pay some costs toward infertility-related medicines (see Section 3.2.2, Funding). There is no requirement for a diagnosis of infertility; however, DAHR treatments are only publicly funded if they are carried out before the individual receiving fertility treatment is 40 years of age (for IVF and ICSI), or 42 years of age (in the case of artificial insemination).[60] For couples, there is no maximum age limit for the partner.

In public centres, each couple or individual is entitled to undergo three artificial inseminations and three cycles of IVF and or ICSI, as long as the beneficiary's age limit is not exceeded. Cryopreserved embryo transfers are not included in the count

of this three-cycle limit.[60] In the case of same-sex couples, the decision regarding the member of the couple who undergoes artificial insemination or IVF rests with the couple, unless there is a clinical reason for not performing a DAHR technique.

In general, the main indications for artificial insemination include ovulation problems, changes in sperm number and motility, and sexual dysfunction. The main indications for IVF include bilateral obstruction or absence of the fallopian tubes, and or endometriosis. The main indications for ICSI include severe infertility in the man or person with male reproductive organs (where appropriate) and cases of zero or very low fertilisation in a previous IVF.[60]

The use of donor gametes and or embryos is permitted and publicly funded when, in the view of the available medical and scientific knowledge, it is not possible to obtain pregnancy or pregnancy without a serious genetic disease through the use of the gametes of the beneficiaries.[56]

DAHR treatment can be justified using:[60]

- donor sperm: in situations including azoospermia, surgical removal of testicles or in treatments for same-sex couples, or individuals.
- donor eggs: in situations including early ovarian failure, repeated failure in treatment using a couple or individuals own eggs, and in late motherhood (from the age of 38 years) where there may be a decreased number of eggs and or the eggs may have genetic alterations.
- double donation or donor embryos: in situations where it is impossible to obtain a pregnancy due to medical infertility or where gametes are not produced by either intended parent.[60]

Further interventions and or services

In Portugal, PGD is permitted for families with alterations that cause early death or serious illness and there is a high risk of transmission to their offspring. However, it is unclear from the resources included if PGD is publicly funded. The Serviço Nacional de Saúde (SNS) (National Health Service) in Portugal also does not allow a same-sex couple to undergo DAHR treatment at the same time, and it is unclear whether ROPA is available within publicly-funded DAHR services.[59]

Sweden

Artificial insemination, IVF and or ICSI

Artificial insemination, IVF and or ICSI using donor gametes or embryos are fully publicly funded for couples and individuals in Sweden. These services must be

undertaken in publicly-funded clinics in University Hospitals. To be eligible for DAHR services an infertility investigation must first be undertaken. This is available to:[33]

- opposite-sex couples who have tried to have a child for a year without a pregnancy (if it is known that there are medical reasons for the infertility, the one-year wait does not apply)
- same-sex couples and individuals who want a child.

For opposite-sex couples, the investigation assesses if there is a reasonable possibility of having children naturally, and if the couple has the potential to become pregnant. For same-sex couples and individuals, the investigation assesses if they have the potential to become pregnant through DAHR. After the investigation, and once the patients meet the age criteria and pass a number of comprehensive assessments (see below), public funding is available for up to six rounds of IUI, three rounds of IVF and or ICSI, or a combination of the two. It is decided individually for each couple and or individual which treatment the healthcare system offers, and the choice of treatment depends on which causes have been found in regard to infertility.[33]

Firstly, to be offered any publicly-funded AHR and or DAHR interventions the Swedish Association of Local Authorities and Regions (SALAR) stipulates that:[35]

- the woman or birthing person must be under the age of 40 years old (any frozen embryos can be transferred until the woman or birthing person turns 45 years old) and (where appropriate) the man or person with male reproductive organs must be under the age of 56 years old
- couples cannot have any joint or adopted children, and individuals cannot be registered guardians of any children.

Additionally, SALAR recommend that the lower age limit for applying for AHR should be at least 25 years old (on par with the age limit that applies for applications for adoption), and at a local level the regions may alter the eligibility criteria (such as age) that they apply to applicants.[35]

Following this, specifically in the case of DAHR, a special assessment must also be undertaken by behavioural specialists. This assessment includes taking into account the couple or single person's:[30, 33]

- age: for example, applicants must be young enough to act as parents at least until the child reaches 18 years.
- health status and any functional impairments: this includes any physical or mental illness or extensive functional impairment, which can mean reduced capacity and parental ability during a child's upbringing, and or any risky use or abuse of alcohol, drugs and so on. The applicant needs to be able to have

close and continuous physical and psychological contact with the child and be able to provide for the child's care and safety needs.

- attitude towards telling the child about their biological origin: a person who has been conceived through donation treatment in Sweden and who has reached sufficient maturity has the right to access information about the donor in the healthcare system.
- previously neglected children: including any known deficiencies in parental ability, such as previous children of the applicant having been neglected or exposed to and or taken into care.
- serious crime: including violent crimes, assaults, and crimes that indicate impulsiveness, poor judgment, lack of empathy and lack of respect or integrity.
- relational aspects: including signs of violence, uncertainty about the relationship and if the request for donation treatment is not well thought out. Couples undergoing donation treatment must be able to handle the fact that one of the parents will have no genetic connection to the potential child.
- uncertainty about relationship: an important prerequisite for someone to undergo donation treatment as a single person is that the person is single. This means that the person is not married, does not have a registered partner, or does not have a cohabitant.
- social networks: lack of a well-functioning social network and thus lack of opportunity for sufficient support and relief are examples of a risk factor to take into account.
- insight and attitude: a person who becomes a parent through donation must be able to deal with the fact that the child has a different genetic origin with a genetic connection to other people.[30, 33]

A medical assessment is then also undertaken which may include a number of elements including the medical history of the applicants, infection samples, and genetic counselling. The purpose of the medical assessment is to ensure that the treatment or pregnancy does not endanger the health of the potential child and the person who will carry them.[33]

Further interventions and or services

In Sweden, PGD is publicly funded; however, it may only be used if an intended parent carries a predisposition for a serious monogenic or chromosomal hereditary disease, which entails a high risk of having a child with a genetic disease.[30] The treatment must not be used to select a trait and must only be aimed at ensuring that the child does not inherit a predisposition for the disease in question. Pre-implantation genetic diagnosis may not be used without permission from the National Board of Health and Welfare to try to have a child with such a gene set that

the child could become a donor of blood stem cells for a seriously ill sibling. Permission may only be granted if there are exceptional reasons to allow use.[30] No information on publicly-funded ROPA in Sweden was identified in the included resources.

UK

Artificial insemination, IVF, and or ICSI

Publicly-funded DAHR services are provided at country-level within the UK (with local variation within countries also apparent). However, the 2013 NICE CG156 guidelines for *Fertility problems: assessment and treatment,*[69] provide evidence-based recommendations on what AHR and DAHR services should be offered (generally) and the medical indications required.[3] Where UK countries offer publicly-funded AHR and or DAHR services in line with NICE recommendations, this is indicated within individual country summaries.

The NICE Guidelines recommend IUI as alternative to vaginal intercourse for those:

- who are unable to, or would find it very difficult to, have vaginal intercourse because of a clinically diagnosed physical disability or psychosexual problem, who are using partner or donor sperm
- in same-sex relationships
- who have not conceived after six IUI cycles with donor or partner sperm, despite evidence of normal ovulation, tubal patency and semen analysis, are then offered a further six cycles of unstimulated IUI before IVF is considered.

There are specific indications for donor insemination also, including obstructive azoospermia, severe deficits in semen quality in couples who do not wish to undergo ICSI, and where there is a high risk of transmitting a genetic disorder to the offspring.

Following this, the recommended eligibility criteria for IVF and ICSI includes, for women or birthing people:

- aged under 40 years:
    - who have not conceived after two years of regular unprotected intercourse or 12 cycles of artificial insemination (where six or more are by IUI), offer three full cycles of IVF, with or without ICSI

[3]NICE CG156 was replaced by NICE NG257 on 31 March 2026. The 2026 guideline was not included for analysis but is discussed in Section 4.

    - if the woman or birthing person reaches the age of 40 during treatment, complete the current full cycle but do not offer further full cycles
    - any previous full IVF cycle, whether self- or NHS-funded, should count towards the total of three full cycles that should be offered by the NHS.

- aged 40 to 42 years:
    - who have not conceived after two years of regular unprotected intercourse or 12 cycles of artificial insemination (where six or more are by IUI), offer one full cycle of IVF, with or without ICSI, provided the following three criteria are fulfilled:
        - they have never previously had IVF treatment
        - there is no evidence of low ovarian reserve
        - there has been a discussion of the additional implications of IVF and pregnancy at this age.

Any woman or birthing person undergoing IVF and or ICSI should also have a body mass index (BMI) between 19 and 30. Indications for the use of donor eggs are also outlined and include premature ovarian failure, gonadal dysgenesis (including Turner syndrome), and bilateral oophorectomy.

Further interventions and or services

For country-specific information on the availability of further interventions and or services that are publicly funded in the UK, see below.

England

Artificial insemination, IVF and or ICSI

In England, public funding for DAHR interventions varies extensively, depending on the Integrated Care Board (ICB). Individual ICBs make final decisions on who should have access to NHS funding in their regions, and their eligibility criteria are often stricter than the criteria recommended by NICE guidelines.[99] The following eligibility criteria for AHR and DAHR services often vary depending on the region:[99]

- the woman or birthing person's age: some ICBs fund treatment for those under 35 years, and others fund treatment for those up to and including 42 years of age (in line with NICE guidelines)
- relationship stability: some ICBs require couples to have been in a relationship for at least two years

- definition of childlessness: some ICBs state that no funding will be granted if either partner already has a child, whilst others will still fund if one partner has a child from a previous relationship
- time to conceive: some ICBs specify a period of one to two years, while others specify a minimum of three years trying to conceive.

Additionally, same-sex couples and or individuals may not be specifically called out in ICB policies or may be required to meet the same eligibility criteria as opposite-sex couples. This may include a requirement of infertility or subfertility. To meet this criteria, same-sex couples and or individuals may need to self-fund up to six rounds of artificial insemination first.[99]

For the ICBs included within the current review the following was identified. For IUI, in Cambridgeshire and Peterborough ICB up to three rounds will be funded under exceptional circumstances,[73] while in Devon,[79] Kent and Medway,[78] North East London[74] and Yorkshire and Humber[76] ICBs six rounds of IUI will be publicly funded, but only after the private funding of six rounds of IUI and or artificial insemination. Additionally, while Devon[79] and Yorkshire and Humber ICBs[76] outline that the donor sperm will be funded, North East London ICB[74] states that the donor sperm must be privately funded, and Staffordshire and Stoke-on Trent ICB state that donor sperm is not routinely funded.[75] Staffordshire and Stoke-on-Trent also do not fund IUI as they state that the NICE guidelines[69] outline that there is no apparent health benefit from it, and there are potential risks associated with IUI both with and without stimulation when compared with expectant management (as in encouraging conception through unprotected vaginal intercourse).[75] For IVF and or ICSI, Cambridgeshire and Peterborough[73] and Yorkshire and Humber[76] will fund one full cycle of IVF and or ICSI (defined as one episode of ovarian stimulation and the transfer of resultant fresh and frozen embryos), while Devon ICB will fund one cycle of IVF and or ICSI (defined as one fresh and one frozen implantation of embryos).[79] Kent and Medway will fund two full cycles (and a maximum of four embryo transfer procedures),[78] and North East London ICB will fund up to three full rounds of IVF and or ICSI for women or birthing people aged less than 40 years old, and one full round of IVF and or ICSI for those aged 40 to 42 years old (in line with NICE guidelines).[74]

In regard to those who require donor sperm, this is funded as previously stated. Additionally, Yorkshire and Humber ICBs state that couples who request the use of a known clinically-appropriate sperm donor will be responsible for all costs associated with the donor, including transportation costs.[76] For those who require donor eggs, six of the included ICBs outline that donor eggs will be publicly funded for those who meet the eligibility criteria outlined by NICE guidelines (see UK).[73-76, 78, 79] Some of the ICBs included will source and fund the donor eggs required, and the patient will

be placed on a waiting list until an altruistic donor can be identified. Alternatively, the patient can provide an egg donor.[73, 78] North East London ICB will not fund or source donor eggs but will fund the cost of the IVF and or ICSI procedure. This is due to significant practical and logistical issues relating to NHS-funding of donor sperm and eggs.[74] Lancashire and South Cumbria ICB outline that AHR to create an embryo entirely from third-party gametes will not be funded.[77]

Further interventions and or services

In England, PGD is commissioned by NHS England and there is a mandatory criteria for couples to receive NHS-funding for three full cycles, these include:[100]

- the couple must be at risk of having a child with a serious genetic condition
- the couple must have been referred to the PGD provider by an NHS Clinical Genetics Service
- the risk of conceiving a pregnancy affected by a serious genetic condition must be 10% or more
- the couple must have received genetic counselling from a clinical geneticist or a registered genetic counsellor.

Further criteria (such as age and BMI) are in line with the eligibility criteria for IVF and or ICSI recommended by the NICE guidelines. In regard to ROPA, Kent and Medway ICB outline that NHS-funded AHR treatment should not be undertaken concurrently in both partners of a couple, or in one partner where the other is pregnant.[78]

Northern Ireland

Artificial insemination, IVF and or ICSI

Publicly-funded DAHR interventions are limited and or unclear in Northern Ireland, specifically in terms of those who meet the eligibility criteria. While a key representative confirmed that the 2013 NICE guidelines have been endorsed as applicable for Northern Ireland, they noted that expansion of the services provided is dependent on the resources available.[101] Firstly, to access IVF and or ICSI in Northern Ireland, in the absence of any known cause of infertility, clinical assessment and investigation should be undertaken where:[81]

- a woman or birthing person has not conceived after one year of unprotected vaginal sexual intercourse, or
- using artificial insemination (with either partner or donor sperm), a woman or birthing person has not conceived after four cycles of artificial insemination. Following these four cycles of artificial insemination, four cycles of IUI should be offered before IVF referral.[81]

There is no indication from the included resources that the initial four cycles of artificial insemination are publicly funded. However, the key representative from Northern Ireland confirmed that donor sperm is provided by the Regional Fertility Centre (RFC) for publicly-funded treatment, if clinically indicated (possibly the latter four cycles if IUI).[101]

Following this, to be eligible for one full cycle of IVF or ICSI (classified as the use of all fresh and frozen embryos created during one IVF and or ICSI cycle):[81]

- a fertility problem must have been demonstrated at the previous investigation
- or a woman or birthing person must have not conceived after two years of regular unprotected vaginal intercourse (including the year prior to being referred for investigation)
- or eight cycles of artificial insemination (where at least four are by IUI) must have been previously undertaken.

Further eligibility criteria for the provision of IUI, and or IVF and or ICSI are:[81]

- the woman or birthing person's age: must be under 40 years of age, or between the age of 40 and 42 and meet the following requirements:
    - have never previously had IVF treatment
    - have no evidence of low ovarian reserve
    - and there has been a discussion of the additional implications of IVF and pregnancy in this age group.
- the woman or birthing person's BMI: in line with NICE guidelines, a BMI of between 19 and 30. Those with a BMI over 30 and who are not ovulating should be informed that losing weight is likely to increase their chance of conception. Those with a BMI of over 30 should be referred to a group programme involving exercise and dietary advice to lose weight.
- previous AHR treatment: neither the woman or birthing person, nor their partner, must have had three or more IVF cycles previously (including both publicly funded and private treatment).
- sterilisation: neither the woman or birthing person, nor their partner, have undergone a voluntary sterilisation procedure, even if reversed. This does not include conditions where sterilisation occurs as a result of another medical problem.
- smoking: women or birthing people who smoke should be informed this is likely to reduce their fertility. They should be encouraged to abstain from smoking for three months prior to IVF.
- alcohol intake: women or birthing people who are trying to become pregnant should be informed that drinking no more than one to two units of alcohol once or twice per week and avoiding intoxication reduces the risk of harming

a developing fetus. Men or people with male reproductive organs should be advised that excessive alcohol intake is detrimental to semen quality.

- treatment will only be provided to people who have been assessed by the clinic as meeting Human Fertilisation and Embryology Authority (HFEA) requirements on the welfare of any child who may be born as a result and of any other child who may be affected by the birth.[81]

As with IUI, donor sperm is provided by the RFC for publicly-funded treatment, if clinically indicated. The RFC does not have a bank of donor eggs, but will advise a treatment recipient on how they can attempt to identify someone who may be able to donate an egg. While treatment using donated embryos may be appropriate, there is no indication that donor embryos are funded.[82]

While the Department of Health in Northern Ireland has outlined that the above eligibility criteria applies to all couples alike,[102] the ability for same-sex couples to meet the criteria may be more difficult as they do not necessarily have an infertility diagnosis and are unable to conceive naturally with their partner.[103] Same-sex couples therefore require a known donor, or private treatment. It is unclear from the resources included if individuals are eligible for publicly-funded DAHR interventions.

Further interventions and or services

In Northern Ireland, PGD is only used for certain approved genetic conditions (outlined by the HFEA)[104] and there must be a licence in place. The Health Boards will fund up to three cycles of PGD if a couple meets the following criteria:[105]

- treatment to start before the woman or birthing person is 40 years of age
- the woman or birthing person must have a BMI of between 19 and 30
- both partners must be nonsmokers
- testing for condition occurred in an accredited genetic laboratory
- couples have had genetic counselling locally
- couples in a year long relationship and co-habiting.

This funding ceases if the couple have a healthy child (regardless of whether the pregnancy was achieved through fertility treatment or natural conception), are not responding to treatment or no longer fit the eligibility criteria. If funding is approved the cost of treatment, travel and accommodation will be covered. Couples will likely attend four or five appointments split between Guys Hospital and Regional Fertility Centre at the Royal Victoria hospital in Belfast for each cycle.[105] No information on publicly-funded ROPA in Northern Ireland was identified in the included resources.

Scotland

Artificial insemination, IVF and or ICSI

Artificial insemination, IVF and or ICSI using donor gametes or embryos are partially publicly funded for couples through NHS Scotland. These services are provided at the four Assisted Conception Units (ACUs) in Aberdeen,[39] Dundee,[40] Edinburgh[88] and Glasgow.[38] No DAHR services are publicly funded for individuals.

To be eligible for DAHR services the couple must first be referred to an infertility clinic due to either having no obvious cause for fertility problems but not falling pregnant after a year of unprotected intercourse, having an obvious cause for infertility, or being in a same-sex couple.[86] Following this, for donor insemination (DI), the following criteria applies:[84]

- live in the catchment of the ACU.
- be in a stable relationship (have been co-habiting at the same address in a stable relationship for a minimum of two years).
- neither partner had voluntary sterilisation nor who have undertaken reversal of sterilisation, even if reversal has been self-funded.
- have one partner with no living biological child. Same-sex couples who have previously conceived through DAHR and are both named on the resulting child's birth certificate are not eligible for future treatment.
- the prospective birth mother must have a BMI above 18.5 and below 30. Couples should be aware that a normal BMI is best for both partners.
- both partners must not smoke, vape or use nicotine for at least three months before referral for treatment and couples must continue to be non-smoking and nicotine free during treatment.
- both partners must abstain from illegal and abusive substances.
- both partners must be methadone free for at least one year prior to referral for treatment.
- neither partner should drink alcohol prior to or during the period of treatment.
- treatment must start before the prospective birth mother's 40th birthday.
- must satisfy the requirements of a Welfare of the Child Assessment.[84]

Having met the criteria, couples will be offered up to six rounds of DI, where there is a reasonable expectation of a live birth. After three to six unsuccessful cycles of DI, the couple can be referred for IVF with donor sperm. However, if the prospective birth mother is referred at 38 or 39 years old, the couple will be provided with the option to start IVF treatment with donor sperm instead of starting DI treatment. Once a couple has started IVF treatment, they are no longer eligible for DI treatment.[84]

The eligibility for IVF and or ICSI is similar to that of DI; however, the following requirements also apply. Firstly, subfertility must be indicated with the following accepted:[83]

- subfertility with an appropriate cause of any duration (all couples)
- unexplained subfertility of two years (opposite-sex couples)
- unexplained subfertility following six cycles of NHS-funded donor insemination (same-sex couples).

Furthermore, the following criteria also apply:[83]

- NHS-funding will not be provided to couples where either partner has already received the number of NHS-funded IVF treatment cycles supported by NHS Scotland regardless of where in the UK they received treatment.
- no person can access more than the number of NHS-funded IVF treatment cycles supported by NHS Scotland under any circumstances, even if they are in a new relationship.
- fresh cycles of treatment must be initiated by the date of the woman or birthing person's 40th birthday and all subsequent frozen embryo transfers must be completed before the person's 41st birthday. If the woman or birthing person turns 40 during their first fresh cycle of treatment, no further fresh cycles will be offered. Each individual treatment cycle, including all frozen transfers, must be completed within 12 months of starting treatment, or before the date of the woman or birthing person's 41st birthday if this is reached first.
- NHS treatment may be given to patients who have previously paid for IVF treatment, if in the treating clinician's view, the individual clinical circumstances warrant further treatment.[83]

Having met the criteria, couples will be offered up to three cycles of IVF and or ICSI with a treatment cycle including ovarian stimulation, egg retrieval, fertilisation, transfer of a fresh embryo, and, followed by the freezing of suitable embryos, the subsequent placement of these. In specific circumstances, couples in which the woman or birthing person is aged 40 to 42 years may be offered one round of IVF.[83] This is in line with NICE guidelines.[69]

While detailed information on the funding of IVF and or ICSI requiring donor eggs was not identified, the Scottish government have previously stated that they expect "NHS Boards to meet the needs of couples who are eligible for NHS fertility treatment and require donor gametes (eggs and sperm) for that treatment. We have always been clear that couples who are eligible for NHS fertility treatment should not pay for any aspect of their treatment, and this includes the purchase and use of donor gametes".[106] No information was found regarding the public-funding of DAHR services using donated embryos.

Further interventions and or services

In Scotland, up to three NHS-funded PGD cycles can be undertaken if a couple meets the following criteria:[107, 108]

- a known genetic condition in the family which conveys a 'significant risk of a serious genetic condition'
- no living, unaffected child, or untested child (for an adult-onset disorder) as a couple or, if one partner has no living biological child
- hormone level (anti mullerian hormone) of 7.5 pmol/L or greater (or an adequate ovarian scan) in the woman or birthing person
- the woman or birthing person's age is less than 39 years
- the woman or birthing person's BMI is less than 30
- both partners should be non-smokers for at least three months, living at the same address for at least two years and both must be eligible for NHS treatment.[107, 108]

While no information was identified on publicly-funded ROPA, due to a shortage of egg donors in Scotland and long waiting lists, egg-sharing is permitted, and egg recipients can be those eligible for NHS-funded IVF and or ICSI treatment (once they meet the appropriate criteria).[40] Additionally, egg donation from a relative or friend is permitted and it has been noted this would reduce wait times for DAHR services.[106]

Wales

Artificial insemination, IVF and or ICSI

Artificial insemination, IVF and or ICSI using donor gametes or embryos are partially publicly funded for couples and individuals, in Wales.[89] Up to six rounds of donor insemination is available and is considered when fertility problems occur in relation to a number of conditions including:[89]

- obstructive azoospermia
- severe oligospermia
- infectious disease in the man or person with male reproductive organs (such as HIV)
- and severe deficits in semen quality in couples who do not wish to undergo intracytoplasmic sperm injection.[89]

Donor insemination is also considered in certain cases where there is a high risk of transmitting a genetic disorder to the offspring. Of note, funding for DAHR services in the NHS in Wales occurs through the Health Boards, with the Welsh Health Specialised Services Committee (WHSSC) (replaced by the NHS Wales Joint Commissioning Committee in 2024) responsible for the planning of specialised and

tertiary services. For DI, where the IUI procedure is the responsibility of the Health Boards, the donated sperm will be funded by the Welsh Health Specialised Services Committee.[89]

To access NHS-funded IVF treatment in Wales, subfertility must be demonstrated. For:[89]

- opposite-sex couples' subfertility is defined as inability to conceive after two years unprotected intercourse or a fertility problem demonstrated at investigation.
- same-sex couples' and individuals' subfertility is defined as no live birth following insemination at or just prior to the known time of ovulation in at least six non-stimulated cycles or a fertility problem demonstrated at investigation. For same-sex couples and individuals, the non-stimulated cycles may be achieved through a private arrangement or through NHS-provided DI.[89]

Further eligibility criteria for IVF treatment include:[89]

- the woman or birthing person's age:
  - the woman or birthing person must be at least 20 years old to access IVF treatment. Those who are aged less than 40 years and who meet the access criteria are entitled to two cycles of IVF with or without ICSI. However, if the woman or birthing person reaches the age of 40 during the first cycle of treatment they will not be entitled to a second cycle of IVF.
  - in line with NICE guidelines, those aged between 40 and 42 years (up to their 43rd birthday), who meet the access criteria, are entitled to one cycle of IVF with or without ICSI provided the following three criteria are also fulfilled:
    - they have never previously had IVF treatment
    - there is no evidence of low ovarian reserve
    - there has been a discussion of the additional implications of IVF and pregnancy at this age.
- the man or person with male reproductive organ's age: 55 years or younger.
- existing children: the following will be allowed - couples where one of the partners does not have any living children (biological or adopted), and or individuals who do not have any living children (biological or adopted).
- BMI: in line with NICE guidelines, the woman or birthing person must have a BMI of between 19 and 30. Those with a BMI below 19 that are ovulating normally may be treated at the discretion of the treating clinician. Men or

people with male reproductive organs who have a BMI of 30 or over should be informed that they are likely to have reduced fertility.

- sterilisation: subfertility is not the result of a sterilisation procedure in either partner, or the individual (this does not include conditions where sterilisation occurs as a result of another medical problem). Couples and or individuals who have undertaken a reversal should not be referred for treatment.
- smoking: couples and or individuals who smoke are not eligible. Only patients who agree to take part in a supported programme of smoking cessation will be accepted on the IVF treatment waiting list and must be non-smoking at time of treatment.
- history of previous treatment: for individuals, three or more IVF cycles by the individual will exclude any further NHS IVF treatment. For couples, three or more IVF cycles by either partner will exclude any further NHS IVF Treatment. Previous cycles, whether NHS or privately funded, will be taken into account.[89]

If a couple consents to treatment but during the waiting period separates then treatment cannot commence. If one or both of the partners wish to proceed with treatment, with either a new partner or by themselves, then a consultation will be undertaken where the fertility history of the couple and or individual will be reviewed, treatment options will be discussed and if the couple and or individual still meet the eligibility criteria, consent is required to proceed with treatment.[89]

No information could be identified on the funding of donor sperm for IVF and or ICSI, and egg donation may be offered where no other treatment is available. Egg donation may be available to women or birthing people who have undergone premature ovarian failure due to an identifiable pathological or iatrogenic cause, or to avoid transmission of inherited disorders to a child where the couple meet the other access criteria.[89] The patient must be able to identify and provide a donor, either through altruistic egg donation or through an individual agreement (for example, with a friend or relative). WHSSC will not fund IVF for patients participating in the egg sharing schemes that may operate within fertility clinics.[89]

Further interventions and or services

The NHS does not routinely fund PGD, and only funds pre-implantation genetic testing (PGT) aneuploidies and PGT structural rearrangements where patients meet the criteria, with indications for PGD including patients with chromosomal disorders and couples at risk of transmitting serious genetic disorders to their offspring.[109] No information on publicly-funded ROPA in Wales was identified in the included resources.

3.2.2 Funding

Information related to the funding of DAHR services was identified for all 10 of the selected countries (see Appendix D, Table D 2).

Subject to the available interventions and the eligibility criteria outlined in Section 3.2.1, in seven of the selected countries (Denmark, England, Northern Ireland, Portugal, Sweden, Scotland, and Wales) access to DAHR is provided through publicly-funded healthcare systems. In Denmark, enhanced funding has recently allowed the Danish health system to expand public IVF and or ICSI capacity, with fertility treatment free of charge at public hospitals, and Danish regions able to offer individuals and couples up to six publicly-funded treatment attempts for a second child. While there are costs associated with medication, these are subsidised by the Danish Medicines Agency with couples or individuals receiving between 50% and 85% reimbursement for DAHR related medication.[45] Additionally, while donor gametes are publicly-funded, these have a set selection criteria (called the standard offering).[97] If patients do not wish to use the standard offering, donor sperm may be purchased directly by individuals and couples, or via a fertility clinic, from a sperm bank. Where a known sperm donor is used, individuals and couples must pay for all costs associated with screening and storage of the donor sperm.[45] In Portugal, the majority of DAHR interventions are publicly-funded in the SNS, however the patient may be required to pay certain costs associated with AHR or DAHR interventions. For example, in Portugal, infertility-related medicines are 90% reimbursed under of the national reimbursement scheme within the National Health Services.[58] Inclusion of these medicines in the reimbursement scheme is subject to applications from Marketing Authorisation Holders (often pharmaceutical companies) and approval by the government member responsible for health (in accordance with any relevant legal and regulatory framework).[58] In Sweden, while publicly-funded AHR services are available in public and private facilities, publicly-funded treatments involving donated gametes are restricted to university hospitals.

Across the UK there is no standardised NHS funding policy for DAHR services. In England, those who do not meet the local access criteria for these services may be eligible to receive public funding through an Individual Funding Request (IFR).[80] An IFR enables a healthcare professional to seek funding on behalf of an identified patient for a specific intervention on the basis of 'clinically exceptional circumstances' (that is, circumstances that differentiate a patient from other similar patients, making them more likely to benefit from the intervention).[80]

Australia, France and Germany have national health insurance schemes, with varied public-funding for AHR and or DAHR services covered by these schemes. In Australia, Medicare, which is Australia's universal health insurance scheme, provides reimbursement for a number of AHR and or DAHR interventions. Reimbursement rates vary by service type, with GP services reimbursed to 100%, while AHR and

DAHR services are typically reimbursed up to 85%. Services include specialist consultations, preparation of frozen or donor embryos, or donor oocytes, gametes or embryo transfer, laboratory services, pathology testing and counselling associated with a treatment cycle.[62, 64] Medicare rebates are based on government set scheduled fees and providers are permitted to set their own charges. As a result, patients are required to pay costs that exceed the schedule of fees. For example, while the cost of a standard IVF cycle may be approximately AUD 10,000, Medicare subsidies can reduce this to around AUD 4,000, depending on eligibility and service used.[110] Additionally, service providers can claim Medicare benefits directly (known as 'bulk billing'), where no payment is required by the patient, or use the 'patient payment' billing method. Here the patient pays the cost of a consultation or procedure at the time of receiving the service and then is reimbursed after.[62] In France, DAHR procedures are fully covered by the National Health Insurance (up to six inseminations and four rounds of IVF and or ICSI, to become pregnant), with the coverage rules applying equally for couples and individuals.[25] Additionally, in France, AHR and or DAHR treatment carried out abroad may benefit from financial coverage, subject to prior authorisation.[27] In Germany, there is no financial support from statutory health insurance for DAHR services at a national level. However, at state-level there may be subsidies for unmarried couples and same-sex couples, but that is the exception rather than the rule.

Information on how service providers are allocated funding for the provision of AHR and DAHR services was also identified for France, where health insurance funding is allocated using an activity-based pricing system. Funding allocations consist of two components: a billable component (which provides funding based on the volume and nature of activities, for example, the number and type of consultations and procedures carried out) and a non-billable component (which is not linked to activity levels and is intended to fund organisational costs, such as personnel and equipment).[27] In Australia, information on how medical practitioners bill Medicare for services provided was also identified. Only clinically relevant services listed in the Medicare Benefits Schedule can be billed for, and non-clinical services, such as home-use goods and components of hospital treatment, must be billed separately. Improper billing from service providers may result in denial of Medicare payment, legal penalties, and recovery of improperly paid funds.[111]

3.2.3 Organisational aspects

Information related to the organisation of publicly-funded DAHR services was identified for nine of the selected countries (see Appendix D, Table D 3). Organisational aspects identified include referral pathways, service provider characteristics, timelines to access services, and any other organisational aspects deemed relevant.

Referral pathways

Information related to referral pathways for publicly-funded DAHR services was identified for nine of the selected countries. In each of the selected countries, it should be noted that AHR and DAHR have the same referral pathways. GP or consultant referral is required for all the referral pathways identified. In Australia and the UK, couples or individuals experiencing infertility generally consult with their GP first. The GP conducts an initial clinical assessment and initiates preliminary investigations.[62, 63, 71] These assessments may include hormonal testing, pathology testing, imaging, semen analysis, and the evaluation of ovulation. If these investigations indicate underlying infertility or the need for specialist treatment, couples or individuals are referred to fertility services.[62, 71] In England (Staffordshire and Stoke-on-Trent ICB[75]), Scotland and Wales, opposite-sex couples who fail to conceive after one or two years of regular unprotected intercourse, in the absence of any known cause of infertility, or same-sex couples following six rounds of artificial insemination, should also be referred to fertility services for further investigation.[38, 75, 88, 89]

In Denmark, France and Sweden, AHR and DAHR referrals include additional assessments before treatment:

- in Denmark, clinicians must assess the ability of an individual or a couple to care for a child after birth, and where doubt exists the case must be referred to the Regional Council which then determines whether treatment should proceed.[20]
- in France, several private interviews between the couple or individual and members of the AHR centre's multidisciplinary medical team must be undertaken. This is followed by a mandatory reflection period, after which consent to AHR treatment can be given.[27]
- in Sweden, specific to DAHR, a special assessment of medical suitability, and a psychological and social evaluation of the intended parent or parents, must be undertaken before any treatment proceeds.[112]

In France, before beginning DAHR with donor sperm, couples and or individuals are expected to meet with a number of healthcare professionals in the AHR centre. These healthcare professionals include a doctor specialising in reproductive medicine (such as a gynaecologist) and a medical biologist for AHR that provides explanations of any procedures to be undertaken. Patients will also be offered an appointment with a psychologist and or psychiatrist, which they are free to accept or decline.[27]

Details regarding information which must be provided by the referring healthcare professional were identified for Australia,[62] and Northern Ireland,[82] and include the patient's:

- reason for referral, including relevant clinical information about the patient's condition for investigation and or opinion and or treatment
- age and parity (the number of times a woman or birthing person has given birth to a baby of viable gestation or fetal weight)
- likelihood of infertility
- date of commencement for treatment and or surgery
- known comorbidities
- time-frame available for fertility preservation services
- information as to whether menarche has already occurred (for women or birthing people).

In Portugal, referral to National Health Service AHR centres for couples and or individuals is managed by primary care or hospital-based services within the national referral network. As outlined in Section 3.2.1 clinicians determine the most appropriate AHR and or DAHR technique based on clinical evidence and patient circumstances.[56-59]

Service provider characteristics

Information related to the characteristics of publicly-funded DAHR service providers was identified for eight countries (Denmark, England, France, Northern Ireland, Portugal, Scotland, Sweden and Wales). In general, fertility services are delivered through regulated public providers, private clinics, and or a mixed model of public and private providers. For example, the Danish government and the Danish Regions allow collaboration with private fertility clinics when public resources or capacity are insufficient.[41] Regions can use tenders or other formal partnership agreements with private providers to ensure adequate service levels and timely access to fertility treatment.[41] Similarly, in all of the UK countries, fertility services are delivered through a combination of public and private providers operating under national regulatory oversight.[103] Although fertility treatment was historically delivered primarily within the NHS, the sector now includes a substantial number of privately operated clinics. Therefore, many NHS-funded treatments are delivered in private clinics under contractual arrangements with the NHS, reflecting a mixed public–private model of service provision.[103]

In Portugal, AHR and DAHR treatment may only be undertaken in public or private centres that are formally authorised by the Minister of Health (see Section 3.2.5, Governance).[56] These authorised centres must have the required human, technical

and organisational resources to perform AHR procedures. Centres may be authorised at one of three levels:

- all AHR and DAHR techniques
- artificial insemination only, or
- donor selection and gamete preservation.[59]

Similarly, in Sweden private providers must obtain permission from the National Board of Health and Welfare (NBHW) to perform assisted fertilisation using donor gametes. Application for authorisation must include details of the planned activity, organisational structure and management systems and the qualifications of the medically responsible practitioner.[33] Where facilities handle human tissue and cells, additional approval under the Tissues and Cells Act, is required.[31, 61] In Northern Ireland, Scotland and Wales, publicly-funded AHR (and DAHR) is delivered by a limited number of NHS public providers. For example, in Northern Ireland fertility treatment is delivered in the Regional Facility Centre in Belfast,[82] in Scotland fertility treatment is delivered in the four ACUs,[38-40, 88] and in Wales fertility treatment is delivered in three designated providers the Hewitt Centre, the Shropshire and Mid Wales Fertility Centre and the Wales Fertility Institute.[89] In Wales, these providers deliver fertility services within the framework of national commissioning policies and clinical guidelines, and are responsible for delivering fertility investigations, AHR and DAHR treatments and related clinical care for eligible patients.[89]

Specific to PGD, both Denmark and Scotland outlined that PGD is undertaken exclusively in specific centres.[46, 87] In Denmark, PGD is provided at two specialised public facilities: the Fertility Department at Rigshospitalet and the Fertility Clinic at Aalborg University Hospital (in collaboration with clinical genetics departments).[46] In Scotland, PGD is provided through designated national centres, including the Glasgow Royal Infirmary and the Royal Infirmary of Edinburgh, which deliver nationally-funded services for genetic testing associated with AHR.[87]

Timelines to access services

Information related to timelines in accessing publicly-funded AHR and DAHR services was identified for seven countries (Australia, France, Portugal, Sweden, England (Staffordshire and Stoke on Trent;[75] Cambridgeshire and Peterborough,[73] and Lancashire and South Cumbria[77] ICBs), Scotland and Wales).

In England (Staffordshire and Stoke-on-Trent,[75] Cambridgeshire and Peterborough,[73] and Lancashire and South Cumbria[77] ICBs), Scotland and Wales waiting times, for AHR in general, are closely linked to referral pathways and eligibility criteria. In England (Staffordshire and Stoke-on-Trent,[75] and Cambridgeshire and Peterborough[73] ICBs) and Wales[89] a diagnosis of unexplained

infertility is required before patients qualify for NHS-funded IVF. However, individuals with clinical indications for infertility or subfertility, such as cancer or premature ovarian insufficiency, and women or birthing people over 36 years of age, can be expedited for fertility treatment.[73, 74, 89] In Scotland, eligible couples are assessed in secondary care within 12 weeks from GP referral, with simple treatments (such as ovulation induction, blood test and ultrasound follicle tracking) commencing within 18 weeks, where appropriate. However, if the patient is referred to tertiary care following baseline investigations, these timelines do not apply.[87] As outlined below, those requiring donor gametes and or embryos may experience increased waiting times dependent on the availability of donor materials and the allocation process.

In Portugal, any waiting time applied to AHR technologies, including DAHR services, is based on objective criteria of clinical need.[59] In Australia, timelines related to accessing fertility treatment and timelines related to the ongoing process of fertility treatment are outlined. Firstly, patient level factors, such as obesity, may affect access to treatment, with some clinics requiring individuals to address health risks before proceeding with treatment.[110] It is also outlined that timelines when undergoing fertility treatment are linked to the clinical definition of treatment cycles, rather than system-wide waiting periods.[63] For example, a treatment cycle begins either when super-ovulatory medications are initiated on the first day of the menstrual cycle and ends within 30 days, or upon completion of procedures, such as oocyte retrieval or embryo transfer.[63]

Four of the selected countries (England, France, Sweden and Wales) outlined that for those requiring donor gametes and or embryos for AHR services, the availability of gametes and or embryos may impact waiting times. In Sweden, the National Healthcare Guarantee requires fertility investigations to begin within three months; however, waiting times for DAHR treatment may vary depending on the availability of donor gametes.[35] Similarly, in France, timelines are highly dependent on service capacity and donor gamete availability. For example, treatment with donor sperm may take approximately six to 12 months between the start of the procedure at the donation centre and or sperm bank, and the allocation of the sperm to the couple or individual. It is noted that access to donor eggs in France takes significantly longer, averaging 12 to 30 months depending on regional demand and donor availability.[27] In England (Lancashire and South Cumbria ICB[77]) when donor eggs are unavailable, patients who are eligible for treatment with donor eggs will be placed on a hospital waiting list for an initial period of three years, after which eligibility is reviewed to determine whether they continue to meet the ICB's fertility policy requirements.[77] Both England (North East London ICB[74]) and Scotland stated that if patients source their own gamete and or embryo donors this may reduce waiting

times.[107] However, with known donors, recipients may be responsible for the costs of screening and storage of gametes and or embryos. In Scotland egg donation from a relative or friend is allowed and it has been noted this would reduce waiting times for DAHR services.[107]

Other organisational aspects

Information related to the other organisational aspects was identified for five countries (Denmark, France, Portugal, Scotland and Sweden). The composition of the healthcare team responsible for AHR and or DAHR services was outlined in France and Portugal. For example, in France, it is outlined, within the Public Health Code, that the multidisciplinary team responsible for the clinical activities of assisted reproduction must include, at a minimum a:[28, 29]

- doctor qualified in gynaecology-obstetrics, medical gynaecology, or endocrinology for clinical activities of oocyte retrieval, embryo transfer and embryo reception for the purpose of AHR or donation,
- doctor qualified in urology, general surgery or gynaecology and obstetrics for sperm retrieval,
- medical biologist and a laboratory technician for AHR or AHR laboratory activities.[29]

A psychiatrist, psychologist, or nurse with expertise in psychiatry, may be requested to conduct a preliminary interview outside the centre if necessary, and a social worker may also be required.[29] Similar requirements were outlined in Portugal, where it is specified that in institutions conducting services related to AHR, institute heads or directors must specialise in gynaecology and or obstetrics, or genetics, endocrinology or urology. Additionally, the centre director is also required to have at least three years' experience in AHR.[56]

Denmark and Portugal have established regulatory processes within their AHR organisations to ensure traceability and monitoring of donor gametes. For example, in Denmark, healthcare professionals are required to report outcomes of DAHR treatments to the relevant distributing tissue establishment within 14 days of a confirmed viable pregnancy.[24] These reporting requirements support donor tracking, monitoring of donor-related sibling limits, and regulatory oversight of DAHR.[24] Similarly, in Portugal, AHR centres must maintain systems that assign a unique identification number to each gamete and or embryo.[57]

Additional organisational arrangements that oversee the import, export, and transport of reproductive cells and embryos, between fertility centres or across national borders, were identified in Portugal and France. In Portugal, reproductive cells may only be imported or exported by authorised AHR centres with explicit

approval from the National Council for Medically Assisted Reproduction.[57] Importation is permitted only from jurisdictions where donor identity disclosure is not legally restricted, reflecting national legislation governing donor anonymity and traceability.[57]

In France, couples and individuals may continue their DAHR process domestically, if it was initiated abroad, by meeting the following criteria:

- the donation procedure must adhere to the principles of being voluntary, free of charge and ID release (so that donor-conceived people can access identifying information about the donor when they reach the national legal age for access)
- couples and or individuals must also obtain authorisation from the Biomedicine Agency to import gametes or transfer embryos
- the use of gametes must occur in an authorised centre and comply with national, legal age requirements.[27]

3.2.4 Donor material management

Information related to donor material management was identified for nine of the selected countries (see Appendix D, Table D 4). As outlined in Section 3.2.1 Germany does not publicly-fund DAHR services. Donor material management aspects identified include arrangements for obtaining materials, storage of materials, access to and or disposal of materials, and serious adverse events or side effects.

Arrangements for obtaining donated gametes or embryos

Information on how donated gametes and or embryos are obtained for publicly-funded DAHR services was identified in eight countries (Australia, Denmark, England, France, Northern Ireland, Scotland, Sweden and Wales). This information was identified in relation to non-ID release (anonymous) donors, ID-release donors and known donors:

- Non-ID release and ID-release donors are both unknown to the recipient when the recipient acquires the donated gametes and or embryos from a fertility clinic and or gamete bank. Non-ID release donors remain anonymous to both the recipient and donor-conceived person. However, donor-conceived people born using ID-release gametes or embryos may get identifying information about the donor when they reach the national legal age stipulated.[113]
- A known donor is when the donor and recipient know each other at the time of donation.[114]

Non-ID release (anonymous) and or ID-release donors

In Denmark, France and Sweden, the treating healthcare professional and or medical team selects or allocates the gamete and or embryo for the recipient(s). In France, gametes and embryos are allocated according to the chronological order of registration of the applicants, with matching of donated gametes offered to recipients.[26] Recipients are advised that this match is not always possible, given the rarity of certain physical characteristics among donors, and may result in long waiting times.[27] In Denmark, as previously outlined in Section 3.2.1, donor gametes and or embryos are ordered by the fertility clinic in the public hospital, free of charge using a set selection criteria outlined within the agreement between the fertility clinic and the gamete bank (the standard offering).[97] If an individual wishes to add additional criteria during gamete selection, then they must purchase the gamete themselves.[97] Many individuals or couples purchase donor sperm via the sperm bank websites and have it distributed to a fertility clinic.[45] If a sperm bank has depots at fertility clinics (called 'loan tanks') from which fertility clinics can purchase sperm straws, the sperm bank must, upon achieving 12 pregnancies for a donor, notify these fertility clinics that they may no longer use sperm from this donor for anything other than sibling depots.[45] In Sweden, for DAHR treatment in a public hospital the doctor selects the sperm, eggs, and or embryo.[30]

In Denmark, cross-donation is also permitted within the publicly-funded health system.[45] This occurs when an individual or couple in need of receiving an egg for treatment identifies a donor (known), who then donates to a pool in which several other donors have also donated. The individual or couple are then guaranteed to receive an egg from the pool, but from another donor whose identity they do not know (non-ID release). The recipient, the recipients partner, and any donor-conceived people will only receive basic profile information about the egg donor (such as the donor's skin colour, hair colour, eye colour, blood type, age, height and weight).[45]

In the UK, while public-funding for gametes and or embryos varies depending on country and or region (such as the ICBs in England), the HFEA recommends that donor sperm is accessed through official channels, such as fertility centres or sperm banks.[70] This is to reduce the risk of blood-borne infection and to ensure that sperm donors are not the genetic parent to children in more than 10 separate families.

In regard to acquiring ID-release donor gametes and or embryos from abroad, Australia, Sweden and the UK all state donated materials can be acquired internationally. In Australia, this can only be performed where it can be established that the gametes were obtained in a manner consistent with any relevant Commonwealth or state legislation.[65] For example, in Victoria, the Assisted Reproductive Treatment Act (2008) outlines how class applications are required for

AHR providers who wish to import and or export donor gametes and or embryos from Victoria.[115] This application must be approved by the Victorian Assisted Reproductive Treatment Authority (VARTA). Factors which VARTA will consider include that, in accordance with the Act, consent has been provided by the donor, the donor is aware of where the gametes will be sent, the number of women or birthing people worldwide who have been treated using the sperm or eggs of a single donor, and the proposed financial arrangement between the Victorian ART provider and the fertility bank.[115] In Sweden, while Swedish sperm banks are preferred (as this ensures control of the screening process), frozen sperm may be brought into the country with permission from the National Board of Health and Welfare.[116] In the UK, sperm can be acquired abroad; however, there is then no guarantee the 'rule of 10' limit (legally in the UK donors can donate to no more than 10 families) still applies.[70] Additionally, in England, Scotland and Wales, any fertility clinics wanting to import gametes and or embryos from outside of the UK must apply to the HFEA for a certificate.[117] To obtain a certificate the fertility clinic will need to provide guarantees that the supplier meets UK quality and safety standards. Of note, in Northern Ireland this applies to the importation of gametes and or embryos from any country outside the European Economic Area, and includes England, Scotland and Wales.[117]

Known donors

Denmark, Sweden and the UK outlined that donations from known donors are allowed. In Denmark, if a known sperm donor is used in connection with treatment at a regional council hospital, the hospital may require that the gamete donation, including testing and evaluation, must be carried out via an approved tissue centre (a gamete bank).[24] Donor screening includes testing for key infectious disease including Human Immunodeficiency Virus (HIV), Hepatitis B Virus, Hepatitis C Virus, and syphilis, and for sperm donors, chlamydia. Where relevant additional testing must be undertaken based on the donor's background and the characteristics of the donated gametes. Additionally, targeted genetic screening for autosomal recessive conditions which may be predominant in the donor's ethic background, or an assessment for hereditary conditions may be required.[118] The recipient of the gametes must be fully informed about any identified risks and the measures taken to address them. Expenses in connection with the gamete bank's testing and evaluation, are borne by the individual or couple seeking treatment. For egg donation, the treating healthcare professional must ensure that the donor does not feel under pressure to donate and ensure that the donation is truly voluntary. If the healthcare professional suspects that the donation is not voluntary the woman or person producing egg cells cannot be accepted as a suitable donor.[24] Similarly, in Sweden if a known donor is to be used, the treating doctor must examine the motives of the people involved and assess their ability to manage their relationships

in the future.[33] In the UK the HFEA states that a known donor may be used in a fertility clinic, but it is unknown if this is permitted in publicly-funded DAHR services.[70]

Information on egg sharing between donors and recipients as part of AHR treatment was also identified in Scotland. Egg sharing occurs where a donor undergoing treatment agrees to share retrieved eggs with a recipient, for a reduced price on their treatment.[40] It should be noted that egg sharing is not offered in the publicly-funded system in Scotland.

Storage of donated gametes and or embryos, allocated to recipients

Limited information related to the storage of donated gametes and or embryos (that had been allocated to recipients) was identified. For many countries it was unclear whether information found was related to the storage of donated materials specifically.

In Denmark, while donor sperm costs are covered for those eligible, couples and individuals also have the option of purchasing multiple sperm and storing them frozen for a fee at a sperm bank or fertility clinic.[45] This is typically called "storing" the donor sperm, and the individual or couple becomes the custodian. The rationale for purchasing and owning donor sperm, even if it is not to be used in the short term, may be, for example, to ensure that a donor-conceived person can have full siblings at a later date in the future.[45]

As with the funding of DAHR services in England, the funding of ongoing storage of gametes and or embryos (in general, not specific to donated material) varies by ICB also. In England:

- Kent and Medway ICB outlined that they would fund the storage of supernumerary embryos for two years following each fresh cycle of IVF, but further storage would need to be self-funded[78]
- Lancashire and South Cumbria ICB outlined that funding for the ongoing storage of supernumerary embryos would only be available for the purposes of fertility preservation[77]
- Yorkshire and Humber ICBs outlined that the cost of egg and sperm storage is included in the funding of the treatment for which it is required. Storage will be funded for a maximum of three years or until six months post successful live birth, whichever is the shorter. Following this period continued storage may be self-funded.[76]

Maximum legal storage period for gametes and or embryos (in general) were outlined for Australia, Denmark, Portugal, Sweden and the UK:

- Australia: gamete storage period can vary depending on the state, for example in Victoria and Western Australia, gametes may be frozen for up to 10 years and 15 years, respectively.[119]
- Denmark: if embryos created from donated gametes have been allocated to a recipient, they can be stored up until the recipient turns 46 years old.[24]
- Portugal: gametes can be stored for renewable periods of five years, and embryos can be legally stored for three years initially, which can then be extended to six years.[120]
- Sweden: there is no legal limit for the duration of gamete storage, and a legal limit of 10 years for embryos.[13]
- the UK: gametes and embryos can be stored for up to 55 years.[70]

Of note these are not publicly-funded periods of storage, and unless stated, it was unclear if these storage limits applied to gametes and or embryos which had been donated and allocated to recipients.

Access to and or disposal of stored donated gametes or embryos

In regard to the disposal of stored donated gametes or embryos, Australia, Denmark and France outline information around who is responsible for the disposal of gametes and or embryos, and when they are required to be disposed of. In Australia, the National Health and Medical Research Council (NHMRC) ethical guidelines outline that:[65]

- When a gamete donor has not specified a recipient for their gametes, the clinic has responsibility for decision-making about the allocation, storage and disposal of the gametes, subject to any directions expressed in the consent of the donor. Once allocated, the responsibility for decision-making is transferred to the recipient.
- When a gamete donor has specified a recipient for their gametes, and consent for treatment has been given by the recipient, the recipient has responsibility for decision-making about the use, storage and disposal of the gametes or resulting embryos (again subject to any directions expressed in the consent of the donor).
- Embryo donors are responsible for decision-making about the use, storage and disposal of an embryo while it is in storage awaiting donation to either an identified or unidentified individual or couple. Following allocation, responsibility, including disposal of the embryos, lies with the recipient (subject to any directions expressed in the consent of the donor).[65]

Additionally, clinics in Australia must have clear policies and procedures in place regarding the disposal of stored gametes and or embryos.[65] In Denmark, it was outlined that fertilised and unfertilised eggs must be disposed of in the event of the

woman or birthing person's death, unless unfertilised eggs have been donated for the purposes of getting someone else pregnant or research.[24] Fertilised eggs must also be disposed of if the couples separates, gets divorced, or stops living together; however, this does not apply if donor sperm is used.[45] In France, if embryos are in storage, and a member of a couple dies, the surviving member of the couple will be consulted in regard to their consent for ongoing embryo storage.[28] The surviving member will be given a one-year period to decide on continued consent. If both members of a couple (or the individual) dies, any embryos will be disposed of. Additionally, if both members of a couple, or the individual have agreed to donate their embryos, but these have not been received within five years of consent to donate, they will be disposed of.[28]

Denmark also outlined that donated sperm may be subject to a permanent ban of its use if there is a risk that the sperm may carry and or transmit a hereditary disease. In this case, sperm from that donor may no longer be provided for fertility treatment.[45] If a couple or individual has purchased donor sperm which becomes subject to a permanent ban, and the donor sperm has been delivered for processing and storage in a clinic, the clinic must inform the intended recipient of the ban.[45]

Serious adverse events or side effects

Denmark, Portugal and Sweden all outlined actions which must be taken if a serious adverse event or side effect occurs in relation to the use of donor gametes and or embryos in DAHR services. These events and or side effects include:

- for Denmark: anything that impacts on or is related to the quality and safety of tissues and cells and that can be attributed to the procurement, testing, processing, storage or distribution of tissues and cells. Treating healthcare professionals must report to the Danish Health Authority and, for sperm, to the sperm bank from which it was requested.[45]
- for Portugal: any type of incorrect identification or exchange of gametes or embryos, and all persons and collection bodies responsible for its application in AHR or DAHR must notify such incidents to the CNPMA.[57]
- for Sweden: anything that affects the quality and safety of tissues and cells, or any serious reactions suspected or observed during or after use that may be attributable to the quality and safety of the tissues and cells.[31]

Denmark also noted that healthcare professionals who treat a donor-conceived person, or who treat a person who has donated sperm or eggs, have a duty to report genetic diseases to the relevant tissue centres and the Danish Health Authority.[45] While Sweden noted that if a contagious disease has been diagnosed or suspected in a recipient, the operations manager shall ensure that a report and an investigation are made.[31]

3.2.5 Governance

Information related to the overall governance of publicly-funded DAHR services was identified for nine of the selected countries (see Appendix D,). In each of the selected countries, it should be noted that DAHR and AHR are overseen by the same regulatory frameworks. No specific regulatory bodies and or agencies were outlined in relation to DAHR specifically.

In Denmark, France, Northern Ireland and Sweden, the Minister of Health, Ministry or Department of Health (as appropriate), or a national state agency under the supervision of the Ministry of Health are the overall governing authority for publicly-funded AHR and DAHR services. In Denmark, the Minister of Health may set detailed rules on donation, including anonymity and conditions for compensation, on storage, and on use, including the number of pregnancies per donor, on human eggs and sperm.[19] In France, the Biomedicine Agency is the reference authority on medical, scientific and ethical aspects of harvesting and transplantation of organs, tissues and cells, and human procreation, embryology and genetics.[27] For AHR and DAHR, it coordinates and controls all activities relating to gamete donation, manages national data on gamete and embryos, authorises AHR techniques, and promotes gametes donation.[27] In Northern Ireland, NICE guidelines are reviewed and endorsed by the Department of Health at a national level, and these guidelines are then issued directly to Health and Social Care (HSC) Trusts and Boards (and other relevant public health agencies as appropriate) for implementation.[121] In Sweden, AHR and DAHR is governed through national legislation which is implemented through the National Board of Health and Welfare (NBHW), together with the Swedish Association of Local Authorities and Regions.[116, 122] The NBHW governs the use of gametes, the eligibility criteria for access to publicly-funded AHR services and the social circumstances required for children born through donation.[33, 116] The regional authorities issue further guidelines around the eligibility for publicly-funded AHR services, and ensuring these complement national legislation and NBHW standards.[122]

In Scotland, while the specific department or ministry responsible for publicly-funded AHR services was not outlined, Fertility Scotland must ensure delivery of improved care to patients and users of NHS Fertility Services in Scotland.[85] Fertility Scotland is funded by the Scottish government, and ultimately responsible to the Scottish government and the NHS Board of Chief Executives.[85] Further governance of NHS Fertility Services in Scotland also includes:

- the National Infertility Group:[87] established to advise the Scottish government on infertility policy and support implementation across NHS Boards.

- an Oversight Board: which provides overall strategic leadership, endorses recommendations from the Core Steering Group and ensures the network remains focussed on delivery.
- a Core Steering Group: which provides a forum for interchange between working groups, the Programme Management Team and relevant stakeholders. The group makes recommendations to the Oversight Board.
- a Programme Management Team: which oversees the day to day running of the Network, monitors progress and reports to the Core Steering Group and the Oversight Board.
- Working Groups: which are established for each specific Project or Programme of work.[85]

In Wales, the Welsh Health Specialised Services Committee (WHSSC) holds national responsibility for the commissioning and funding of publicly-funded DAHR services. The WHSSC commissions fertility services for all seven Health Boards, sets country-wide eligibility criteria and determines which AHR and DAHR procedures are funded. Therefore, Welsh clinics deliver services in line with WHSSC policy and HFEA licensing conditions.[89, 90]

As previously outlined, in Sweden the local authorities have a role in governing the delivery of publicly-funded AHR and DAHR services to those living in their catchment areas.[122] Similar is observed in Australia, England and Sweden. In Australia, state governing frameworks in Victoria, South Australia, Western Australia and New South Wales add further requirements including mandatory donor registers and identity release laws.[67] In England, ICBs hold the legal responsibility for commissioning fertility and AHR services and therefore make local decisions as to the provision of these services.[80] This has led to significant regional variation for the provision of AHR services, primarily due to varying interpretation of NICE guidelines, varying budgets and priorities, and the development of policies which are written and signed off locally.[80]

Information related to the governance or regulation of the facilities delivering publicly-funded AHR and or DAHR services was identified for nine of the selected countries. More specifically, a number of regulatory bodies, or agencies with regulatory functions in their remit, were outlined, including in:

- Australia, the Reproductive Technology Accreditation Committee, which is responsible for setting the Code of Practice for AHR performance and the granting of licences to practice AHR.[66]
- Portugal, the CNPMA, which has overall governance in relation to the regulation of AHR centres.[60] Their functions include receiving annual reports from AHR centres, auditing and inspecting AHR centres (in collaboration with

the General Inspection of Health Activities) and training AHR centre auditors.[56, 57]
- the UK, the HFEA, which is the independent regulator of fertility treatment and research using human embryos.[70]
- Northern Ireland, the Regulation and Quality Improvement Authority, which assesses the implementation of endorsed NICE clinical guidelines.[121]

3.2.6 Counselling, communication and information provision

Information related to counselling, communication and information provision for DAHR services was identified for all 10 of the selected countries (see Appendix D, Table D 6).

Counselling to support people to make well-informed and emotionally supported decisions about DAHR was identified in all selected countries. Australia and the UK provided the most detailed guidance.[65, 69, 70] In the UK, counselling for donor-related treatments is explicitly required and must be provided by professionals independent of the fertility treatment team, in order to ensure a neutral and supportive environment. In Scotland specifically, a clear distinction is made between supportive counselling (which addresses the immediate emotional distress associated with infertility treatment) and implications counselling (which focuses on the longer term social, psychological and ethical considerations of DAHR, for donors, recipients and donor-conceived people).[69, 88] In Australia, while counselling is not legally required, professional standards (such as those from the Australian and New Zealand Infertility Counsellors Association) establish counselling as a minimum standard of care, often recommending a minimum of two to three sessions for donors and recipients.[65] Across Australia, Sweden and the UK the content of counselling is broadly consistent, with key areas commonly addressed including:

- the long-term psychosocial impacts on donors, recipients and donor-conceived people
- the significance of genetic relationships
- disclosure to children about their genetic origins
- any potential future contact between donor-conceived people and donors, family dynamics and relationships.[65, 69, 88]

Requirements related to the provision of information prior to treatment were identified in Australia,[65] Denmark,[45] Portugal,[60] Sweden[30] and the UK.[68, 69] Healthcare professionals are required to provide clear, comprehensive and relevant information to individuals or couples using DAHR services. This typically includes:

- success rates and likelihood of achieving pregnancy
- risks and complications of treatment

- genetic and hereditary risks
- legal implications, including parentage and donor rights
- practical aspects such as storage, use and disposal of gametes or embryos.[30, 45, 60, 65, 68, 69]

In the UK, information provision extends to lifestyle factors, with guidance indicating that individuals should be informed about the potential negative impact of smoking, alcohol consumption and caffeine intake on the effectiveness and success rates of AHR and DAHR treatments.[68, 69] Additionally, information regarding care and treatment options should be provided in a form that is accessible to people who have additional needs, such as people with physical, cognitive or sensory disabilities, and people who do not speak or read English.[71]

Information provision requirements outlined within the selected countries are in place to enable patients to provide informed and voluntary consent for DAHR treatment. For example, in Denmark,[45] Sweden[30] and Portugal,[60] written consent is required from donor and recipients' before treatment initiation, storage and use of donor gametes or embryos. Sweden also require consent from a spouse or partner where applicable.[30] In Portugal, the legal framework centres on mandatory informed consent, supported by comprehensive written information on the medical, ethical and legal implications of DAHR.[56] Similarly, in Australia, clinics are required to obtain clear consent before any use and or storage of gametes or embryos, and must give donors and recipients enough time and information to make an informed decision.[65] The consent includes:

- donors and recipients must receive clear information about all agreed arrangements, including any limits set by the donor on how gametes or embryos can be used (including the number of families created from their donation), stored, discarded or reallocated.
- recipients must also be informed about the donor's genetic link to any child that may be born.
- donors and recipients must give permission for their information to be shared with each other and with any child born from the donation.[65]

Additionally, Australia, Portugal and Sweden highlighted that donors and recipients have the right to withdraw or change their consent before the recipient's treatment cycle begins or before an embryo is created.[30, 56, 65]

Of note, it was also identified that the rights of donor-conceived people to know their genetics origins should be supported by counselling and information provision. This includes preparing parents of donor-conceived people for early disclosure and supporting donor-conceived people in seeking information about their origins.

Additionally, counselling and information provision should cover the potential emotional and relational implications associated with DAHR.[30, 45, 60, 65, 68, 69] Further detail regarding the rights of donor-conceived people to know their genetics origins is outlined in Section 3.2.7.

3.2.7 Ethical and social considerations

Information related to ethical and social considerations in AHR and DAHR services was identified for eight of the selected countries (Australia, England, France, Northen Ireland, Portugal, Scotland, Sweden, and Wales) (see Appendix D, Table D 7).

A major ethical consideration identified across eight of the selected countries was informed consent. It is a central requirement in DAHR interventions, ensuring that donors and recipients fully understand and agree to the procedures involved. To ensure that the process of informed consent is ethically undertaken, counselling and or information provision is required prior to consent. This counselling and or information provision is outlined in detail in Section 3.2.6.

In Australia, the NHMRC ethical guidelines outline considerations and guiding principles for the use of AHR (including DAHR interventions) in clinical practice and research.[65] These guiding principles are applicable to all Australian fertility clinics and their practices and include maximising benefits and minimising harms to individuals, couples and children; and supporting decision-making processes that respect the relevant social and cultural contexts, as well as the autonomy, of all relevant parties.[65] The NHMRC guidelines also provide specific considerations for DAHR services such as ethical guidance around informed consent, donor recruitment and allocation, limits on the number of families created per donor, privacy and information-sharing, and equity of access.[65]

Consideration of, or commentary on, equity, non-discrimination and fair access was identified in resources for five of the selected countries (Australia, England, Germany, Portugal, and Scotland). In Australia, despite ethical commitments to equitable and accessible fertility care, disparities persist for LGBTQI+ couples, those living in remote areas, smokers, and those with lower socioeconomic status (which may lead to increased barriers to access due to lower health literacy, reduced healthcare access, and difficulty navigating services).[110, 123] In Germany, ethical concerns related to gender equality and family formation were also highlighted.[124] It was noted that the prohibition of egg donation creates unequal treatment and limits reproductive options for women or birthing people who cannot produce eggs due to medical conditions such as cancer.[125] Resources identified for England, Portugal, and Scotland emphasised that no discrimination should occur based on race, faith, gender identity, sexual orientation, or disability, in the provision of

infertility services.[56, 76, 87] However, in England, infertility-based eligibility criteria may create barriers for same-sex couples to access publicly-funded DAHR.[73] Additionally, in the UK, HFEA data has outlined that ethnic minorities experience unequal access to and outcomes from fertility treatment, with white patients significantly overrepresented in donor insemination.[103] Age-based eligibility rules for IVF also produce unequal treatment, as women or birthing people face stricter age limits than men or people with male reproductive organs. While these age limits may be a reflection of both evidence-based fertility success considerations and resource constraints, they result in more restrictive access for women or birthing people overall.[126]

Information on policy and guidance regarding donor anonymity, openness, and the right of donor-conceived people to know their origins was identified for Australia, France, Scotland, Sweden and the UK. For example, the need for the donor to consent to the release of their information was also outlined in Australia. It was stated that clinics should, when requested by donor-conceived people, review donor consent and make reasonable efforts to facilitate access to identifying information. This should be through counselling of the donor-conceived person.[65] In France in 2021 the revision of the Bioethics Law ended anonymity of donations made after September 2022.[27] From this date, donors had to consent to the possibility of their data being disclosed to any donor-conceived people once they are 18 years of age. For those who donated prior to this date, access to donor identity is permitted only if the donor consents to the release of their information.[27] In the UK, donor anonymity ended in 2005, with non-identifying information about donors available to donor-conceived people (by request) from age 16 years. Identifying details, such as the donor's name and last known address, are then available on request once the donor-conceived person turns 18 years old.[70] Specific to known donors, Australia and Scotland further emphasise a child's right to know their origins and, through counselling with couples or individuals, outline how the identity of the known donor may affect the child's wellbeing and family relationships.[88] In Sweden donor-conceived people who have reached sufficient maturity have a legal right to access information about their donor and donor-siblings. Additionally, parents receive support and guidance about the importance of early disclosure of genetic origins in line with children's rights.[30, 33]

Further ethical and social considerations outlined in the selected countries include the potential impact of DAHR on child welfare and future outcomes. Sweden and Scotland both require assessment of whether intended parents can provide stable, supportive psychological and social environments.[87, 112] For example, in Sweden, assessment of the psychological and social circumstances of individuals applying for DAHR is a legal requirement (see Section 3.2.5), grounded in the principle that the

best interests of the child must come first. Legislation requires that anyone seeking treatment must be able to offer a stable and supportive environment and the conditions necessary for a good upbringing.[112] In Scotland, clinics regulated by the HFEA are prohibited from providing treatment unless there is sufficient consideration for the welfare of any child born. This includes whether the child will receive supportive parenting, and the welfare of any existing child who may be affected by the birth.[87]

Information regarding the rights of the recipients of DAHR services was identified for Portugal. These rights were established to ensure safe, informed and equitable access to treatment, and include that recipients:[56]

- do not undergo techniques that lack a reasonable chance of success or that carry significant risks
- are treated in a medically appropriate environment with the necessary expertise and facilities
- are fully informed about the likely medical, social and legal implications of treatment
- understand the reasons if treatment is refused, and
- receive information about alternatives (such as adoption), and the broader social significance of these options.[56]

Further ethical concerns also identified include:

- in the UK, concerns regarding egg-sharing arrangements. There are concerns over the risk that donors may feel pressured to participate in egg sharing to access treatment, which raises questions about the voluntariness of their consent. Concerns also exist about the psychological well-being of donors, particularly the potential for regret if their own treatment is unsuccessful while a recipient conceives using their eggs.[127]
- in Australia and the UK, concerns regarding the use of unlicensed settings for donor conception. While licensed clinics in Australia and the UK limit the number of children per donor, these restrictions do not apply to private or overseas donations. As a result, donors may unknowingly contribute to more families, increasing ethical concerns about inadequate screening, inconsistent safeguards, and the risk of accidental consanguinity.[70, 88, 128]

3.2.8 Legislation

Legislation governing, and or related to, publicly-funded DAHR services was identified for all 10 selected countries (see Appendix D, Table D 8). Similar to Section 3.2.5 Governance, in each of the selected countries, it should be noted that

the legislation regulating DAHR and AHR were often the same. Where specific legislation was identified in relation to DAHR, this was noted.

In Denmark, France, Portugal and Sweden, legislation governing the populations eligible and or medical indications required for publicly-funded DAHR services was identified. These documents include:

- Denmark: the Act on Assisted Reproduction[19] (and the associated amendments[20-24])
- France: the Bioethics Law, which is enshrined in the Public Health Code[28, 29]
- Portugal: Medically assisted procreation: Law No.32/2006 (Consolidated Legislation)[56]
- Sweden: the Act on Genetic Integrity.[30]

Of note, in Germany, while sperm and embryo donation are legally permitted (although not publicly funded), egg donation is prohibited within the legislation (Embryo Protection Act – EschG).[53]

In Australia, France and Germany, there is legislation governing the AHR treatments that can be provided through their national health insurance services. In Australia, the Universal Health Insurance scheme Medicare is contained within the Health Insurance Act 1973;[111] in France L'Assurance Maladie is the state-run health insurance that outlines reimbursements for publicly-funded healthcare treatments,[26] while the Public Health Code is the legislation governing what is offered and to who;[28, 29] in Germany artificial insemination is legislated within the Social Code Fifth Book,[52] which outlines what costs are covered by the national health insurance fund (with no costs covered for DAHR services).

In Australia, Denmark, France, Portugal, Sweden and the UK, the number of times in which a donor can donate, the number of children born, or the number of viable pregnancies and or families in which children are born, from donor gametes and or embryos is legally regulated:

- Australia: donor limits vary because of jurisdictional differences in legislation that occurs across states.[129] For example, in Western Australia and New South Wales, donors are limited to a maximum of five families, with no limit to the number of children conceived with the same donor within these five families. In Victoria, a donor is legally permitted to donate to 10 women or birthing people.[129]
- Denmark: a sperm donor can donate to 12 families (with geographical distribution), and an egg donor can donate six times in their lifetime.[19, 24]
- France: the use of gametes from the same donor may not deliberately lead to the birth of more than 10 children.[29]

- Portugal: egg donors can donate four times in their lifetime, and sperm donors can donate to up to eight families.[60]
- Sweden: donors can donate to no more than six families.[31]
- the UK: donors can donate to no more than 10 families.[70]

Further legislation was also identified, that, while not directly governing the provision of publicly-funded DAHR services, may impact service delivery, including legislation related to:

- the handling of human tissues and cells (for example, the Danish Tissue Act in Denmark,[130] Law No.12/2009 in Portugal,[57] and the Use of tissues and cells in healthcare and clinical research in Sweden[31])
- the provision of broader healthcare services (for example, the Health and Care Act 2022 in the UK[131])
- the obligations of healthcare professionals and tissue establishments in connection to AHR (for example, ROAD no 9351 of 26/05/2015 in Denmark which provides guidance on serious adverse events, when pre-implantation genetic diagnosis can be performed and so on[45])
- and medicinal products (for example, Ordinance No. 300/2024/1 in Portugal which outlines that medicines intended for the treatment of infertility are reimbursed at 90%[58]).

4 Discussion

Donor-assisted human reproduction has expanded AHR services to those who previously may not have been able to conceive.[11] As with AHR, there are significant costs associated with DAHR.[132] However, it has been noted that it is cost-effective for societies to pay for fertility treatments through public funding, due to the value of the societal and economic contributions of the children conceived as a result of the fertility treatment, over the course of their lives.[11] Despite this, the extent to which AHR, or more specifically DAHR, services are publicly-funded, still varies internationally. As of 2026, in Ireland there are currently no publicly-funded services for DAHR.[3] An understanding of which DAHR services are publicly funded internationally, and who is eligible to access such services, will inform the consideration of and development of a policy in relation to publicly-funded services for DAHR in Ireland. An international scoping review of 10 countries was undertaken; these countries were selected based on a combination of factors, including having a similar health service structure, population size and geographical proximity to Ireland. For European countries, equality of access to safe and efficient fertility treatments was also considered using the *European Fertility Treatment Policy Atlas 2024* .[133]

4.1 DAHR interventions and eligible populations

Donor-assisted human reproduction interventions which require donor sperm, donor eggs, or donor sperm and donor eggs (double donation) were identified as having at least part-funding in nine of the selected countries. The three most commonly publicly-funded DAHR interventions across the selected countries, were IUI, IVF and ICSI. Germany is the notable exception of the selected countries, as it does not legally permit egg donation through the Embryo Protection Act, and does not publicly fund any DAHR services through its national statutory health insurance system.[52] This has led to a number of women or birthing people in Germany seeking cross-border reproductive care,[134] and a review of the ban on egg donation.[135]

In countries where full or partial public funding for DAHR services is available, the number of cycles or rounds for the DAHR intervention may be limited. Within the selected countries, the number of cycles or rounds publicly funded ranged from one full cycle of IVF or ICSI in Northern Ireland, to up to six cycles of IVF or ICSI for a first and second child in Denmark.[43] Of note, Australia was the only country identified within the current scoping review that did not limit the number of rounds and or cycles a couple or individual can undergo with the support of public reimbursement, but as stated previously, only partial reimbursement is provided.[95] Additionally, while the 2013 NICE guidelines recommend that three full IVF cycles are funded for eligible people,[69] of the ICBs included within the current review, only North East London ICB funds three full IVF cycles.[74] Of note, the updated 2026 NICE guidelines now recommends a further three IVF cycles are offered, if the first three are unsuccessful.[91] In 2013, Berg Brigman et al.[136] stated that in general, the more generous the IVF coverage (in terms of the number of cycles funded and the share of the cost publicly funded), the greater the restrictions employed in regard to who may be covered. This is not reflected within the current scoping review, with Denmark providing the highest number of publicly-funded IVF cycles (six for first and second children), and what is deemed as a liberal eligibility criteria (access for couples and individuals, requiring donor sperm, eggs and or double donation).[19] While it was noted that budgetary constraints are likely to play a role in any restrictions placed on publicly-funded IVF, with a declining fertility rate in recent years (1.5 children per woman in 2023),[137] the Danish government has actively invested 45 million kroner (approximately six million euro) annually to increase the number of IVF rounds publicly-funded since 2024.[43]

In terms of eligible populations, across the selected countries, the eligibility criteria for DAHR were the same as that for AHR, with the countries then further outlining if they funded the use of donor gametes and or embryos where necessary. Couples were most commonly eligible for publicly-funded IUI, IVF and or ICSI using donor

sperm, donor eggs and or double donation, across the selected countries. It was unclear in Northern Ireland if individuals can avail of publicly-funded DAHR services,[81] while the eligibility criteria in Scotland stipulates that recipients must be in a stable couple.[83] Previously it was noted that there could be two groups of countries distinguished: those with more liberal regulations extending access to AHR to individuals and LGBTQI+ couples, and those with more restrictive policies limiting access to opposite-sex couples with medical indications.[136] However, in recent years there has been progressive movement for countries to be more inclusive in who can receive AHR and or DAHR services, and who is publicly-funded. In 2016 Sweden permitted individuals access to DAHR services in the publicly-funded system;[33] in 2021 France amended the Bioethics law to permit individuals and LGBTQI+ couples to access DAHR services through their national statutory health insurance system;[28, 29] and in 2024 Australia broadened their definition of infertility to ensure individuals and LGBTQI+ couples are eligible for Medicare rebate for DAHR services.[92]

Further eligibility criteria outlined by the selected countries included the need for treatment (such as an indication of sub-fertility or infertility, or being in a same-sex couple or being an individual), restrictions on age and or BMI, use of substances such as alcohol and tobacco, and or having children already. It is noted that in countries where an indication of sub-fertility or infertility is required for access to DAHR, this can lead to increased barriers to access for certain groups. For example, in England, where access to DAHR services depends on evidence of infertility, for same-sex couples this may require self-funded insemination attempts or additional assessments. This may lead to same-sex couples facing increased financial and time-related barriers compared to opposite-sex couples.[99] While indications were outlined as to when donor gametes and or embryos are typically funded (for example, in Portugal donor sperm use is justified in situations including azoospermia),[60] across the selected countries this was generally at the discretion of the treating medical professional. Additionally, in Northern Ireland and Wales, any previous privately-funded AHR treatment is considered when assessing eligibility for access to publicly-funded AHR and or DAHR services.[81, 89] These restrictions, as a whole, may reflect attempts to balance clinical effectiveness, cost effectiveness and fairness in the allocation of limited healthcare resources.[138] The European Society of Human Reproduction and Embryology (ESHRE) Task Force further emphasised that access to AHR should be guided by principles of equity and non-discrimination, while recognising the need for the responsible use of public funds.[139]

4.2 Funding

In regard to funding sources, the services highlighted within this scoping review were primarily funded through national public healthcare systems[19, 33, 56, 81, 86, 89] or

national statutory health insurance system.[25, 62, 64] In 2008, the ESHRE Task Force on Ethics and Law recommended that countries should at least provide partial reimbursement for reproductive care treatment, to ensure equitable access for all citizens.[139] This is similar to what was identified for Australia, Denmark and Portugal, where the patient may incur costs for DAHR services; such as partial costs for DAHR interventions in Australia,[62, 64] and costs toward medicine in Portugal and Denmark.[58] Additionally, in England, two ICBs (North East London[74] and Staffordshire and Stoke-on-Trent[75]) outlined that while the AHR intervention itself (such as IUI and or IVF) may be fully publicly funded (once eligibility was met), the donor sperm and or donor eggs required must be privately funded.[74, 75] A 2020 (unpublished) Health Research Board (HRB) evidence brief highlighted that partial funding coverage models are common internationally and reflect efforts to balance equity, affordability and service capacity.[138]

4.3 Organisational aspects

Across the selected countries, information around how publicly-funded DAHR services are organised was identified for referral pathways, service provider characteristics and timelines to access services. In nine of the selected countries, access to publicly-funded DAHR services follows a stepwise model of care, beginning with referral from primary care or consultant services, and progressing from initial assessment to advanced treatments (including IVF with donor gametes and or embryos). In countries such as Denmark, France and Sweden referrals also include additional psychological and social assessments or interviews prior to AHR and DAHR treatment.[20, 27, 112] For AHR generally these assessments explore if the couple or individual will be able to provide the necessary care for a child after birth. Specific to DAHR, in France, the interviews undertaken must include discussion around access to non-identifying donor data, and the identity of the donor by the donor-conceived person.[27] In Sweden, a special assessment is undertaken which takes into account the medical, psychological and social conditions of the couple and or individual.[33] This assessment includes investigating if the request for donation treatment is well sought out, and if the person to become a parent understands there will not be a genetic connection with the potential child (where appropriate).[33] While these additional steps may enhance donor-conceived person safeguarding, they may also extend timelines to undergo DAHR interventions, and introduce variability in access, particularly for same-sex couples (due to possible discrimination) and individuals (as being a single parent may be seen as a risk factor).[140] This stepwise approach to accessing DAHR services aligns with the 2020 HRB evidence brief on assisted reproductive technologies which highlighted that stepwise referral and treatment models are widely used in publicly-funded systems and aim at balancing clinical

appropriateness, with the efficient use of resources.[138] This is of particular importance given the high costs associated with advanced AHR procedures.[138]

Findings from this scoping review also identified that DAHR services are commonly delivered through a mixed public-private model, with publicly-funded DAHR interventions often delivered in private clinics through contractual arrangements. A 2024 European survey on ART and IUI legislation, regulation and funding outlined that mixed provider models can improve capacity and reduce waiting times when appropriately regulated, but that they also require robust governance frameworks to ensure consistency, transparency, and quality of care.[13] Centralisation of DAHR services was also identified in Northern Ireland, Scotland and Wales and while this may support quality and safety, centralisation of services can also lead to regional variation in regard to access.[141]

It was also identified that timelines to access DAHR services were influenced by a combination of referral pathways, eligibility criteria, service capacity, and donor material availability. Across the selected countries, donor material availability, particularly donor egg availability, was identified as a key time constraint to accessing services. In France, waiting times for donor eggs are reported to average between 12 and 30 months,[27] while in England (Lancashire and South Cumbria ICB), where donor eggs are unavailable, eligible patients may be placed on a hospital waiting list for up to three years (prior to a review of eligibility).[77] A 2021 UK study outlined that while a shortfall of egg donors in the UK is likely multi-factorial, there is a significant lack of knowledge around the practice of egg donation in the general public.[142] Specific to donor sperm, a 2025 article outlining an ESHRE Journal Club discussion on sperm donation highlighted that donor shortages are a major limiting factor in the delivery of DAHR services.[143] It was stated that policies that allow the use of known donors may reduce waiting times, but can also introduce additional financial and ethical considerations, and may not be equally accessible to all patients.[143]

4.4 Donor material management

Across the selected countries, donor gametes and embryos are primarily accessed through regulated fertility clinics or licensed gamete banks, rather than through informal or private arrangements. This aligns with recommendations from the International Federation of Gynaecology and Obstetrics which emphasises the importance of traceability, quality assurance and minimisation of infectious risk in the use of donated gametes or embryos.[16] Evidence from the 2024 ESHRE European survey on ART and IUI legislation, regulation and funding, highlighted that most European countries also rely on centrally regulated arrangements for donor material allocation, often with fertility clinics or healthcare professionals responsible

for matching donors and recipients according to legal and clinical criteria.[13] Findings from this scoping review are consistent with this model, particularly in Denmark, France, and Sweden where recipients generally do not select specific donors themselves within publicly-funded DAHR services, and donor allocations are managed by clinical teams.[26, 30, 97]

The distinction between anonymous (non-ID release), ID-release, and known donors was highlighted across the counties. The majority of countries are shifting from anonymous donation towards identity-release models, reflecting the growing recognition of the rights of the donor-conceived person to access information about their genetic origins.[144] Allowing the use of known donors in publicly-funded systems, as identified in Denmark, Sweden and the UK, may reduce waiting times but can also introduce additional ethical, legal and financial considerations.[24, 33, 70] To address this somewhat, enhanced assessments of donor motivation and relationship dynamics are required in countries where known donors can be used (such as Sweden),[33] and countries such as Denmark clearly outline that recipients must pay the costs of donor screening and donor material storage when using a known donor.[24] This is supported by a 2024 systematic review synthesising third-party reproduction guidelines around the management and care of donors.[145] This review outlined that known-donor arrangements are associated with additional psychosocial assessment, counselling, and regulatory safeguards to ensure voluntariness, manage relational risks, and maintain safety in DAHR.[145] In Denmark, a cross-donation model was also identified, where a known donor contributes to a pool of donors rather than directly to the recipient, while maintaining donor anonymity and reducing relational risks.[45]

Australia, Sweden, and the UK allow donor material to be imported from abroad, subject to regulatory approval.[65, 70, 116] While cross-border movement of donor gametes has been used to address domestic donor shortages, this practice may raise challenges related to donor limits, record-keeping, regulatory oversight, and long-term traceability of donor-conceived people, particularly where donor material moves across jurisdictions with differing legal frameworks.[146] Limited information was identified on the funding of gamete and or embryo storage, after the materials have been allocated to recipients. While the DAHR intervention may be publicly funded, storage is often time limited or subject to additional cost. Who is responsible for storing and disposing of gametes and or embryos was identified in Australia, Denmark and France, and was governed by legal and ethical rules linked to consent, life events such as death and couple separation, and legal storage time limits.[24, 28, 65] In 2021 it was noted that issues surrounding the storage, transport and disposition of gametes and embryos will continue to rise and become more complex as AHR interventions become more advanced.[119] Clear policies by fertility providers

and clinics around the management of donor material, are needed to ensure patients and healthcare professionals alike are adequately informed.[119]

4.5 Governance and legislation

Governance and legislation related to publicly-funded DAHR services was identified for all of the selected countries. It was noted that in all of the selected countries, AHR and DAHR are overseen by the same regulatory frameworks, with no specific regulatory bodies and or agencies identified in relation to DAHR specifically. This is in line with the results of the 2024 European survey on ART and IUI legislation, regulation and funding.[13] This survey outlined that in 39 of the 43 countries included, AHR services were governed through national legal and regulatory frameworks that cover multiple treatment types, including those used in DAHR. Specific rules on gamete and or embryo donation are incorporated within these frameworks, rather than being separated into a distinct governance structure.[13]

Generally, in the selected countries, the AHR and or DAHR legal framework is governed by ministries or departments of health, and supported by regulatory bodies responsible for the licensing, inspection and quality assurance of the clinics undertaking AHR and DAHR.[19, 27, 60, 66, 70, 85, 121] Additionally, in Australia, England and Sweden governance is multi-layered, with national legislation complemented by regional or local decision-making, particularly in relation to service commissioning and eligibility criteria.[67, 80, 122] This is reflected in the 2024 European survey on ART and IUI legislation, regulation and funding, which reported that public funding and eligibility criteria may vary regionally within countries.[13] It was stated that this may be caused by decentralised policy decisions, and differing local interpretations of national frameworks.[13] While such decentralisation may allow services to meet local needs, it may also lead to differences in who receives services, how services are provided, and how fairly services are accessed.[13]

In was also noted that in the majority of selected countries donor-related aspects of DAHR services are regulated within national legislation, including limits on the number of donations allowed and or families created,[19, 24, 29, 31, 60, 70, 129] maximum storage periods for gametes and embryos,[13, 70, 119] and about when information on genetic origins can be accessed.[27, 70] In regard to limits on the number of donations allowed and or families created, within the selected countries the limits ranged from an egg donor being allowed to donate four times in their lifetime in Portugal,[60] to a sperm donor being able to donate to 12 families in Denmark.[29] A 2025 ESHRE position paper outlined that the ESHRE is in favour of setting an international limit on the number of offspring per donor.[147] This will provide clarity and secure the expectations of all involved in DAHR services. Additionally, the ESHRE suggests that all donors should be offered the possibility to a set a lower limit on the number of

families created from their own gametes, that is lower than any regulated limit.[147] Overall, the legislation identified demonstrates that not only are clinical processes and DAHR service delivery governed through national legislation, but ethical and social considerations are also covered, particularly in relation to donor identity, the relationship between the donor and the donor-conceived person, and the rights of the donor conceived person. This is consistent with the 2020 HRB evidence brief, which highlighted that AHR legislation often seeks to balance medical, ethical, and societal factors.[138]

4.6 Counselling, communication and information provision

Counselling, communication and information provision related to DAHR services was identified for all 10 of the selected countries. This included providing information to raise awareness of publicly-funded DAHR services in those who are eligible, and ensuring informed, voluntary and emotionally supported decision-making is undertaken by donors and recipients.

Counselling was identified as an important element of DAHR service provision, with the UK and Australia providing the most detailed guidance, focusing on the psychological and ethical implications of donor conception.[65, 69, 70] A 2026 mapping review of psychosocial support provisions in DAHR outlined that while DAHR services were once primarily viewed as medical interventions, it is now widely recognised that these services have wide-reaching, complex ethical, social and psychological implications for all involved.[148] This had led to many organisations, such as the International Infertility Counsellors' Organisation, arguing in favour of comprehensive psychosocial service provision, encompassing a number of areas including decision-making support, implications counselling, and therapeutic counselling for those undergoing DAHR interventions.[148] The 2015 ESHRE guidelines around psychosocial care in infertility and AHR also acknowledges that some patients may be more vulnerable to the demands of AHR treatment, and may require specialised psychosocial care (such as infertility counselling or psychotherapy) before, during and after treatment.[149]

This scoping review also identified what information is provided to patients, prior to undergoing DAHR treatment in the selected countries. In Australia, Denmark, Portugal, Sweden and the UK, healthcare professionals are required to provide comprehensive information on clinical success rates, risks and complications, genetic and hereditary risks, legal implications, and practical aspects of treatment.[30, 45, 60, 65, 68, 69] This information should be provided in an accessible and appropriate way, and should be tailored to a patients individual needs.[71] This approach aligns with ethical standards on informed consent, which emphasise the provision of clear, understandable and relevant information, prior to a medical intervention.[150]

4.7 Ethical and social considerations

A central ethical consideration identified within this scoping review was informed consent, which underpinned all DAHR interventions. Informed consent was often supported by counselling and information provision to ensure that donors and recipients understood the medical, psychological, social and legal implications of the treatment. This is consistent with a 2022 study comparing AHR regulation in Ireland with other developed countries,[151] which highlighted that informed consent in AHR (including in relation to donor conception) must address not only clinical risks but also the long-term implications of DAHR interventions for individuals, families and donor-conceived people.[151]

Although some countries promote equitable access to AHR and or DAHR through liberal eligibility criteria and broad funding systems (such as France[28]), disparities in access are still apparent, in particular for LGBTQI+ couples, those living in remote or rural areas,[128] ethnic minorities,[103] and those from lower socioeconomic backgrounds.[128] The 2026 update of the NICE guidelines for fertility problems supports more inclusive access to fertility care for everyone, and uses terminology such as women, trans men and non-binary people with reproductive organs when discussing the eligibility criteria for IVF.[91] A 2024 systematic review investigating the cost effectiveness of AHR interventions outlined that access to AHR and DAHR is frequently determined by funding mechanisms, eligibility criteria and social determinants, raising persistent ethical concerns regarding equity in publicly-funded or regulated systems.[132]

The importance of transparency and the rights of donor-conceived people was highlighted in Australia, France, Sweden and the UK. These countries recognise a child's right to information about their genetic origins, once they reach adulthood. This is aligned with a 2024 scoping review investigating the ethical, legal and social implications of gamete donation, which noted that Australia, France and Sweden underwent legislative reforms to ensure that donor-conception policies prioritise the long-term interests and well-being of donor-conceived people.[152] These changes in legislation reflected a growing commitment to enabling donor-conceived people to access their genetic heritage, fostering identity formation and psychosocial wellbeing.[152] Additionally, concerns regarding child welfare may have also resulted in countries such as Sweden assessing whether intended parents can provide a stable and supportive home environment, prior to undergoing publicly-funded DAHR interventions.[30, 33] This practice reflects the ethical considerations set out by the ESHRE Task Force on Ethics and Law, where it is outlined that the wellbeing of the donor-conceived person should be a central consideration of DAHR.[140] The ESHRE Task Force on Ethics and Law supports psychological assessment of the intended parents, while cautioning against discriminatory application of such

assessments, ensuring that decisions are based on evidence rather than subjective judgments.[140]

4.8 Limitations

While this scoping review presents a comprehensive descriptive analysis of publicly-funded DAHR services in 10 selected countries, there are notable limitations. Firstly, this review is a descriptive analysis and does not include an evaluation of the effectiveness or delivery of DAHR services. Furthermore, AHR and DAHR services provided nationally in the selected countries were often heavily linked. Many of the selected countries used the same (or very similar) eligibility criteria for limiting access to AHR and DAHR services, and funded the same (or very similar) interventions for both AHR and DAHR services. This made it increasingly difficult to identify public funding related specifically to donor components of services, such as the storage of donor materials. Additionally, while efforts were made to ensure that the services outlined are currently in place (through triangulation of grey and published literature, and contacting key representatives in selected countries), some of the outlined services may represent what is intended or recommended to be provided, rather than those that are actually being delivered. Lastly, the DAHR landscape is complex, spanning multiple clinical specialties and impacting many patient subgroups. The literature search conducted within this review focused on the identification of national policy documents and information related to DAHR services. While an inclusive search strategy was adopted, it is possible that some policy documents and information that focused on specific sub-groups (such as those with specific rare diseases or disorders) may have been missed.

5 Conclusion

This scoping review of publicly-funded services for DAHR identified that IUI, IVF and or ICSI using donor gametes and or embryos are typically partially or fully publicly funded for couples, and or individuals, in the selected countries examined. While eligibility criteria vary by country, they are generally the same as the criteria used for AHR within any given country, with donor materials then funded where required (as decided by the treating healthcare professional). Funding is provided through national public health systems or national statutory health insurance systems, and in countries where partial funding is provided, patients may pay costs towards treatments, medications and or donor materials. DAHR services typically follow a stepwise model of care, beginning with referral from primary care or consultant services, and progressing from initial assessment to advanced treatments.

Information on the management of donor material was limited but indicated that publicly-funded donor materials were typically obtained through licensed fertility

clinics and gamete banks, and often selected by the treating healthcare professionals. While known donors can be used in a number of countries, increased assessment, counselling and costs were associated with this method. Governing bodies accountable for publicly-funded DAHR services are the same as those for AHR services, and included national ministries for health, or equivalent, and state agencies under their supervision. Legislation in certain countries specifies the number of times in which a donor can donate, the number of children that can be born, or the number of viable pregnancies and or families in which children are born, from donor gametes and or embryos. Ethical and social considerations around DAHR were also highlighted and included obtaining informed consent, consideration of equity, non-discrimination and fair access, and guidance regarding donor anonymity, openness, and the right of donor-conceived people to know their origins.

This review provides insights into what DAHR interventions countries offer, how services are delivered, how donor materials are managed, and the governance and funding structures used to support service delivery, and will inform the consideration of and development of a policy in relation to publicly-funded services for DAHR in Ireland, through supporting the work of the Department of Health.

References

1. Government of Ireland. Children and Family Relationships Act 2015 [Internet]. Ireland: Government of Ireland; 2015 [cited 2025 May 06]. Available from: https://www.irishstatutebook.ie/eli/2015/act/9/enacted/en/print#sec4.
2. Citizens Information. Fertility treatments and assisted human reproduction in Ireland [Internet]. Ireland: Citizens Information; 2025 [cited 2025 May 07]. Available from: https://www.citizensinformation.ie/en/birth-family-relationships/before-your-baby-is-born/fertility-treatments-and-dahr/.
3. Health Service Executive (HSE). Getting IVF and other specialist treatment through the HSE [Internet]. Ireland: HSE; 2025 [cited 2025 January 05]. Available from: https://www2.hse.ie/pregnancy-birth/trying-for-a-baby/your-fertility/getting-ivf-icsi-iui-hse/.
4. Cryos Denmark. Cryos International Sperm and Egg Bank [Internet]. Denmark: Cryos Denmark; 2025 [cited 2025 December 09]. Available from: https://www.cryosinternational.com/en-gb/dk-shop/private/?utm_source=google&utm_medium=cpc&utm_campaign=IE_Search_Customer_Sperm_All_Brand&gad_source=1&gad_campaignid=12374903278&gbraid=0AAAAAC6Nb55cgaTGPYoC88_sMwqOe-h9Z&gclid=EAIaIQobChMIpIa9luqwkQMVm4pQBh0IWSQPEAAYASAAEgKv6fD_BwE.
5. Merrion Fertility Clinic. Donor Sperm Handbook [Internet]. Ireland: Merrion Fertility Clinic; 2026 [cited 2026 January 21]. Available from: https://merrionfertility.ie/wp-content/uploads/2024/06/PIL1.45-Donor-Sperm-Handbook.pdf.
6. Merrion Fertility Clinic. Donor Egg Handbook [Internet]. Ireland: Merrion Fertility Clinic; 2026 [cited 2026 January 21]. Available from: https://merrionfertility.ie/wp-content/uploads/2025/03/PIL1.52-Donor-Egg-Handbook.pdf.
7. Clinic W. Price List [Internet]. Ireland: Waterstone Clinic; 2026 [cited 2026 January 21]. Available from: https://online.flippingbook.com/view/563537657/.
8. Merrion Fertility Clinic. Pricelist [Internet]. Ireland: Merrion Fertility Clinic; 2026 [cited 2026 January 21]. Available from: https://merrionfertility.ie/wp-content/uploads/2025/11/PIL3.6-MFC-Pricelist-12.pdf.
9. Beacon Care Fertility. IVF Costs / Pricing [Internet]. Ireland: Beacon Care Fertility; 2026 [cited 2026 January 21]. Available from: https://www.beaconcarefertility.ie/ivf-costs/?gad_source=1&gad_campaignid=19655019259&gbraid=0AAAAABTn_B4D30d7BNKp88skJfSQVyogo&gclid=CjwKCAiAj8LLBhAkEiwAJjbY73VVXOK19IJZKux7nFqk6UV111HdYS3nB8j-QApFl7fLaQEsxUyH2RoCtGUQAvD_BwE.
10. Therapie Fertility. All Inclusive Fertility Treatments For One Price [Internet]. Ireland: Therapie Fertility; 2026 [cited 2026 January 21]. Available from: https://therapiefertility.com/pricing/?utm_source=google&utm_medium=paid_search&utm_campaign=IE_SEARCH_IVF_ALL&utm_content={adgroup}&gad

_source=1&gad_campaignid=21406589496&gbraid=0AAAAABRRJT555hk0jP6U_b4UCI3759quJ&gclid=CjwKCAiAj8LLBhAkEiwAJjbY73u-qgIQc30DbwdG-nf9ihRTMJq5tlbnWXfv_4KKCGos6d9fZaVuKxoC7YcQAvD_BwE.
11. Adamson GD, Zegers-Hochschild F, Dyer S. Global fertility care with assisted reproductive technology. Fertility and Sterility. 2023;120(3, Part 1):473-82.
12. Centres for Disease Control and Prevention. About ART [Internet]. United States: CDC; 2024 [cited 2026 March 30]. Available from: https://www.cdc.gov/art/about/index.html.
13. Calhaz-Jorge C, Smeenk J, Wyns C, De Neubourg D, Baldani DP, Bergh C, et al. Survey on ART and IUI: legislation, regulation, funding, and registries in European countries-an update. Hum Reprod. 2024;39(9):1909-24.
14. Calhaz-Jorge C, De Geyter CH, Kupka MS, Wyns C, Mocanu E, Motrenko T, et al. Survey on ART and IUI: legislation, regulation, funding and registries in European countries: The European IVF-monitoring Consortium (EIM) for the European Society of Human Reproduction and Embryology (ESHRE). Hum Reprod Open. 2020;2020(1):hoz044.
15. Department of Health (Ireland). Minister for Health announces expansion eligibility of access criteria for state-funded Assisted Human Reproduction treatments [Internet]. Ireland: Deaprtment of Health; 2025 [cited 2026 January 21]. Available from: https://www.gov.ie/en/department-of-health/press-releases/minister-for-health-announces-expansion-eligibility-of-access-criteria-for-state-funded-assisted-human-reproduction-treatments/.
16. Henry L, Antsaklis A, Feldberg D, Malhotra J, Pandit S, Salazar C, et al. FIGO position statement: Gamete donations. Int J Gynaecol Obstet. 2025;170(1):15-24.
17. Ovumia. Ovumia, high quality fertility treatments [Internet]. Finland: Ovumia; 2025 [cited 2025 December 09]. Available from: https://ovumia.fi/en/.
18. Retsinformation (Denmark). CIS No 9468 of 09/06/2006: Regarding amendment of the Act on Artificial Insemination in Connection with Medical Treatment, research, etc. [Internet]. Denmark: Retsinformation; 2006 [cited 2025 December 15]. Available from: https://www.retsinformation.dk/eli/retsinfo/2006/9468.
19. Retsinformation (Denmark). LBK nr 902 of 23/08/2019: Executive Order on the Act on Assisted Reproduction in Connection with Treatment, Diagnostics and Research, etc. [Internet]. Denmark: Retsinformation; 2019 [cited 2025 December 15]. Available from: https://www.retsinformation.dk/eli/lta/2019/902.
20. Retsinformation (Denmark). BEK nr 316 af 27/03/2019: Executive Order on Assessment of Parental Unsuitability in Connection with Treatment with Assisted Reproduction [Internet]. Denmark: Retsinformation; 2019 [cited 2025 December 15]. Available from: https://www.retsinformation.dk/eli/lta/2019/316.
21. Retsinformation (Denmark). LAW No 129 of 30/01/2021: Act amending the Act on Assisted Reproduction in Connection with Treatment, Diagnostics and Research, etc. [Internet]. Denmark: Retsinformation; 2021 [cited 2025 December 15]. Available from: https://www.retsinformation.dk/eli/lta/2021/129#P1.

22. Retsinformation (Denmark). ACT No 1212 of 26/11/2024: Act amending the Act on Assisted Reproduction in Connection with Treatment, Diagnostics and Research, etc. [Internet]. Denmark: Retsinformation; 2024 [cited 2025 December 15]. Available from: https://www.retsinformation.dk/eli/lta/2024/1212.
23. Retsinformation (Denmark). ACT No 1213 of 26/11/2024: Act amending the Act on Assisted Reproduction in Connection with Treatment, Diagnostics and Research, etc. [Internet]. Denmark: Retsinformation; 2024 [cited 2025 December 15]. Available from: https://www.retsinformation.dk/eli/lta/2024/1213.
24. Retsinformation (Denmark). BEK nr 1452 of 01/12/2025: Executive Order on Assisted Reproduction [Internet]. Denmark: Retsinformation; 2025 [cited 2025 December 15]. Available from: https://www.retsinformation.dk/eli/lta/2025/1452.
25. Service Public (France). Medically assisted procreation (ART) [Internet]. France: Service Public; 2025 [updated 2025; cited 2025 December 15]. Available from: https://www.service-public.gouv.fr/particuliers/vosdroits/F31462.
26. L'Assurance Maladie: Assisted Reproductive Technology (ART) (France). Assisted reproductive technology (ART) [Internet]. France: L'Assurance Maladie; 2025 [cited 2025 December 15]. Available from: https://www.ameli.fr/assure/remboursements/rembourse/assistance-medicale-la-procreation-amp.
27. Biomedicine Agency (France). Biomedicine Agency: Procreation-medicale.fr [Internet]. France: Biomedicine Agency; 2025 [updated 2025; cited 2025 December 15]. Available from: https://www.procreation-medicale.fr/.
28. LegiFrance. Public Health Code: Title IV: Medically assisted procreation (Articles L2141-1 to L2143-9) [Internet]. France: LegiFrance; 2025 [cited 2025 December 15]. Available from: https://www.legifrance.gouv.fr/codes/section_lc/LEGITEXT000006072665/LEGISCTA000006155015/#LEGISCTA000006155015.
29. LegiFrance. Public Health Code: Chapter IV: Donation and use of gametes. (Articles L1244-1 to L1244-9) [Internet]. France: LegiFrance; 2025 [cited 2025 December 15]. Available from: https://www.legifrance.gouv.fr/codes/id/LEGIARTI000006686238/2025-11-26.
30. Ministry of Health and Social Affairs (Sweden). Act (2006:351) on Genetic Integrity etc. [Internet]. Sweden: Ministry of Health and Social Affairs; 2018 [cited 2025 December 12]. Available from: https://www.riksdagen.se/sv/dokument-och-lagar/dokument/svensk-forfattningssamling/lag-2006351-om-genetisk-integritet-m-m_sfs-2006-351/.
31. The National Board of Health and Welfare (Sweden). SOSFS 2009:32 Use of tissues and cells in healthcare and clinical research etc. [Internet]. Sweden: The National Board of Health and Welfare; 2009 [cited 2025 December 17]. Available from: https://www.socialstyrelsen.se/publikationer/sosfs-200932-anvandning-av-vavnader-och-celler-i-halso--och-sjukvarden-och-vid-klinisk-forskning-m.m.-2010-1-17/.

32. Ministry of Justice (Sweden). Bill 2017/18:155: More modern rules on assisted reproduction and parenthood [Internet]. Sweden: Ministry of Justice; 2018 [cited 2025 December 17]. Available from: https://regeringen.se/rattsliga-dokument/proposition/2018/03/prop.-201718155.
33. The National Board of Health and Welfare (Sweden). Assisted fertilisation with donated gametes guidelines [Internet]. Sweden: The National Board of Health and Welfare; 2016 [cited 2025 December 17]. Available from: https://www.socialstyrelsen.se/contentassets/5c31419fe5c74d72aa2a02c39de1e514/2016-12-36.pdf.
34. The National Board of Health and Welfare (Sweden). Assisted reproduction with embryo donation and double donation [Internet]. Sweden: The National Board of Health and Welfare; 2020 [updated 2024; cited 2025 December 17]. Available from: https://www.socialstyrelsen.se/kunskapsstod-och-regler/omraden/organ-vavnad-celler-och-blod/assisterad-befruktning-med-embryodonation-och-dubbeldonation.
35. SALAR (Swedish Association of Local Authorities and Regions). Recommendations for homogeneity in county councils' and regions' publicly funded assisted reproduction offers [Internet]. Sweden: SALAR (Swedish Association of Local Authorities and Regions); 2016 [cited 2025 December 17]. Available from: https://www.1177.se/api/hjv/unit/SE2321000040-4GHX/offers/7/files/1/SKL-Rekommendation-assisterad-befruktning.pdf.
36. Government Offices of Sweden. About parenthood [Internet]. Sweden: Government Offices of Sweden; 2025 [cited 2025 December 12]. Available from: https://www.government.se/government-policy/family-law/about-parenthood/.
37. NHS Lothian. Edinburgh Fertility Centre: Access Criteria for NHS IVF Treatment in Scotland [Internet]. Scotland: NHS Lothian; 2025 [cited 2025 January 09]. Available from: https://services.nhslothian.scot/edinburghfertilitycentre/wp-content/uploads/sites/48/2025/02/Access-Criteria-for-NHS-IVF-Treatment-v15.pdf.
38. NHS Greater Glasgow and Clyde. Glasgow Royal Infirmary Assisted Conception Service [Internet]. Scotland: NHS Greater Glasgow and Clyde; 2026 [cited 2026 February 05]. Available from: https://www.nhsggc.scot/hospitals-services/services-a-to-z/assisted-conception-service/.
39. NHS Grampian. Aberdeen Fertility Centre [Internet]. Scotland: NHS Grampian; 2026 [cited 2026 February 05]. Available from: https://www.nhsgrampian.org/aberdeen-fertility-centre.
40. Ninewells Dundee. Assisted Conception Unit Ninewells Dundee [Internet]. Scotland: Ninewells Dundee; 2026 [cited 2026 February 05]. Available from: https://www.acudundee.org/.
41. Ministry of the Interior and Health (Denmark). New agreement to help involuntarily childless people get pregnant [Internet]. Denmark: Ministry of the Interior and Health; 2024 [cited 2026 February 24]. Available from: https://www.ism.dk/nyheder/2024/februar/ny-aftale-skal-hjaelpe-ufrivilligt-barnloese-med-at-blive-gravide-.

42. Ministry of the Interior and Health (Denmark). Implementation agreement for multiple fertility treatment trials [Internet]. Denmark: Ministry of the Interior and Health; 2024 [cited 2026 February 24]. Available from: https://www.ism.dk/Media/638435167365558016/Udm%C3%B8ntningsaftale%20FL24%20fertilitetsomr%C3%A5det.pdf.
43. Ministry of the Interior and Health (Denmark). New agreement provides twice as many fertility attempts for child number two [Internet]. Denmark: Ministry of the Interior and Health; 2025 [cited 2026 February 24]. Available from: https://www.ism.dk/nyheder/2025/december/ny-aftale-giver-dobbelt-saa-mange-fertilitetsforsoeg-til-barn-nummer-to.
44. Ministry of the Interior and Health (Denmark). Implementation agreement for multiple attempts at fertility treatment for a second child [Internet]. Denmark: Ministry of the Interior and Health; 2025 [cited 2026 February 24]. Available from: https://www.ism.dk/Media/6390199123475696 34/Udm%C3%B8ntningsaftale%20om%20flere%20fors%C3%B8g%20til%20fertilitetsbehandling%20til%20andet%20barn.pdf.
45. Ministry of the Interior and Health (Denmark). Guidance on the activities and obligations of healthcare professionals and tissue establishments in connection with assisted reproduction [Internet]. Denmark: Ministry of the Interior and Health; 2015 [cited 2025 May 14]. Available from: https://www.retsinformation.dk/eli/retsinfo/2015/9351.
46. Trianglen Fertility Clinic (Denmark). Fertility treatment via a public health referral at Trianglen [Internet]. Denmark: Trianglen Fertility Clinic; 2026 [cited 2026 February 11]. Available from: https://www.trianglen.dk/en/fertility-treatments-services/prices/free-fertility-treatment.
47. LGBT Familie (Denmark). Access to assisted reproduction [Internet]. Denmark: LGBT Familie; 2026 [cited 2026 February 11]. Available from: https://lgbtfamilie.dk/lgbtfamilie/en/lgbt-family-formation/assisted-reproduction/access-to-assisted-reproduction/.
48. Skive Fertility Clinic (Denmark). Fertility Treatment [Internet]. Denmark: Skive Fertility Clinic; 2026 [cited 2026 February 11]. Available from: https://www.hospitalsenhedmidt.dk/afdelinger-og-steder/regionshospitalet-viborg/kvindesygdomme-og-fodsler/fertilitetsklinikken-skive/fertilitetsbehandling/.
49. Rigshospitalet (Denmark). The Fertility Clinic [Internet]. Denmark: Rigshospitalet; 2026 [cited 2026 February 11]. Available from: https://www.rigshospitalet.dk/english/departments/juliane-marie-centre/gynaecology-fertility-and-obstetrics/fertility/Pages/default.aspx.
50. Federal Republic of Germany. Apply for cost coverage for measures to induce pregnancy [Internet]. Germany: Federal Republic of Germany,; 2025 [cited 2025 December 12]. Available from: https://verwaltung.bund.de/leistungsverzeichnis/EN/leistung/99134005017000/herausgeber/LeiKa-584439/region/00.
51. Federal Ministry for Family Affairs SC, Women and Youth (Germany),. Fertility Information Portal [Internet]. Germany: Federal Ministry for Family Affairs,

Senior Citizens, Women and Youth (Germany); 2026 [cited 2026 February 05]. Available from: https://www.informationsportal-kinderwunsch.de/.
52. Federal Ministry of Justice and Consumer Protection (Germany). Social Code (SGB) Fifth Book (V) - Statutory Health Insurance - (Article 1 of the Act of 20 December 1988, Federal Law Gazette I p. 2477) § 27a Artificial Insemination [Internet]. Germany: Federal Ministry of Justice and Consumer Protection (Germany),; 1988 [cited 2025 December 12]. Available from: https://www.gesetze-im-internet.de/sgb_5/__27a.html.
53. Federal Ministry of Justice and Consumer Protection (Germany). Act for the Protection of Embryos (Embryo Protection Act - ESchG) § 1 Misuse of reproductive techniques [Internet]. Germany: Federal Ministry of Justice and Consumer Protection (Germany); 1990 [cited 2025 December 15]. Available from: https://www.gesetze-im-internet.de/eschg/__1.html.
54. Federal Ministry for Family Affairs SC, Women and Youth (Germany),. Guideline of the Federal Ministry for Family Affairs, Senior Citizens, Women and Youth on the granting of subsidies for the promotion of ART measures [Internet]. Germany: Federal Ministry for Family Affairs, Senior Citizens, Women and Youth; 2015 [cited 2026 January 13]. Available from: https://www.informationsportal-kinderwunsch.de/resource/blob/147120/7174105f36b4c515d017f72af22a48d2/bundesfoerderrichtlinie-201802-data.pdf.
55. Bartnitzky S, Blumenauer V, Czeromin U, Fehr D, Grewe C, Krussel JS, et al. D·I·R Annual 2023 – The German IVF-Registry [Internet]. Germany: Journal of Reproductive Medicine and Endocrinology; 2024 [cited 2026 February 23]. Available from: https://www.deutsches-ivf-register.de/perch/resources/dir-annual-2023-english.pdf.
56. Diario Da Republica (Portugal). Law No. 32/2006 of 26 July: Medically assisted procreation [Consolidated version] [Internet]. Portugal: Diario Da Republica; 2006 [cited 2025 January 09]. Available from: https://diariodarepublica.pt/dr/legislacao-consolidada/lei/2006-34529775.
57. Diario Da Republica (Portugal). Law No. 12/2009: Establishes the legal framework for quality and safety relating to the donation, collection, analysis, processing, preservation, storage, distribution and application of tissues and cells of human origin, transposing into national law Directives No. 2004/23/EC of the European Parliament and of the Council of 31 March, 2006/17/EC of the Commission of 8 February and 2006/86/EC, of 24 October [Internet]. Portugal: Diario Da Republica; 2009 [cited 2025 January 09]. Available from: https://diariodarepublica.pt/dr/legislacao-consolidada/lei/2009-75286810.
58. Diario Da Republica (Portugal). Ordinance No. 300/2024/1, of 25 November [Internet]. Portugal: Diario Da Republica; 2024 [cited 2025 January 09]. Available from: https://diariodarepublica.pt/dr/detalhe/portaria/300-2024-897543551.
59. Diario Da Republica (Portugal). Regulatory Decree No. 6/2016, of 29 December [Internet]. Portugal: Diario Da Republica; 2016 [cited 2025 January 09]. Available from: https://diariodarepublica.pt/dr/detalhe/decreto-regulamentar/6-2016-105643546.

60. National Council for Medically Assisted Reproduction. National Council for Medically Assisted Reproduction [Internet]. Portugal: National Council for Medically Assisted Reproduction; 2025 [cited 2025 January 09]. Available from: https://www.cnpma.org.pt/.
61. (Sweden) NBoHaW. Appendix – Correction SOSFS 2009:32 Use of tissues and cells in health care and clinical research, etc. [Internet]. Sweden: National Board of Health and Welfare (Sweden); 2009 [cited 2026 January 13]. Available from: https://www.socialstyrelsen.se/contentassets/d775fa8a3835413ba142606fe52bc411/2010-1-17-rattelseblad.pdf.
62. Department of Health DaA-AG. MBS Online - Medicare Benefits Schedule [Internet]. Australian Government; 2025 [cited 2025 December 12]. Available from: https://www.mbsonline.gov.au/.
63. Services Australia. Assisted reproductive technology services [Internet]. Australia: Services Australia; 2025 [cited 2025 December 12]. Available from: https://www.servicesaustralia.gov.au/mbs-billing-for-assisted-reproductive-technology-services?context=20.
64. Services Australia. Item numbers for billing Assisted Reproductive Technology services [Internet]. Australia: Services Australia; 2025 [cited 2026 January 13]. Available from: https://www.servicesaustralia.gov.au/mbs-item-numbers-for-billing-assisted-reproductive-technology-services?context=20.
65. National Health and Medical Research Council (Australia). Ethical guidelines on the use of assisted reproductive technology [Internet]. Australia: NHMRC; 2017 [updated 2023; cited 2025 December 15]. Available from: https://www.nhmrc.gov.au/about-us/publications/art.
66. Department of Health and Aged Care (Australian Government). Assisted Reproductive Technology Storage Funding Program: Guidelines [Internet]. Australia: Australian Government; 2025 [cited 2025 December 15]. Available from: https://www.health.gov.au/sites/default/files/2024-08/art-storage-funding-program-guidelines.pdf.
67. Parliament of Australia. CHAPTER 2 - Regulation of donor conception practices [Internet]. Australia: Parliament of Australia; 2026 [cited 2026 March 02]. Available from: https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Legal_and_Constitutional_Affairs/Completed_inquiries/2010-13/donorconception/report/c02.
68. Legislation.gov.uk. Human Fertilisation and Embryology Act 2008 [Internet]. United Kingdom: Legislation.gov.uk; 2008 [cited 2025 December 12]. Available from: https://www.legislation.gov.uk/ukpga/2008/22.
69. National Institute for Health and Care Excellence (UK). Fertility problems: assessment and treatment (CG156) [Internet]. United Kingdom: NICE; 2013 [updated 2017; cited 2025 December 12]. Available from: https://www.nice.org.uk/guidance/cg156/.
70. Human Fertilisation & Embryology Authority (HFEA) (UK). Donation [Internet]. United Kingdom: HFEA; 2025 [cited 2025 December 12]. Available from: https://www.hfea.gov.uk/donation/?utm_source.

71. Fertility Network UK. Fertility Network UK [Internet]. UK: Fertility Network UK; 2025 [cited 2025 January 09]. Available from: https://fertilitynetworkuk.org/.
72. House of Commons Library. General debate: IVF provision [Internet]. UK: House of Commons Library; 2023 [cited 2026 January 14]. Available from: https://researchbriefings.files.parliament.uk/documents/CDP-2023-0194/CDP-2023-0194.pdf.
73. NHS Cambridgeshire & Peterborough. Clinical Threshold Policy: Assisted Conception [Internet]. England: NHS Cambridgeshire & Peterborough; 2022 [cited 2026 January 12]. Available from: https://view.officeapps.live.com/op/view.aspx?src=https%3A%2F%2Fwww.cpics.org.uk%2Fdownload%2Fassisted-conception-july-2022-v8pdf.pdf%3Fver%3D4318%26doc%3Ddocm93jijm4n1146&wdOrigin=BROWSELINK.
74. NHS North East London. North East London Integrated Care Board (ICB) Fertility Policy [Internet]. England: NHS North East London; 2023 [cited 2026 January 12]. Available from: https://northeastlondon.icb.nhs.uk/wp-content/uploads/2023/04/NHS-North-East-London-Fertility-Policy_FINAL_April-2023.pdf.
75. NHS Staffordshire and Stoke-on-Trent. Commissioning Policy: Assisted Conception for Infertility [Internet]. England: NHS Staffordshire and Stoke-on-Trent; 2024 [cited 2026 January 12]. Available from: https://staffsstoke.icb.nhs.uk/your-nhs-integrated-care-board/our-publications/governance-handbook/all-policies/commissioning/ivf-aligned-policy-v1-1-march-2024/?layout=file.
76. NHS Humber and North Yorkshire ICB, NHS South Yorkshire ICB, NHS West Yorkshire ICB. Access to Infertility Treatment Commissioning Policy Document 2025-2028 [Internet]. England: NHS Humber and North Yorkshire ICB, NHS South Yorkshire ICB and NHS West Yorkshire ICB; 2025 [cited 2026 January 12]. Available from: https://syics.co.uk/application/files/7017/6544/4065/SY_ICB_Access_to_Infertility_Treatment_Policy_V1.0_3.12.25_Final.pdf.
77. NHS Lancashire and South Cumbria. Policy for Assisted Conception Services [Internet]. England: NHS Lancashire and South Cumbria; 2022 [cited 2026 January 12]. Available from: https://www.healthierlsc.co.uk/application/files/1817/0721/6841/LSCICB_Clin20_Policy_for_Assisted_Conception_Services_v2.1.pdf.
78. NHS Kent and Medway. Schedule of policy statements for assisted reproductive technologies (ART) for Kent and Medway Integrated Care Board [Internet]. England: NHS Kent and Medway; 2024 [cited 2026 January 12]. Available from: https://www.kentandmedway.icb.nhs.uk/download/kentandmedwayartpolicydocumentjune2024-1pdf.pdf?ver=2633&doc=docm93jijm4n1340.
79. NHS Devon. Assisted Conception [Internet]. England: NHS Devon; 2022 [cited 2026 December 12]. Available from: https://onedevon.org.uk/download/assisted-conception/?wpdmdl=2061&refresh=69650271203e81768227441.

80. UK Government. Guidance: NHS-funded in vitro fertilisation (IVF) in England [Internet]. England: UK Government; 2025 [cited 2026 January 12]. Available from: https://www.gov.uk/government/publications/nhs-funded-ivf-in-england/nhs-funded-in-vitro-fertilisation-ivf-in-england#icb-commissioning-policies-for-nhs-funded-ivf-in-england.
81. Department of Health (Northern Ireland). Eligibility for HSC funded IVF and related treatments effective from 1st June 2019 [Internet]. Northern Ireland: Department of Health; 2020 [cited 2025 January 09]. Available from: https://belfasttrust.hscni.net/wp-admin/admin-ajax.php?juwpfisadmin=false&action=wpfd&task=file.download&wpfd_category_id=208&wpfd_file_id=1999&token=&preview=1.
82. Belfast Health and Social Care Trust (NI). Other services [Internet]. Northern Ireland: Belfast Health and Social Care Trust (NI); 2025 [cited 2025 December 10]. Available from: https://belfasttrust.hscni.net/services/rfc/treatment-options/other-services/.
83. NHS Scotland. Access CriteriaNHS IVF Treatment Scotland [Internet]. Scotland: NHS Scotland; 2017 [cited 2026 January 12]. Available from: https://www.fertility.nhs.scot/wp-content/uploads/2025/02/Access-Criteria-NHS-IVF-Treatment-Scotland.pdf.
84. NHS Lothian. Edinburgh Fertility Centre: Access Criteria for NHS Funded Donor Insemination [Internet]. Scotland: 2025 [cited 2025 January 09]. Available from: https://services.nhslothian.scot/edinburghfertilitycentre/wp-content/uploads/sites/48/2025/05/NHS-Funded-DI-Access-Criteria.pdf.
85. NHS Scotland. Fertility Scotland [Internet]. Scotland: NHS Scotland; 2025 [cited 2025 January 09]. Available from: https://www.fertility.nhs.scot/.
86. NHS Scotland. Right Decision Service: supporting decisions for Scotland's health and care: Infertility [Internet]. Scotland: NHS Scotland; 2025 [cited 2025 January 09]. Available from: https://www.rightdecisions.scot.nhs.uk/borders-ref-help-toolkit/gynaecology/infertility/.
87. Scottish Government. National Infertility Group Report - March 2016 Scotland: Scottish Government; 2016 [cited 2016 February 05]. Available from: https://www.gov.scot/binaries/content/documents/govscot/publications/progress-report/2016/06/national-infertility-group-report/documents/00501403-pdf/00501403-pdf/govscot%3Adocument/00501403.pdf.
88. NHS Lothian. Our services [Internet]. Scotland: NHS Scotland; 2026 [cited 2026 February 05]. Available from: https://services.nhslothian.scot/edinburghfertilitycentre/#.
89. Welsh Health Specialised Services Committee (WHSSC). Specialised Services Commissioning Policy: CP38 Specialist Fertility Services [Internet]. Wales: WHSSC; 2017 [cited 2025 December 12]. Available from: https://whssc.nhs.wales/commissioning/nwjcc-policies/fertility/specialist-fertility-services-commissioning-policy-cp38-april-2025/.
90. Wales Fertility Institute. Wales Fertility Institute [Internet]. Wales: Wales Fertility Institute; 2025 [cited 2025 January 09]. Available from: https://www.thefertilityinstitute.co.uk/.

91. National Institute for Health and Care Excellence (UK). Fertility problems: assessment and treatment: NICE guideline NG257 [Internet]. UK: National Institute for Health and Care Excellence; 2026 [cited 2026 April 16]. Available from: https://www.nice.org.uk/guidance/ng257.
92. Department of Health DaA-AG. Patient Information Sheet. Medicare and benefits for Assisted. Reproductive Technology – definition of infertility [Internet]. Australia: Australian Government; 2025 [cited 2026 April 08]. Available from: https://www.mbsonline.gov.au/internet/mbsonline/publishing.nsf/650f3eec0dfb990fca25692100069854/dd094f6c05afacc3ca258ce4007d0733/$FILE/PDF%20Version%20Information%20Sheet%20-%20Changes%20to%20the%20definition%20of%20Infertility.pdf.
93. City Fertility. IVF and Medicare [Internet]. Australia: City Fertility; 2026 [cited 2026 April 08]. Available from: https://www.cityfertility.com.au/costs/medicare-rebate/.
94. Tremellen K, Wilkinson D, Savulescu J. Should obese women's access to assisted fertility treatment be limited? A scientific and ethical analysis. Aust N Z J Obstet Gynaecol. 2017;57(5):569-74.
95. Services Australia. Medicare services for conceiving, pregnancy and birth [Internet]. Australia: Australian Government; 2025 [cited 2026 April 08]. Available from: https://www.servicesaustralia.gov.au/medicare-services-for-conceiving-pregnancy-and-birth?context=60092.
96. Department of Health (Australia). Pre-implantation Genetic Testing (PGT) services [Internet]. Australia: Australian Government; 2021 [cited 2026 April 08]. Available from: https://www.mbsonline.gov.au/internet/mbsonline/publishing.nsf/Content/A2E8EA4302A4DE8ECA258717007A0572/$File/Factsheet-pre-imp-gentes.pdf.
97. Hospitalsenhed Midt. Ordering donor sperm [Internet]. Denmark: Hospitalsenhed Midt; 2026 [cited 2026 April 08]. Available from: https://www.hospitalsenhedmidt.dk/patientvejledninger/fertilitetsklinikken/bestilling-af-donorsad/.
98. Schneider Stein and Partner. No coverage of costs for pre-implantation genetic diagnosis (PGD) [Internet]. Germany: Schneider Stein and Partner; 2025 [cited 2026 April 07]. Available from: https://www.anwaelte-schneider-stein.de/en/ssp-news/bsg-no-cost-coverage-for-pre-implantation-genetic-diagnosis-pid/.
99. Tippett A. Reproductive rights where conditions apply: an analysis of discriminatory practice in funding criteria against would-be parents seeking funded fertility treatment in England. Human Fertility. 2023;26(3):483-93.
100. NHS England. Clinical Commissioning Policy: Pre-implantation Genetic Diagnosis (PGD) [Internet]. England: NHS England; 2014 [cited 2026 March 19]. Available from: https://www.england.nhs.uk/wp-content/uploads/2014/04/e01-med-gen-0414.pdf.
101. Key representative from the Women Children and Organ Donation Unit - Department of Health (Northern Ireland) Email communication from key representative. 2026. Personal Communication HIQA.

102. BBC. Fertility treatment: Lesbian couple says criteria for free care 'impossible to meet' [Internet]. Northern Ireland: BBC; 2016 [cited 2026 March 16]. Available from: https://www.bbc.com/news/uk-northern-ireland-35866541#:~:text=They%20had%20approached%20their%20GPs,they%20couldn't%20fund%20us.
103. Taylor F, Turner-Moore R, Pacey A, Jones G. Accessing publicly funded donor insemination treatment in the UK: is funding information available on fertility clinic websites? Hum Fertil (Camb). 2023;26(3):512-8.
104. Human Fertilisation & Embryology Authority (HFEA) (UK). PGT-M conditions [Internet]. UK: HFEA; 2026 [cited 2026 March 16]. Available from: https://www.hfea.gov.uk/pgt-m-conditions/.
105. Belfast Health and Social Care Trust (NI). Information leaflet for Patients: Pre-Natal Testing [Internet]. Northern Ireland: Belfast Health and Social Care Trust; 2026 [2026]. Available from: https://belfasttrust.hscni.net/download/571/clinical-genetics/13231/19-prenatal-testing-information-leaflet.pdf.
106. Scottish Parliament. PE2146: Allow the use of privately sourced donor eggs in NHS funded IVF treatment [Internet]. Scotland: Scottish Parliament,; 2025 [cited 2026 March 13]. Available from: https://www.parliament.scot/~/media/committ/10284/Petition-PE2146.
107. NHS Lothian. Edinburgh Fertility Centre: Preimplantation Genetic Testing (PGT) - Information Sheet [Internet]. Scotland: NHS Lothian; 2022 [cited 2026 March 13]. Available from: https://services.nhslothian.scot/edinburghfertilitycentre/wp-content/uploads/sites/48/2022/06/Preimplantation-Genetic-Testing-PGT-Patient-Info-v4.pdf.
108. NHS Lothian. PREIMPLANTATION GENETIC DIAGNOSIS (PGD): Information for patients [Internet]. Scotland: NHS Lothian; 2022 [cited 2026 March 13]. Available from: https://services.nhslothian.scot/geneticservice/wp-content/uploads/sites/54/2022/07/Preimplantation-Genetic-Diagnosis.pdf.
109. Wales Fertility Institute. Preimplantation Genetic Testing (PGT) Patient Information [Internet]. Wales: Wales Fertility Institute; 2022 [cited 2026 March 2026]. Available from: https://www.thefertilityinstitute.co.uk/image/PGT%20Patient%20Information%20v4.pdf.
110. Dempsey D, Power J, Kelly F. A perfect storm of intervention? Lesbian and cisgender queer women conceiving through Australian fertility clinics. Critical Public Health. 2022;32(2):206-16.
111. Department of Health DaA-AG. Understanding Medicare Provider Handbook [Internet]. Australia: Australian Government; 2024 [cited 2026 March 02]. Available from: https://www.health.gov.au/sites/default/files/2025-09/understanding-medicare-provider-handbook.pdf.
112. Lind J. [The best interests of the child in assisted reproduction] Barnets bästa vid assisterad befruktning. Socialvetenskaplig tidskrift. 2023;3(2).
113. Cryos Denmark. Non-ID Release and ID Release Donors [Internet]. Denmark: Cryos; 2026 [cited 2026 March 11]. Available from:

https://www.cryosinternational.com/en-us/us-shop/client/how-to/how-to-choose-a-donor/id-release-or-non-id-release-donors/.
114. Cryos Denmark. Using a Known Sperm Donor [Internet]. Denmark: Cryos; 2026 [cited 2026 March 11]. Available from: https://www.cryosinternational.com/en-gb/dk-shop/private/how-to/other-services/use-a-known-donor/.
115. Victorian Assisted Reproductive Treatment Authority. Guidelines for class applications to import donor gametes from an overseas sperm or egg bank [Internet]. Australia: Victorian Assisted Reproductive Treatment Authority; 2021 [cited 2026 May 01]. Available from: https://www.varta.org.au/sites/default/files/2021-01/guidelines_for_class_applications_to_import_donor_gametes.pdf.
116. Irwin R. Politics, law and a lack of sperm: single women and fertility treatment in the Swedish health system. Anthropol Med. 2024;31(1-2):89-103.
117. Human Fertilisation & Embryology Authority (HFEA) (UK). Clinics approved for multiple imports from third country suppliers [Internet]. UK: HFEA; 2026 [cited 2026 May 01]. Available from: https://www.hfea.gov.uk/treatments/explore-all-treatments/importing-and-exporting-sperm-eggs-and-embryos/clinics-approved-for-multiple-imports-from-third-country-suppliers/.
118. Retsinformation (Denmark). BEK nr 58 of 18/01/2019: Executive Order on Quality and Safety in the Handling of Human Tissues and Cells [Internet]. Denmark: 2019 [cited 2026 May 08]. Available from: https://www.retsinformation.dk/eli/lta/2019/58#id4d413132-547a-449e-830e-322a01adf661.
119. Rinehart LA. Storage, transport, and disposition of gametes and embryos: legal issues and practical considerations. Fertility and Sterility. 2021;115(2):274-81.
120. Baía I, de Freitas C, Silva S. Priority of Access to Fertility Treatments Based on Sexual Orientation and Marital Status: the Views of Gamete Donors and Recipients. Sexuality Research and Social Policy. 2021;18(2):368-76.
121. Department of Health SSaPSNI. Circular HSC (SQSD) 3/13: NICE Clinical Guidelines - Process for Endorsement, Implementation, Monitoring and Assurance in Northern Ireland [Internet]. Northern Ireland: Department of Health, Social Services and Public Safety; 2013 [cited 2026 March 10]. Available from: https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/hsc-sqsd-3-13.pdf.
122. Lind J. Child welfare assessments and the regulation of access to publicly funded fertility treatment. Reprod Biomed Soc Online. 2020;10:19-27.
123. Fernandez RC, Moore V, Boyle J, Rumbold AR, Davies M, Mazza D, et al. Trends in clinical encounters and management for infertility among women attending Australian general practice: a national longitudinal study using MedicineInsight, 2011 to 2021. BMJ Open. 2025;15(2):e085149.
124. Bauer T, Meier-Credner A. Intra-familial dynamics of knowledge and ignorance experienced by donor-conceived adults in Germany. SN Social Sciences. 2024;4(9):163.

125. Beier HM, Bujard M, Diedrich K, Dreier H, Frister H, Kentenich H, et al. Ein Fortpflanzungsmedizingesetz für Deutschland. Ethik in der Medizin. 2018;30(2):153-8.
126. Cavaliere G, Fletcher JR. Age-discriminated IVF Access and Evidence-based Ageism: Is There a Better Way? Science, Technology, & Human Values. 2022;47(5):986-1010.
127. Bracewell-Milnes T, Saso S, Abdalla H, Thum MY. A systematic review investigating psychosocial aspects of egg sharing in the United Kingdom and their potential effects on egg donation numbers. Hum Fertil (Camb). 2018;21(3):163-73.
128. Department of Health DaA-AG. National Health and Medical Research Council Act 1992 [Internet]. Australia: Australian Government; 2026 [cited 2026 March 02]. Available from: https://www.tga.gov.au/resources/legislation/national-health-and-medical-research-council-act-1992.
129. Adams DH, Ullah S, de Lacey S. Does the removal of anonymity reduce sperm donors in Australia? J Law Med. 2016;23(3):628-36.
130. Retsinformation (Denmark). LBK no. 955 of 21/08/2014: Executive Order on the Act on Requirements for Quality and Safety in Handling Human Tissues and Cells (Tissue Act) [Internet]. Denmark: Ministry of the Interior and Health; 2014 [cited 2026 March 11]. Available from: https://www.retsinformation.dk/eli/lta/2014/955.
131. Legislation.gov.uk. Health and Care Act 2022 [Internet]. UK: UK Government; 2026 [cited 2026 March 11]. Available from: https://www.legislation.gov.uk/ukpga/2022/31/contents.
132. Olive E, Bull C, Gordon A, Davies-Tuck M, Wang R, Callander E. Economic evaluations of assisted reproductive technologies in high-income countries: a systematic review. Human Reproduction. 2024;39(5):981-91.
133. Fertility Europe. European Atlas of Fertility Treatment Policies [Internet]. Europe: Fertility Europe; 2024 [cited 2026 February 09]. Available from: https://www.epfweb.org/sites/default/files/2024-06/FERTIL%20Atlas_EN%202024-JUN11.pdf.
134. Altmann J, Kummer J, Herse F, Hellmeyer L, Schlembach D, Henrich W, et al. Lifting the veil of secrecy: maternal and neonatal outcome of oocyte donation pregnancies in Germany. Arch Gynecol Obstet. 2022;306(1):59-69.
135. Leopoldina. Reproductive Medicine in Transition: Debate on Reforming Egg Donation [Internet]. Germany: Leopoldina; 2026 [cited 2026 April 15]. Available from: https://www.leopoldina.org/en/newsroom/detail/reproductive-medicine-in-transition-debate-on-reforming-egg-donation.
136. Berg Brigham K, Cadier B, Chevreul K. The diversity of regulation and public financing of IVF in Europe and its impact on utilization. Human reproduction. 2013;28(3):666-75.
137. University of Southern Denmark. Declining fertility is a huge problem for Denmark [Internet]. Denmark: University of Southern Denmark; 2026 [cited 2026 April 15]. Available from: https://www.sdu.dk/en/nyheder/faldende-fertilitet.

138. Health Research Board. International approaches to the regulation of assisted human reproduction and associated research: Evidence brief. 2024.
139. Pennings G, de Wert G, Shenfield F, Cohen J, Tarlatzis B, Devroey P. ESHRE Task Force on Ethics and Law 14: equity of access to assisted reproductive technology. Hum Reprod. 2008;23(4):772-4.
140. Pennings G, de Wert G, Shenfield F, Cohen J, Tarlatzis B, Devroey P. ESHRE Task Force on Ethics and Law 13: the welfare of the child in medically assisted reproduction. Hum Reprod. 2007;22(10):2585-8.
141. OECD. Health at a Glance 2025: OECD; 2025.
142. Bracewell-Milnes T, Holland JC, Jones BP, Saso S, Almeida P, Maclaran K, et al. Exploring the knowledge and attitudes of women of reproductive age from the general public towards egg donation and egg sharing: a UK-based study. Human Reproduction. 2021;36(8):2189-201.
143. Mincheva M, Fraire-Zamora JJ, Sharma K, Liperis G, Ammar OF, Kirkman-Brown J, et al. To be or not to be a sperm donor: global factors affecting sperm donation in the 21st century. Human Reproduction. 2025;40(6):1234-40.
144. Skoog Svanberg A, Sydsjö G, Lampic C. Psychosocial aspects of identity-release gamete donation - perspectives of donors, recipients, and offspring. Ups J Med Sci. 2020;125(2):175-82.
145. Iranifard E, Ebrahimzadeh Zagami S, Amirian M, Ebrahimipour H, Latifnejad Roudsari R. A systematic review of assisted and third-party reproduction guidelines regarding management and care of donors. Reproductive Health. 2024;21(1):75.
146. Kirkman-Brown J, Calhaz-Jorge C, Dancet EAF, Lundin K, Martins M, Tilleman K, et al. Good practice recommendations for information provision for those involved in reproductive donation(†). Hum Reprod Open. 2022;2022(1):hoac001.
147. ESHRE. ESHRE position paper: international limits on the number of offspring per gamete donor [Internet]. ESHRE; 2025 [cited 2026 April 16]. Available from: https://www.eshre.eu/-/media/sitecore-files/Advocacy/Stakeholder-review-version---ESHRE-position-on-donor-offspring-limits.pdf.
148. Goedeke S, Indekeu A, Crawshaw M. Donor conception and psychosocial support provisions across jurisdictions – what's out there? Human Fertility. 2026;29(1):2595800.
149. Gameiro S, Boivin J, Dancet E, de Klerk C, Emery M, Lewis-Jones C, et al. ESHRE guideline: routine psychosocial care in infertility and medically assisted reproduction-a guide for fertility staff. Hum Reprod. 2015;30(11):2476-85.
150. Graham ME, Blee S, Pentz RD, Roebuck E, Hoon AH, Jr., Black M. Informed consent in assisted reproductive technology: Implications for pediatric clinicians. Dev Med Child Neurol. 2025;67(4):443-9.
151. McDermott O, Ronan L, Butler M. A comparison of assisted human reproduction (AHR) regulation in Ireland with other developed countries. Reproductive Health. 2022;19(1):62.
152. Alon I, Cassou M, Golan OC, Ravitsky V. Mapping Ethical, Legal, and Social Implications (ELSI) of gamete donation. J Assist Reprod Genet. 2024;41(11):2855-75.

153. Adamson GD, Dyer S, Chambers G, Ishihara O, De Mouzon J, Kupka M, et al. O-151 ICMART preliminary world report 2018. Human Reproduction. 2022;37(Supplement_1).
154. Adamson G, Dyer S, Chambers G, Ishihara O, Mansour R, Banker M, et al., editors. Icmart preliminary world report 2016. Human Reproduction; 2020: Oxford Univ Press, Great Clarendon st, Oxford OX2 6DP, England.
155. Adamson G, Dyer S, Chambers G, Ishihara O, Mansour R, Banker M, et al., editors. ICMART preliminary world report 2015. Human Reproduction; 2019: Oxford Univ Press, Great Clarendon st, Oxford OX2 6DP, England.
156. Adamson GD, Dyer S, Zegers-Hochschild F, Chambers G, De Mouzon J, Ishihara O, et al. O-154 ICMART preliminary world report 2019. Human Reproduction. 2023;38(Supplement_1).
157. Adamson GD, Dyer S, Zegers-Hochschild F, Chambers G, De Mouzon J, Ishihara O, et al. O-122 ICMART Preliminary World Report 2020. Human Reproduction. 2024;39(Supplement_1).
158. Adamson GD, Dyer S, Zegers-Hochschild F, Chambers G, De Mouzon J, Ishihara O, et al. O-161 ICMART Preliminary World Report 2021. Human Reproduction. 2025;40(Supplement_1).
159. Akbarzadeh N, Omani Samani R. Health status as criteria for access of infertile couples to assisted reproductive technology. International Journal of Fertility and Sterility. 2016;10:29.
160. Alland IA, Tsai S, Svedberg AD, Rosenwaks Z, Melnick AP. Oocyte donor characteristics and preferences towards an open-identity donation program. Fertility and Sterility. 2024;122(4):e139.
161. Allison J. Enduring politics: the culture of obstacles in legislating for assisted reproduction technologies in Ireland. Reproductive Biomedicine & Society Online. 2016;3:134-41.
162. Appelgren Engström H, Häggström-Nordin E, Borneskog C, Almqvist AL. Mothers in Same-Sex Relationships Describe the Process of Forming a Family as a Stressful Journey in a Heteronormative World: A Swedish Grounded Theory Study. Matern Child Health J. 2018;22(10):1444-50.
163. Baccino G, Dejewski J. P-490 Patient Care Guidance: Development of a unique tool for fertility clinics based on best practice evidence. Human Reproduction. 2022;37(Supplement_1).
164. Baker VL, Dyer S, Chambers GM, Keller E, Banker M, de Mouzon J, et al. International Committee for Monitoring Assisted Reproductive Technologies (ICMART): world report for cycles conducted in 2017–2018. Human Reproduction. 2025;40(6):1110-26.
165. Bellés M, Florensa M, Esbert M. Is the use of donated sperm advisable for patients with advanced paternal age? Fertility and Sterility. 2022;118(4):e286-e7.
166. Bloechle M. Reproductive medicine: Legal aspects: what is allowed in Germany? About oocyte donation, embryo donation and surrogacy motherhood. Gynakologische Praxis. 2025;53(2):155-62.
167. Bolton VN, Hayden C, Robinson M, Abdo D, Pericleous-Smith A. Human oocyte cryopreservation: revised evidence for practice. Hum Fertil (Camb). 2023;26(1):2-16.

168. Bowen-Simpkins P, Wang JJ, Ahuja KK. The UK´s anomalous 10-year limit on oocyte storage: time to change the law. Reprod Biomed Online. 2018;37(4):387-9.
169. Bracewell-Milnes T, Rajendran S, Saso S, Jones B, Platts S, Cato S, et al. Investigating knowledge and perceptions of egg sharing among healthcare professionals in the United Kingdom. Eur J Obstet Gynecol Reprod Biol. 2019;236:98-104.
170. Bracewell-Milnes T, Saso S, Bora S, Ismail AM, Al-Memar M, Hamed AH, et al. Investigating psychosocial attitudes, motivations and experiences of oocyte donors, recipients and egg sharers: a systematic review. Hum Reprod Update. 2016;22(4):450-65.
171. Brandão P, Ceschin N. Lesbian shared IVF: the ROPA method: a systematic review. Porto Biomed J. 2023;8(2):e202.
172. Brandão P, de Pinho A, Ceschin N, Sousa-Santos R, Reis-Soares S, Bellver J. ROPA - Lesbian shared in vitro fertilization - Ethical aspects. Eur J Obstet Gynecol Reprod Biol. 2022;272:230-3.
173. Brown RCH. Irresponsibly Infertile? Obesity, Efficiency, and Exclusion from Treatment. Health Care Anal. 2019;27(2):61-76.
174. Côté I, Fournier C, Aslett A, Lavoie K. L'accès aux services de fertilité pour les femmes lesbiennes, bisexuelles ou pansexuelles et les personnes queer, trans ou non-binaires: une revue rapide des écrits scientifiques. Science of Nursing and Health Practices. 2024;7(1):51-74.
175. Chautems C, Palaz M, i Escoda MR. Lesbian couples' assisted reproductive technologies trajectories in Switzerland and abroad: Navigating heteronormative norms and healthcare disparities. Social Inclusion. 2025;13.
176. Chehimi M, Boursier A, Lefebvre-Khalil V, Decanter C, Keller L, Fournier V, et al. Sociodemographic profile of women seeking elective egg freezing when financed by the public healthcare system. Reprod Biomed Online. 2025;50(5):104705.
177. Clarke H, Harrison S, Perez MJ, Kirkman-Brown J. UK guidelines for the medical and laboratory procurement and use of sperm, oocyte and embryo donors (2019). Hum Fertil (Camb). 2021;24(1):3-13.
178. Compans M-C, Zagel H. Medically assisted reproduction and non-normative family forms: legislation and public opinion in Europe. European Societies. 2025;27(1):171-203.
179. Connolly M, Kotsopoulos N, Li J, Chambers G. Estimating the Fiscal Value of Children Conceived from Assisted Reproduction Technology in Australia Applying a Public Economic Perspective. J Health Econ Outcomes Res. 2025;12(1):148-54.
180. Correia M, Rego G, Nunes R. The right to be forgotten versus the right to disclosure of gamete donors ID: Ethical and legal considerations. Acta bioethica. 2021;27(1).
181. Pinto da Silva S, de Freitas C, Silva S. Medical ethics when moving towards non-anonymous gamete donation: the views of donors and recipients. J Med Ethics. 2022;48(9):616-23.

182. Moura A, Silva S, de Freitas C, Abreu L, Baía I, Samorinha C. Concerns with educating the public about donating and receiving gametes. The European Journal of Contraception & Reproductive Health Care. 2019;24(6):420-1.
183. Dickens BM. The use and disposal of stored embryos. Int J Gynaecol Obstet. 2016;134(1):114-7.
184. Diedrich K, Grewe S, Al-Hasani S. Forty years of in vitro fertilization—past achievements and future perspectives. Gynakologe. 2020;53(9):562-72.
185. Domar A, Vassena R, Dixon M, Costa M, Vegni E, Collura B, et al. Barriers and factors associated with significant delays to initial consultation and treatment for infertile patients and partners of infertile patients. Reprod Biomed Online. 2021;43(6):1126-36.
186. Dyer SJ, Adamson GD, Inhorn MC, Zegers-Hochschild F. Achieving more equitable access to assisted reproduction. BMJ. 2024;385:e077111.
187. Abstracts 41st Hybrid Annual Meeting of the European Society of Human Reproduction and Embryology. Human Reproduction. 2025;40.
188. Assisted reproduction with advancing paternal and maternal age: an Ethics Committee opinion. Fertil Steril. 2025;123(6):999-1005.
189. Eustache F, Drouineaud V, Mendes N, Delépine B, Dupont C, Mirallié S, et al. Fertility preservation and sperm donation in transgender individuals: The current situation within the French CECOS network. Andrology. 2021;9(6):1790-8.
190. Ezeome IV. Gamete donation-A review of ethical and legal issues. Afr J Reprod Health. 2022;26(3):124-35.
191. Fauser B, Boivin J, Barri PN, Tarlatzis BC, Schmidt L, Levy-Toledano R. Beliefs, attitudes and funding of assisted reproductive technology: Public perception of over 6,000 respondents from 6 European countries. PLoS One. 2019;14(1):e0211150.
192. Findeklee S, Diedrich K. IVF und ICSI – Von den Anfängen bis zur Gegenwart. Die Gynäkologie. 2022;55(12):895-900.
193. Forshall GC, Jones GL, Turner-Moore R. Acceptance and rejection of "morally challenging" behaviour in online sperm donation communities: narrative interviews with recipients and donors. Front Reprod Health. 2024;6:1222601.
194. Giblin A, Schaler L, Glover L, Wingfield M, editors. Attitudes of healthcare professionals to draft national legislation on assisted human reproduction (AHR). Irish Journal of Medical Science; 2022: Springer London Ltd 236 Grays Inn Rd, 6th Floor, London WC1X 8HL, England.
195. Gilbar R, Tamir S. Surplus embryo donation: terminology and ethico-legal perspectives. J Law Biosci. 2025;12(2):lsaf009.
196. Gilman L, Redhead C, Hudson N, Fox M, Nordqvist P, MacCallum F, et al. Direct-to-consumer genetic testing and the changing landscape of gamete donor conception: key issues for practitioners and stakeholders. Reprod Biomed Online. 2024;48(1):103421.
197. Gilman L, Nordqvist P. Organizing Openness: How UK Policy Defines the Significance of Information and Information Sharing about Gamete Donation. International Journal of Law, Policy and the Family. 2018;32(3):316-33.

198. Goedeke S, Daniels K, Thorpe M, du Preez E. The Fate of Unused Embryos: Discourses, Action Possibilities, and Subject Positions. Qual Health Res. 2017;27(10):1529-40.
199. Harrison BJ, Hilton TN, Rivière RN, Ferraro ZM, Deonandan R, Walker MC. Advanced maternal age: ethical and medical considerations for assisted reproductive technology. Int J Womens Health. 2017;9:561-70.
200. Harrison K. A virtual promise of happiness: kinship on the websites of Danish fertility clinics and sperm banks. Feminist Media Studies. 2019;19(8):1096-113.
201. Hudson N. O-169 Advances in oocyte freezing: implications for donors, recipients, counsellors and clinics. Human Reproduction. 2024;39(Supplement_1):deae108. 94.
202. Hudson N, Coveney C, Culley L, Goethals T, Herbrand C, Lafuente S, et al., editors. Egg providers' views on the use of surplus eggs in the UK, Spain and Belgium: implications for information giving and informed consent. 35th Annual Meeting of the European-Society-of-Human-Reproduction-and-Embryology (ESHRE); 2019.
203. Hudson N, Culley L, Herbrand C, Pavone V, Pennings G, Provoost V, et al. Reframing egg donation in Europe: new regulatory challenges for a shifting landscape. Health Policy and Technology. 2020;9(3):308-13.
204. Hudson N, Weis C, Pavone V, Herbrand C, Provoost V. The emergence of egg intermediaries in the European fertility landscape: the creation of value in reproductive bioeconomies. Social Science & Medicine. 2025:118448.
205. Jackson E, Millbank J, Karpin I, Stuhmcke A. Learning from Cross-Border Reproduction. Med Law Rev. 2017;25(1):23-46.
206. Jaspal R, Prior T, Denton J, Salim R, Banerjee J, Christoph L. The impact of cross-border IVF on maternal and neonatal outcomes in multiple pregnancies: Experience from a UK fetal medicine service. Eur J Obstet Gynecol Reprod Biol. 2019;238:63-7.
207. Johnston M, Fuscaldo G, Gwini SM, Catt S, Richings NM. Financing future fertility: Women's views on funding egg freezing. Reprod Biomed Soc Online. 2022;14:32-41.
208. Kalampalikis N, Doumergue M, Zadeh S. Sperm donor regulation and disclosure intentions: Results from a nationwide multi-centre study in France. Reprod Biomed Soc Online. 2018;5:38-45.
209. Keller E, Botha W, Chambers GM. Does in vitro fertilization (IVF) treatment provide good value for money? A cost-benefit analysis. Front Glob Womens Health. 2023;4:971553.
210. Kelly F, Dempsey D. The family law implications of early contact between sperm donors and their donor offspring. Family Matters. 2016(98):56-63.
211. Kentenich H, Diedrich K. Zum Verbot der Eizellspende: medizinische und ethische Überlegungen. Der Gynäkologe. 2020;53(9):582-7.
212. Kentenich H, Stief G, Von Plauen I, Werling M, Tandler-Schneider A. Tandler-Schneider A: Egg donation: Considerations from a medical and psychosomatic point of view. 92. 2019;4:569-75.

213. Kentenich H, Stief G, Von Plauen I, Werling M, Tandler-Schneider A. Egg donation: Considerations from a medical and psychosomatic point of view. Gynakologische Praxis 2018;43(4):428-34.
214. Kieu V, Lensen S, Polyakov A, Lew R, Agresta F, Caughey L, et al. P-712 A national survey of women's perspectives and experiences of pursuing donor eggs. Human Reproduction. 2024;39(Supplement_1).
215. Kotroušová D. Cohabitation and Assisted Reproduction in the Czech Republic and in the European Context. COFOLA 2021 Conference for Young Lawyers, part 22021.
216. Kreß H. Ethische Kriterien der Reproduktionsmedizin. In: Nieschlag E, Behre HM, Kliesch S, Nieschlag S, editors. Andrologie: Grundlagen und Klinik der reproduktiven Gesundheit des Mannes. Berlin, Heidelberg: Springer Berlin Heidelberg; 2020. p. 1-13.
217. Kreß H. Ethische Kriterien der Reproduktionsmedizin. In: Nieschlag E, Behre HM, Kliesch S, Nieschlag S, editors. Andrologie: Grundlagen und Klinik der reproduktiven Gesundheit des Mannes. Berlin, Heidelberg: Springer Berlin Heidelberg; 2023. p. 865-77.
218. Kupka MS, Chambers GM, Dyer S, Zegers-Hochschild F, de Mouzon J, Ishihara O, et al. International Committee for Monitoring Assisted Reproductive Technology world report: assisted reproductive technology, 2015 and 2016. Fertil Steril. 2024;122(5):875-93.
219. Lafuente-Funes S, Weis C, Hudson N, Provoost V. Egg donation in the age of vitrification: A study of egg providers' perceptions and experiences in the UK, Belgium and Spain. Sociol Health Illn. 2023;45(2):259-78.
220. Lee E, Zhang J. Which assisted reproductive technology (ART) treatment strategy is the most clinically and cost-effective for women of advanced maternal age: a Markov model. BMC Health Serv Res. 2022;22(1):1197.
221. Lensen S, Hammarberg K, Polyakov A, Wilkinson J, Whyte S, Peate M, et al. How common is add-on use and how do patients decide whether to use them? A national survey of IVF patients. Hum Reprod. 2021;36(7):1854-61.
222. Macklon NS, Fauser BCJM. Context-based infertility care. Reproductive BioMedicine Online. 2020;40(1):2-5.
223. Martin N, Mahmoodi N, Hudson N, Jones G. Recipient and donor experiences of known egg donation: implications for fertility counselling. J Reprod Infant Psychol. 2020;38(4):354-66.
224. Mazi M, James G, Temple-Smith P, Mol BWJ. Modelling and comparing the use of IVF and ICSI in Australia. J Assist Reprod Genet. 2024;41(7):1783-91.
225. Mazzilli R, Rucci C, Vaiarelli A, Cimadomo D, Ubaldi FM, Foresta C, et al. Male factor infertility and assisted reproductive technologies: indications, minimum access criteria and outcomes. J Endocrinol Invest. 2023;46(6):1079-85.
226. Mburu G, Kiarie J, Allotey P. WHO guideline on infertility: an opportunity to reduce global health inequalities. The Lancet Global Health. 2026;14(1):e12-e3.
227. Milewski N, Passet-Wittig J, Bujard M. Infertility and Seeking Medical Help to Have a Child Vary Across Migrant Origin Groups in Germany. Population Research and Policy Review. 2025;44(2):25.

228. Millbank J. What is the Responsibility of Australian Medical Professionals Whose Patients Travel Abroad for Assisted Reproduction? Med Law Rev. 2019;27(3):365-89.
229. Mills C, Johnston M, Langford J. P-342 Improving consent procedures to increase oocyte donation rates. Human Reproduction. 2024;39(Supplement_1).
230. Mishtal J, Radkowska-Walkowicz M. Introduction. Reproductive Biomedicine & Society Online. 2016;3:36-40.
231. Mounce G, Allan HT, Carey N. 'Just have some IVF!': A longitudinal ethnographic study of couples' experiences of seeking fertility treatment. Sociol Health Illn. 2022;44(2):308-27.
232. Ng A, Bridges E, Whearty K. P-739 A retrospective analysis of family type data within the United Kingdom (UK) national fertility register, over a 10-year period. Human Reproduction. 2025;40(Supplement_1).
233. ART must be accessible and sustainable. Nature Medicine. 2023;29(12):2961-.
234. O Brien S, Petch S, Glover L, Crosby D, Wingfield M. O-119 Investigating new perceptions in fertility care access in Ireland. Human Reproduction. 2025;40(Supplement_1).
235. O'Brien S, Schaler L, Giblin A, Glover LE, Wingfield M. Assisted human reproduction legislation: Listening to the voice of patients. Eur J Obstet Gynecol Reprod Biol. 2023;284:169-74.
236. Ombelet W, van Eekelen R, McNally A, Ledger W, Doody K, Farquhar C. Should couples with unexplained infertility have three to six cycles of intrauterine insemination with ovarian stimulation or in vitro fertilization as first-line treatment? Fertil Steril. 2020;114(6):1141-8.
237. Pennings G. Sperm sharing: as problematic as oocyte sharing? Hum Reprod. 2022;37(6):1101-5.
238. Pennings G. Letter to the editor. Journal of Assisted Reproduction and Genetics. 2025;42(11):4015-6.
239. Pennings G, Ravel C, Girard JM, Domin-Bernhard M, Provoost V. Attitude towards reciprocity as a motive for oocyte donation. Eur J Obstet Gynecol Reprod Biol. 2018;225:194-8.
240. Petch S, Stokes J, Glover L, O'Reilly S, Crosby D. Knowledge, Attitudes, and Challenges: Irish General practitioners' preparedness for publicly funded Assisted reproductive technologies. European Journal of Obstetrics & Gynecology and Reproductive Biology. 2024;301:160-5.
241. Petra T, Wischmann T, Mayer-Lewis B. Evaluation of infertility counselling in Germany. Arch Gynecol Obstet. 2024;309(3):1065-73.
242. Pettle S. Building families through MAR (medically assisted reproduction), donor conception and surrogacy: Where does this fit into clinical psychology?
243. Pettle S. Family Complexities Around Donor Conception and Surrogacy: A Perspective from the United Kingdom. eLS.3:1-12.
244. Piek SR, Pennings G, Provoost V. Age-based restrictions on reproductive care: discerning the arbitrary from the necessary. Theor Med Bioeth. 2024;45(1):41-56.

245. Pikal A. § 5 Medizinische und rechtliche Grundlagen der assistierten Reproduktion. Die rechtliche Zulässigkeit ärztlicher Mitwirkung an verbotenen Kinderwunschbehandlungen im Ausland: Springer; 2020. p. 47-114.
246. Pikal A. § 7 Die strafrechtliche Relevanz einer inländischen ärztlichen Mitwirkung an nach dem ESchG verbotenen Methoden der Kinderwunschbehandlung im Ausland. Die rechtliche Zulässigkeit ärztlicher Mitwirkung an verbotenen Kinderwunschbehandlungen im Ausland: Springer; 2020. p. 173-306.
247. Power J, Dempsey D, Kelly F, Lau M. Use of fertility services in Australian lesbian, bisexual and queer women's pathways to parenthood. Aust N Z J Obstet Gynaecol. 2020;60(4):610-5.
248. Präg P, Mills MC. Cultural determinants influence assisted reproduction usage in Europe more than economic and demographic factors. Human Reproduction. 2017;32(11):2305-14.
249. Qiu RM, Muthakana R, Mao W. Toward global reproductive justice: a universal framework for evaluating equity and autonomy in in-vitro fertilization policies. Reprod Health. 2025;22(1):214.
250. Quigley J, Sweetman D, Allen C, Higgins MF, Cantwell C, Doyle B, et al. Donor oocyte-facilitated reproduction: Time to revisit the BSH antenatal guidelines? Transfus Med. 2020;30(6):525-6.
251. Rausch MA, Wikoff HD, Newton T. Support for Lesbian Couples Navigating Fertility Treatment: An Ecological Systems Perspective. Journal of LGBTQ Issues in Counseling. 2021;15(2):224-39.
252. Rivet-Danon D, Ly A, Prades-Borio M, Berthaut I, Ogouma-Aworet L, Panissard C, et al. [The revision of the Bioethics Act, two years on: major principles and consequences for practice in the reproductive biology laboratory]. Ann Biol Clin (Paris). 2024;81(6):621-7.
253. Ronan L, McDermott O, Butler M, Trubetskaya A. The Lack of Ireland's Assisted Human Reproduction (AHR) Regulation Viewed under the Lens of the Patient's Experience. International Journal of Environmental Research and Public Health. 2022;19(15):9534.
254. Salazar A, Diaz-García C, García-Velasco JA. Third-party reproduction: a treatment that grows with societal changes. Fertil Steril. 2023;120(3 Pt 1):494-505.
255. Schaler L, Giblin A, Glover LE, Wingfield M. Assisted human reproduction legislation: Acknowledging the voice of health care professionals. Eur J Obstet Gynecol Reprod Biol. 2023;280:28-33.
256. Shaw RM. Introduction: Reproductive Citizenship and Meanings of Infertility. In: Shaw RM, editor. Reproductive Citizenship: Technologies, Rights and Relationships. Singapore: Springer Nature Singapore; 2022. p. 1-28.
257. Shenfield F, Messinis I, Mahmood T. EBCOG position statement on "Ethical analysis of cross-border reproductive care". Eur J Obstet Gynecol Reprod Biol. 2020;252:568-9.
258. Shufaro Y, Hochberg A, Schenker JG. Medical, Social, Legal, and Religious Aspects of Genetic Donation. In: Schenker JG, Birkhaeuser MH, Genazzani AR, Mettler L, Sciarra JJ, editors. Hot Topics in Human Reproduction: Ethics, Law and Society. Cham: Springer International Publishing; 2023. p. 141-53.

259. Siegel AM, Ravitsky V. Women With Mental Illness Seeking Assisted Reproduction Considerations in Ethical Candidate Selection. Curr Psychiatry Rep. 2018;20(9):70.
260. Skedgel C, Ralphs E, Finn E, Whitty JA, Markert M, Samuelsen C. Is the public supportive and willing to pay for a national assistive reproductive therapies programme? Results from a multicountry survey. BMJ Open. 2021;11(3):e044986.
261. Soave I, Marci R. Chapter 39 - Regulation, data management, informed consent, and legal issues for ART. In: Laganà AS, Guglielmino A, editors. Management of Infertility: Academic Press; 2023. p. 405-9.
262. Tanderup M, Vassard D, Nielsen BB, Pande A, Kroløkke C, Humaidan P, et al. Permanently infertile couples and family building-a cross-sectional survey in Denmark. Hum Reprod. 2024;39(11):2525-36.
263. Theodoridis A, Taupitz J, Kentenich H. Effects of the Sperm Donor Registry Act on extraction facilities and facilities of medical care. Journal fur Reproduktionsmedizin und Endokrinologie 2018;15(4):174-9.
264. Tonkens R. Infertilitism: unjustified discrimination of assisted reproduction patients. Monash Bioeth Rev. 2018;35(1-4):36-49.
265. Viuff MH, Gravholt CH. Care of adult women with Turner syndrome: the state of affairs in Germany. Endocr Connect. 2019;8(12):C1-c4.
266. Volks C, Goedeke S, Griffin L, Kelly F. From clicks to creating kin: how Australian online egg donors craft relationships with recipients and donor-conceived children. Human Fertility. 2025;28(1):2585670.
267. Würfel W. Reproductive medicine: The current situation in Germany. Padiatrische Praxis. 2018;89(3):516-46.
268. Wiecki A, Dejewski J. P-737 Global Insights from Patients Seeking IVF Treatment Abroad. Human Reproduction. 2025;40(Supplement_1).
269. Wilinska-Zelek A. O-034 Infertility treatment law making in Europe: the clash of knowledge, ethics and business. Human Reproduction. 2021;36(Supplement_1).
270. Wilson-Nash C, Al-ma'ani N, Takhar J, Salu O, He C. P-732 Beyond the rainbow bunting: examining the realities of uk fertility care for LGBTQ+ patients. Human Reproduction. 2025;40(Supplement_1).
271. Zweifel JE, Woodward JT, Rebar RW, Sauer MV. Is it time to establish age restrictions in ART? J Assist Reprod Genet. 2020;37(2):257-62.
272. Adrian SW, Kroløkke C. Passport to Parenthood: Reproductive Pathways In and Out of Denmark. NORA - Nordic Journal of Feminist and Gender Research. 2018;26(2):112-28.
273. Agopiantz M, Malmanche H, Mougniotte G, Courduriès J, Morel O. [The donation of begetting in France: The proposal of a new model]. Gynecol Obstet Fertil Senol. 2025;53(5):264-9.
274. Armuand G, Sydsjö G, Skoog Svanberg A, Lampic C. Attitudes towards embryo donation among healthcare professionals working in child healthcare: a survey study. BMC Pediatr. 2019;19(1):209.
275. Asplund K. Use of in vitro fertilization-ethical issues. Ups J Med Sci. 2020;125(2):192-9.

276. Bals-Pratsch M, du Bois G. Doctors call for the modernization of the German Embryo Protection Act (ESchG). Journal fur Reproduktionsmedizin und Endokrinologie. 2022;19(6):331-3.
277. Bartholomaeus C, Riggs DW. Embryo donation and receipt in Australia: views on the meanings of embryos and kinship relations. New Genetics and Society. 2019;38(1):1-17.
278. Catalini L, Fedder J, Nørgård BM, Jølving LR. Assisted Reproductive Technology Results Using Donor or Partner Sperm: A Danish Nationwide Register-Based Cohort Study. J Clin Med. 2023;12(7).
279. Compans M-C. Alignment, Anticipation, Adaptation, or Lagging Behind? Age-Based Regulations in Assisted Reproduction and Late Fertility. Population and Development Review. 2024;50(4):1319-51.
280. Cooper S. Assisted Reproductive Technologies. Analysing Gender in Healthcare: The Politics of Sex and Reproduction: Springer Nature; 2023.
281. Crawshaw M, Pericleous-Smith A, Dark S. Counselling challenges associated with donor conception and surrogacy treatments - time for debate. Hum Fertil (Camb). 2022;25(5):806-12.
282. de Melo-Martín I. How best to protect the vital interests of donor-conceived individuals: prohibiting or mandating anonymity in gamete donations? Reprod Biomed Soc Online. 2016;3:100-8.
283. Elenis E, Skoog Svanberg A, Leandersson P, Lind J, Sydsjö G. Access to infertility evaluation and treatment in two public fertility clinics and the reasons for withholding it: a prospective survey cohort study of healthcare professionals. BMJ Open. 2020;10(12):e041538.
284. Elenis E, Holm CM, Axelsson O, Svanberg AS, Lampic C, Sydsjö G. Perinatal outcomes and maternal health before and after single motherhood through assisted conception: A multiregistry study in Sweden. Acta Obstet Gynecol Scand. 2025;104(11):2078-92.
285. Galhardo A. O-179 From secrecy to transparency: The journey of donor identity in reproductive medicine in Portugal. Human Reproduction. 2024;39(Supplement_1):deae108. 208.
286. Gianaroli L, Ferraretti AP, Magli MC, Sgargi S. Current regulatory arrangements for assisted conception treatment in European countries. Eur J Obstet Gynecol Reprod Biol. 2016;207:211-3.
287. Gigstad K, Li Y, Thaler J, Irwin R. HIV and access to fertility treatment in the European and Swedish contexts. Sex Reprod Healthc. 2023;35:100812.
288. Gilman L, Nordqvist P. The case for reframing known donation. Hum Fertil (Camb). 2023;26(5):1385-92.
289. Goedeke S, Rodino IS. Embryo donation: Counselling practice issues and dilemmas within the context of identity-release donor programmes. Patient Educ Couns. 2023;108:107616.
290. Goedeke S, Shepherd D, Rodino IS. Fertility stakeholders' concerns regarding payment for egg and sperm donation in New Zealand and Australia. Reproductive Biomedicine & Society Online. 2022;14:8-19.
291. Goedeke S. Donor Conception in the Interests of the Well-Being of Donor-Conceived Persons, and Other Parties Connected through Donor Conception–A Review. Fertility & Reproduction. 2025;7(01):16-26.

292. Kentenich H, Thorn P, Wischmann T. Medical and psychosocial aspects of consultation. Der Gynäkologe. 2018;51:647-52.
293. Lemke T, Rüppel J. Social dimensions of preimplantation genetic diagnosis: a literature review. New Genetics and Society. 2019;38(1):80-112.
294. Lindell Pettersson M, Sydsjö G, Lampic C, Skoog Svanberg A, Elenis E. Perceived social support in solo women seeking treatment with donor gametes and in women in heterosexual couples seeking IVF-treatment with own gametes. Sci Rep. 2023;13(1):2733.
295. Matorras R, Chaudhari VS, Roeder C, Schwarze JE, Bühler K, Hwang K, et al. Evaluation of costs associated with fertility treatment leading to a live birth after one fresh transfer: A global perspective. Best Pract Res Clin Obstet Gynaecol. 2023;89:102349.
296. Meads C, Thorogood LR, Lindemann K, Bewley S. Why Are the Proportions of In-Vitro Fertilisation Interventions for Same Sex Female Couples Increasing? Healthcare (Basel). 2021;9(12).
297. Mohr S, Koch L. Transforming social contracts: the social and cultural history of IVF in Denmark. Reprod Biomed Soc Online. 2016;2:88-96.
298. Mohr S, Herrmann JR. The politics of Danish IVF: reproducing the nation by making parents through selective reproductive technologies. BioSocieties. 2022;17(2):297-319.
299. Passet-Wittig J, Greil AL, McQuillan J, Bujard M. Social disparities across different stages of medical help-seeking to have a child in Germany. Social Inclusion. 2025;13.
300. Gunnarsson Payne J, Korolczuk E. Reproducing politics: the politicisation of patients' identities and assisted reproduction in Poland and Sweden. Sociology of Health & Illness. 2016;38(7):1074-91.
301. Pennings G. Donor sperm: only for the rich and straight. Reproductive BioMedicine Online. 2025;50(1).
302. Piek SR, Martani A, Pennings G. Against age limits for men in reproductive care. Med Health Care Philos. 2024;27(3):299-307.
303. Raperport C, Chronopoulou E, McLaughlin A, Cox S, Srivastava G, Shah A, et al. 'It takes a village' – fertility treatment using donor gametes, embryos and/or surrogacy. The Obstetrician & Gynaecologist. 2022;24(4):251-9.
304. Riggs DW, Bartholomaeus C. Formal and informal support and counselling for embryo donation and receipt: An Australian qualitative study. Health Soc Care Community. 2020;28(3):950-7.
305. Rozée V, de La Rochebrochard É. La PMA en France: une reproduction des inégalités de genre? Travail, genre et sociétés. 2023;50(2):43-60.
306. Rozée V, de La Rochebrochard E. L'aide à la procréation en dehors du cadre légal et médical français: quels enjeux aujourd'hui? Population & sociétés. 2021;593(9):1-4.
307. Rozée V, Malmanche H. Pour être «seule aux manettes»: parcours solo de la PMA en France. Enfances Familles Générations Revue interdisciplinaire sur la famille contemporaine. 2023(44).
308. Siermann M, van der Schoot V, Bunnik EM, Borry P. Ready for polygenic risk scores? An analysis of regulation of preimplantation genetic testing in European countries. Hum Reprod. 2024;39(5):1117-30.

309. Silva SPD, Freitas C, Baía I, Samorinha C, Machado H, Silva S. [Gamete donation: (un)answered social and ethical issues in Portugal]. Cad Saude Publica. 2019;35(2):e00122918.
310. Taylor F, Turner-Moore R, Pacey A, Jones GL. Are UK Policies and Practices for Regulated Donor Insemination Forcing Women to Find Unregulated Sperm Donors Online? A Perspective on the Available Evidence. Front Glob Womens Health. 2022;3:644591.
311. Thorn P, Hilbig-Lugani K, Wischmann T. Mein, dein, unser Embryo. Gynäkologische Endokrinologie. 2017;15(1):73-6.
312. Volgsten H, Schmidt L. Exploring Swedish single women's decision to choose motherhood through medically assisted reproduction - a qualitative study. Hum Fertil (Camb). 2023;26(2):237-48.
313. Volgsten H, Schmidt L. Motherhood through medically assisted reproduction - characteristics and motivations of Swedish single mothers by choice. Hum Fertil (Camb). 2021;24(3):219-25.
314. Zagel H. Reproduction policy as life course policy: Normative modelling of reproductive life courses in Germany. Zeitschrift für Sozialreform. 2024;70(1):31-53.
315. Department of Health (Northern Ireland). Increase in funded IVF provision [Internet]. Northern Ireland: Department of Health; 2024 [cited 2026 March 16]. Available from: https://www.health-ni.gov.uk/news/increase-funded-ivf-provision.
316. Services Australia. Bulk billing [Internet]. Australia: Australian Government; 2026 [cited 2026 April 01]. Available from: https://www.servicesaustralia.gov.au/bulk-billing?context=60092.
317. National Health Service (NHS). Service specifications: fertility preservation and restoration [Internet]. National Health Service (NHS); 2023 [cited 2024 July 22]. Available from: https://www.england.nhs.uk/publication/service-specifications-fertility-preservation-and-restoration/.
318. National Council for Medically Assisted Reproduction. Informed Consent [Internet]. Portugal: National Council for Medically Assisted Reproduction; 2026 [cited 2026 March 05]. Available from: https://www.cnpma.org.pt/cidadaos/Paginas/modelos-de-consentimento-informado.aspx.
319. Legislation.gov.uk. The Health and Care Act 2022 (Storage of Gametes and Embryos) (Transitional Provision) Regulations 2024 [Internet]. UK: UK Government; 2022 [cited 2026 March 03]. Available from: https://www.legislation.gov.uk/uksi/2024/625/made.
320. Manchester University NHS. Making decisions about your stored embryos [Internet]. England: NHS; 2022 [cited 2026 March 04]. Available from: https://mft.nhs.uk/app/uploads/2023/12/Patient-Information-Leaflet-making-decisions-about-your-stored-embryos-Nov-2022.pdf.

Appendices

Appendix A – Database search results

Databases	Number of results	Date searched
Medline Complete via Ebscohost	402	05/01/2026
Embase via Elsevier	1376	05/01/2026
Total	1778	
Total after duplicates removed by Endnote and Covidence	**1,364**	

Citation Chasing	Number of results	Date searched
Backward citation chasing	609	22/01/2026
Forward citation chasing	511	22/01/2026
Total	1,120	
Total after duplicates and publications pre 2016 are removed in Endnote and Covidence	**662**	

Database name		Medline Complete via Ebsco		
Date run		05 Jan 2025		
#	**Query**	**Limiters/Expanders**	**Last Run Via**	**Results**
S21	S15 AND S20	Limiters - Publication Date: 20160101-20260131 Expanders - Apply equivalent subjects	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - MEDLINE Complete	402

		Search modes - Proximity		
S20	S16 OR S17 OR S18 OR S19	Expanders - Apply equivalent subjects Search modes - Proximity	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - MEDLINE Complete	3,529,605
S19	XB (policy OR policies OR guidance OR guideline* OR statemen* OR consensus OR regulation* OR regulatory OR statute* OR 'government initiative*')	Expanders - Apply equivalent subjects Search modes - Proximity	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - MEDLINE Complete	3,098,250
S18	(MH "Public Policy+") OR (MH "Public Sector") OR (MH "Government Regulation")	Expanders - Apply equivalent subjects Search modes - Proximity	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - MEDLINE Complete	203,405
S17	XB ('public provision' OR 'public* fund*' OR 'government* fund*' OR 'public insurance' OR 'social insurance' OR 'health coverage' OR 'out-of-pocket expenditure' OR subsidise* OR subsidize* OR subsidies OR subsidy OR 'access to healthcare' OR 'access to assistive	Expanders - Apply equivalent subjects Search modes - Proximity	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - MEDLINE Complete	44,364

	reproduct*' OR 'access to art' OR 'access to fertility' OR 'availability of art' OR 'tax credit')			
S16	(MH "Health Care Costs+") OR (MH "Health Services Accessibility+") OR (MH "Public Expenditures") OR (MH "Insurance, Health+")	Expanders - Apply equivalent subjects Search modes - Proximity	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - MEDLINE Complete	361,598
S15	S10 AND S14	Expanders - Apply equivalent subjects Search modes - Proximity	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - MEDLINE Complete	8,279
S14	S11 OR S12 OR S13	Expanders - Apply equivalent subjects Search modes - Proximity	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - MEDLINE Complete	10,197
S13	XB ((donor* OR donat*) N1 (gamete* OR embryo* OR egg* OR sperm OR oocyte OR insemination))	Expanders - Apply equivalent subjects Search modes - Proximity	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - MEDLINE Complete	8,384
S12	XB 'heterologous artificial insemination'	Expanders - Apply equivalent subjects Search modes - Proximity	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - MEDLINE Complete	26
S11	(MH "Insemination, Artificial, Heterologous") OR (MH "Oocyte	Expanders - Apply equivalent subjects	Interface - EBSCOhost Research Databases	4,537

	Donation") OR (MH "Donor Conception")	Search modes - Proximity	Search Screen - Advanced Search Database - MEDLINE Complete	
S10	S1 OR S2 OR S3 OR S4 OR S5 OR S6 OR S7 OR S8 OR S9	Expanders - Apply equivalent subjects Search modes - Proximity	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - MEDLINE Complete	135,890
S9	XB ('fertility preservation' OR 'cryopreservation' OR 'cryoconservation' OR 'cryo-conservation' OR 'cryo-preservation')	Expanders - Apply equivalent subjects Search modes - Proximity	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - MEDLINE Complete	25,773
S8	XB ('artificial insemination' OR 'oviduct insemination' OR 'oviductal insemination')	Expanders - Apply equivalent subjects Search modes - Proximity	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - MEDLINE Complete	8,641
S7	XB ('insemination treatment*' OR 'insemination therap*)	Expanders - Apply equivalent subjects Search modes - Proximity	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - MEDLINE Complete	112
S6	XB ('test-tube fertilisation' OR 'test-tube fertilization')	Expanders - Apply equivalent subjects Search modes - Proximity	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - MEDLINE Complete	11
S5	XB IVF	Expanders - Apply equivalent subjects Search modes - Proximity	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - MEDLINE Complete	32,341

S4	XB ("in vitro" N1 (fertilization OR fertilisation))	Expanders - Apply equivalent subjects Search modes - Proximity	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - MEDLINE Complete	31,604
S3	XB ((fertility OR infertility) N1 (treatment* OR therap*))	Expanders - Apply equivalent subjects Search modes - Proximity	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - MEDLINE Complete	12,035
S2	XB (assisted N1 (reproduct* OR fertili*))	Expanders - Apply equivalent subjects Search modes - Proximity	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - MEDLINE Complete	24,443
S1	(MH "Reproductive Techniques, Assisted+")	Expanders - Apply equivalent subjects Search modes - Proximity	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - MEDLINE Complete	87,164

Database name	Embase via Elsevier	
Date run	05 Jan 2026	
No.	**Query**	**Results**
#22	#15 AND #20 AND [2016-2026]/py	1376
#21	#15 AND #20	2540
#20	#16 OR #17 OR #18 OR #19	4732353
#19	policy:ab,ti OR policies:ab,ti OR guidance:ab,ti OR guideline*:ab,ti OR statement*:ab,ti OR consensus:ab,ti OR regulation*:ab,ti OR regulatory:ab,ti OR statute*:ab,ti OR 'government initiative*':ab,ti	3932312
#18	'public policy'/exp OR 'public sector'/exp OR 'public health service'/exp OR 'government regulation'/exp	373787
#17	'public provision':ab,ti OR 'public* fund*':ab,ti OR 'government* fund*':ab,ti OR 'public insurance':ab,ti OR 'social insurance':ab,ti OR 'health coverage':ab,ti OR 'out-of-pocket expenditure':ab,ti OR subsidise*:ab,ti OR subsidize*:ab,ti OR subsidies:ab,ti OR subsidy:ab,ti OR 'access to healthcare':ab,ti OR 'access to assistive reproduct*':ab,ti OR 'access to art':ab,ti OR 'access to fertility':ab,ti OR 'availability of art':ab,ti OR 'tax credit':ab,ti	56356
#16	'health care cost'/exp OR 'access to treatment'/exp OR 'public expenditure'/exp OR 'reimbursement'/exp OR 'health insurance'/exp	697290
#15	#10 AND #14	12770
#14	#11 OR #12 OR #13	14962
#13	((donor* OR donat*) NEAR/1 (gamete* OR embryo* OR egg* OR sperm OR oocyte OR insemination)):ab,ti	12968
#12	'heterologous artificial insemination':ab,ti	26
#11	'heterologous artificial insemination'/exp OR 'oocyte donation'/exp OR 'donor conception'/exp	5894
#10	#1 OR #2 OR #3 OR #4 OR #5 OR #6 OR #7 OR #8 OR #9	233507
#9	'fertility preservation':ab,ti OR 'cryopreservation':ab,ti OR 'cryoconservation':ab,ti OR 'cryo-conservation':ab,ti OR 'cryo-preservation':ab,ti	40076
#8	'artificial insemination':ab,ti OR 'oviduct insemination':ab,ti OR 'oviductal insemination':ab,ti	9567

#7	'insemination treatment*':ab,ti OR 'insemination therap*':ab,ti	159
#6	'test-tube fertilisation':ab,ti OR 'test-tube fertilization':ab,ti	13
#5	'ivf':ab,ti	60587
#4	('in vitro' NEAR/1 (fertilization OR fertilisation)):ab,ti	43967
#3	((fertility OR infertility) NEAR/1 (treatment* OR therap*)):ab,ti	13462
#2	(assisted NEAR/1 (reproduct* OR fertili*)):ab,ti	37654
#1	'infertility therapy'/exp	189816

Appendix B – Excluded published literature

Author(s) [Reference] (Year)	Title	Reason for exclusion
Adamson et al.[153] (2022)	ICMART preliminary world report 2018	No mention of publicly-funded DAHR services
Adamson et al.[154] (2020)	ICMART preliminary world report 2016	No mention of publicly-funded DAHR services
Adamson et al.[155] (2019)	ICMART preliminary world report 2015	No mention of publicly-funded DAHR services
Adamson et al.[156] (2023)	ICMART preliminary world report 2019	No mention of publicly-funded DAHR services
Adamson et al.[157] (2024)	ICMART Preliminary World Report 2020	No mention of publicly-funded DAHR services
Adamson et al.[158] (2025)	ICMART Preliminary World Report 2021	No mention of publicly-funded DAHR services
Akbarzadeh and Samani[159]	Health status as criteria for access of infertile couples to assisted reproductive technology	Wrong country or specific country not specified
Alland et al.[160] (2024)	Oocyte donor characteristics and preferences towards an open-identity donation program	Focused on initial gamete/embryo donation
Allison[161] (2016)	Enduring politics: the culture of obstacles in legislating for assisted reproduction technologies in Ireland	Wrong country or specific country not specified
Alon et al.[152] (2024)	Mapping Ethical, Legal, and Social Implications (ELSI) of gamete donation	Focused on initial gamete/embryo donation
Appelgren Engström et al.[162] (2019)	Mothers in same-sex relationships-Striving for equal parenthood: A grounded theory study	Not focused on DAHR services
Baccino and Dejewski[163] (2022)	Patient Care Guidance: Development of a unique tool for fertility clinics based on best practice evidence	Not focused on DAHR services
Baker et al.[164] (2025)	International Committee for Monitoring Assisted Reproductive Technologies (ICMART): world report for cycles conducted in 2017-2018	No mention of publicly-funded DAHR services
Bellas et al.[165] (2022)	Is the use of donated sperm advisable for patients with advanced paternal age?	No mention of publicly-funded DAHR services

Author(s) [Reference] (Year)	Title	Reason for exclusion
Bloechle[166] (2025)	Reproductive medicine: Legal aspects: what is allowed in Germany? About oocyte donation, embryo donation and surrogacy motherhood	No access to the full text
Bolton et al.[167] (2023)	Human oocyte cryopreservation: revised evidence for practice	Not focused on DAHR services
Bowen-Simpkins et al.[168] (2018)	The UK's anomalous 10-year limit on oocyte storage: time to change the law	Information out of date
Bracewell-Milnes et al.[169] (2019)	Investigating knowledge and perceptions of egg sharing among healthcare professionals in the United Kingdom	No mention of publicly-funded DAHR services
Bracewell-Milnes et al.[170] (2016)	Investigating psychosocial attitudes, motivations and experiences of oocyte donors, recipients and egg sharers: a systematic review	No mention of publicly-funded DAHR services
Brandao and Ceschin[171] (2023)	Lesbian shared IVF: the ROPA method: a systematic review	Wrong country or specific country not specified
Brandao et al.[172] (2022)	ROPA - Lesbian shared in vitro fertilization - Ethical aspects	Wrong country or specific country not specified
Brown[173] (2019)	Irresponsibly Infertile? Obesity, Efficiency, and Exclusion from Treatment	Not focused on DAHR services
Calhaz-Jorge et al.[14] (2020)	Survey on ART and IUI: legislation, regulation, funding and registries in European countries: The European IVF-monitoring Consortium (EIM) for the European Society of Human Reproduction and Embryology (ESHRE)	Updated article included
Cote et al.[174] (2024)	Access to Fertility Services for Lesbian, Bisexual, or Pansexual Women and Queer, Trans, or Non-Binary People: A Rapid Review of the Scientific Literature	Wrong country or specific country not specified
Chautems et al.[175] (2025)	Lesbian Couples' Assisted Reproductive Technologies Trajectories in Switzerland and Abroad: Navigating Heteronormative Norms and Healthcare Disparities	Wrong country or specific country not specified
Chehimi et al.[176] (2025)	Sociodemographic profile of women seeking elective egg freezing when financed by the public healthcare system	Not focused on DAHR services
Clarke et al.[177] (2021)	UK guidelines for the medical and laboratory procurement and use of sperm, oocyte and embryo donors (2019)	No mention of publicly-funded DAHR services
Compans et al.[178] (2025)	Medically assisted reproduction and non-normative family forms: legislation and public opinion in Europe	No mention of publicly-funded DAHR services

Author(s) [Reference] (Year)	Title	Reason for exclusion
Connolly et al.[179] (2025)	Estimating the Fiscal Value of Children Conceived from Assisted Reproduction Technology in Australia Applying a Public Economic Perspective	No mention of publicly-funded DAHR services
Correia et al.[180]	The right to be forgotten versus the right to disclosure of gamete donors ID: Ethical and legal considerations	Focused on initial gamete/embryo donation
da Silva et al.[181] (2022)	Medical ethics when moving towards non-anonymous gamete donation: the views of donors and recipients	Not focused on DAHR services
de Moura et al.[182] (2019)	Concerns with educating the public about donating and receiving gametes	No mention of publicly-funded DAHR services
Dickens[183] (2016)	The use and disposal of stored embryos	No mention of publicly-funded DAHR services
Diedrich et al.[184] (2020)	Forty years of in vitro fertilization: past achievements and future perspectives	No mention of publicly-funded DAHR services
Domar et al.[185] (2021)	Barriers and factors associated with significant delays to initial consultation and treatment for infertile patients and partners of infertile patients	Not focused on DAHR services
Dyer et al.[186] (2024)	Achieving more equitable access to assisted reproduction	Wrong country or specific country not specified
ESHRE[187] (2025)	Abstracts 41st Hybrid Annual Meeting of the European Society of Human Reproduction and Embryology	Relevant abstracts included individually
Ethics Committee of the American Society for Reproductive Medicine[188] (2025)	Assisted reproduction with advancing paternal and maternal age: an Ethics Committee opinion	Wrong country or specific country not specified
Eustache et al.[189] (2021)	Fertility preservation and sperm donation in transgender individuals: The current situation within the French CECOS network	No mention of publicly-funded DAHR services
Ezeome[190] (2022)	Gamete donation-A review of ethical and legal issues	Focused on initial gamete/embryo donation
Fauser et al.[191] (2019)	Beliefs, attitudes and funding of assisted reproductive technology: Public perception of over 6,000 respondents from 6 European countries	Wrong country or specific country not specified
Findeklee and Diedrich[192] (2022)	[IVF and ICSI—From the beginnings to the present day] IVF und ICSI – Von den Anfängen bis zur Gegenwart	No mention of publicly-funded DAHR services

Author(s) [Reference] (Year)	Title	Reason for exclusion
Forshall et al.[193] (2024)	Acceptance and rejection of "morally challenging" behaviour in online sperm donation communities: narrative interviews with recipients and donors	No mention of publicly-funded DAHR services
Giblin et al.[194]	Attitudes of healthcare professionals to draft national legislation on assisted human reproduction (AHR)	Not focused on DAHR services
Gilbar and Tamir[195] (2025)	Surplus embryo donation: terminology and ethico-legal perspectives	Focused on initial gamete/embryo donation
Gilman et al.[196] (2024)	Direct-to-consumer genetic testing and the changing landscape of gamete donor conception: key issues for practitioners and stakeholders	Wrong country or specific country not specified
Gilman and Nordqvist[197] (2018)	Organising openness: How UK policy defines the significance of information and information sharing about gamete donation	No mention of publicly-funded DAHR services
Goedeke et al.[198] (2017)	The Fate of Unused Embryos: Discourses, Action Possibilities, and Subject Positions	Wrong country or specific country not specified
Harrison et al.[199] (2017)	Advanced maternal age: Ethical and medical considerations for assisted reproductive technology	No mention of publicly-funded DAHR services
Harrison[200] (2019)	A virtual promise of happiness: kinship on the websites of Danish fertility clinics and sperm banks	No mention of publicly-funded DAHR services
Henry et al.[16] (2025)	FIGO position statement: Gamete donations	Wrong country or specific country not specified
Hudson[201] (2024)	Advances in oocyte freezing: implications for donors, recipients, counsellors and clinics	No mention of publicly-funded DAHR services
Hudson et al.[202] (2019)	Egg providers' views on the use of surplus eggs in the UK, Spain and Belgium: implications for information giving and informed consent	Focused on initial gamete/embryo donation
Hudson et al.[203] (2020)	Reframing egg donation in Europe: new regulatory challenges for a shifting landscape	Focused on initial gamete/embryo donation
Hudson et al.[204] (2025)	The emergence of egg intermediaries in the European fertility landscape: the creation of value in reproductive bioeconomies	Focused on initial gamete/embryo donation
Jackson et al.[205] (2017)	Learning from Cross-Border Reproduction	No mention of publicly-funded DAHR services
Jaspal et al.[206] (2019)	The impact of cross-border IVF on maternal and neonatal outcomes in multiple pregnancies: Experience from a UK fetal medicine service	Not focused on DAHR services

Author(s) [Reference] (Year)	Title	Reason for exclusion
Johnston et al.[207] (2022)	Financing future fertility: Women's views on funding egg freezing	Not focused on DAHR services
Kalampalikis et al.[208] (2018)	Sperm donor regulation and disclosure intentions: Results from a nationwide multi-centre study in France	No mention of publicly-funded DAHR services
Keaney (2023)	Making Gaybies: Queer Reproduction and Multiracial Feeling	No access to full text
Keller et al.[209] (2023)	Does in vitro fertilization (IVF) treatment provide good value for money? A cost-benefit analysis	Not focused on DAHR services
Kelly and Dempsey[210] (2016)	The family law implications of early contact between sperm donors and their donor offspring	No mention of publicly-funded DAHR services
Kentenich and Diedrich[211] (2020)	On the ban on egg donation: medial and ethical considerations	Focused on initial gamete/embryo donation
Kentenich et al.[212] (2019)	Tandler-Schneider A: Egg donation: Considerations from a medical and psychosomatic point of view	No access to the full text
Kentenich et al.[213] (2018)	Egg donation: Considerations from a medical and psychosomatic point of view	No access to the full text
Kieu et al.[214] (2024)	A national survey of women's perspectives and experiences of pursuing donor eggs	No mention of publicly-funded DAHR services
Kirkman-Brown et al.[146] (2022)	Good practice recommendations for information provision for those involved in reproductive donation	Recommendations not necessarily endorsed
Kotroušová[215] (2021)	Cohabitation and Assisted Reproduction inÂ the Czech Republic and inÂ the European Context	Information out of date
Kreb[216] (2022)	[Ethical criteria in reproductive medicine] Ethische Kriterien der Reproduktionsmedizin	No access to the full text
Kreb[217] (2023)	[Ethical criteria in reproductive medicine] Ethische Kriterien der Reproduktionsmedizin	No access to the full text
Kupka et al.[218] (2024)	International Committee for Monitoring Assisted Reproductive Technology world report: assisted reproductive technology, 2015 and 2016	Not focused on DAHR services
Lafuente-Funes et al.[219] (2023)	Egg donation in the age of vitrification: A study of egg providers' perceptions and experiences in the UK, Belgium and Spain	Focused on initial gamete/embryo donation

Author(s) [Reference] (Year)	Title	Reason for exclusion
Lee and Zhang[220] (2022)	Which assisted reproductive technology (ART) treatment strategy is the most clinically and cost-effective for women of advanced maternal age: a Markov model	Information on costs covered in grey literature
Lensen et al.[221] (2021)	How common is add-on use and how do patients decide whether to use them? A national survey of IVF patients	Not focused on DAHR services
Macklon and Fauser[222] (2020)	Context based infertility care	Not focused on DAHR services
Martin et al.[223] (2020)	Recipient and donor experiences of known egg donation: implications for fertility counselling	No mention of publicly-funded DAHR services
Mazi et al.[224] (2024)	Modelling and comparing the use of IVF and ICSI in Australia	Not focused on DAHR services
Mazzilli et al.[225] (2023)	Male factor infertility and assisted reproductive technologies: indications, minimum access criteria and outcomes	No mention of publicly-funded DAHR services
Mburu et al.[226] (2026)	WHO guideline on infertility: an opportunity to reduce global health inequalities	Not focused on DAHR services
Milewski et al.[227] (2025)	Infertility and Seeking Medical Help to Have a Child Vary Across Migrant Origin Groups in Germany	Not focused on DAHR services
Millbank[228] (2019)	What is the Responsibility of Australian Medical Professionals Whose Patients Travel Abroad for Assisted Reproduction?	Not focused on DAHR services
Mills et al.[229] (2024)	Improving consent procedures to increase oocyte donation rates	Focused on initial gamete/embryo donation
Mishtal[230] (2016)	Brocher symposium: perspectives on access to reproductive healthcare: Introduction	No mention of publicly-funded DAHR services
Mounce et al.[231] (2022)	'Just have some IVF!': A longitudinal ethnographic study of couples' experiences of seeking fertility treatment	Not focused on DAHR services
Ng et al.[232] (2025)	A retrospective analysis of family type data within the United Kingdom (UK) national fertility register, over a 10- year period	Not focused on DAHR services
[No authors][233] (2023)	ART must be accessible and sustainable	Wrong country or specific country not specified
O Brien et al.[234] (2025)	Investigating new perceptions in fertility care access in Ireland	Wrong country or specific country not specified

Author(s) [Reference] (Year)	Title	Reason for exclusion
O'Brien et al.[235] (2023)	Assisted human reproduction legislation: Listening to the voice of patients	Wrong country or specific country not specified
Ombelet et al.[236] (2020)	Should couples with unexplained infertility have three to six cycles of intrauterine insemination with ovarian stimulation or in vitro fertilization as first-line treatment?	Not focused on DAHR services
Pennings[237] (2022)	Sperm sharing: As problematic as oocyte sharing?	No mention of publicly-funded DAHR services
Pennings[238] (2025)	Letter to the editor	Focused on initial gamete/embryo donation
Pennings et al.[239] (2018)	Attitude towards reciprocity as a motive for oocyte donation	No mention of publicly-funded DAHR services
Petch et al.[240] (2024)	Knowledge, Attitudes, and Challenges: Irish General practitioners' preparedness for publicly funded Assisted reproductive technologies	No mention of publicly-funded DAHR services
Petra et al.[241] (2024)	Evaluation of infertility counselling in Germany	Not focused on DAHR services
Pettle[242] (2024)	Building families through MAR (medically assisted reproduction), donor conception and surrogacy: Where does this fit into clinical psychology?	No access to the full text
Pettle[243] (2024)	Family Complexities Around Donor Conception and Surrogacy: A Perspective from the United Kingdom	No access to the full text
Piek et al.[244] (2024)	Age-based restrictions on reproductive care: discerning the arbitrary from the necessary	Not focused on DAHR services
Pikal[245] (2020)	[5 Medical and legal foundations of assisted reproduction] 5 Medizinische und rechtliche Grundlagen der assistierten Reproduktion	No access to the full text
Pikal[246] (2020)	[7. The criminal relevance of domestic medical involvement in methods of fertility treatment abroad that are prohibited under the Embryo Protection Act] 7 Die strafrechtliche Relevanz einer inländischen ärztlichen Mitwirkung an nach dem ESchG verbotenen Methoden der Kinderwunschbehandlung im Ausland	No access to the full text
Power et al.[247] (2020)	Use of fertility services in Australian lesbian, bisexual and queer womens pathways to parenthood	No mention of publicly-funded DAHR services

Author(s) [Reference] (Year)	Title	Reason for exclusion
Prag and Mills[248] (2024)	Cultural determinants influence assisted reproduction usage in Europe more than economic and demographic factors	Not focused on DAHR services
Qiu et al.[249] (2025)	Toward global reproductive justice: a universal framework for evaluating equity and autonomy in in-vitro fertilization policies	No mention of publicly-funded DAHR services
Quigley et al.[250] (2020)	Donor oocyte-facilitated reproduction: Time to revisit the BSH antenatal guidelines?	No mention of publicly-funded DAHR services
Rausch et al.[251]	Support for Lesbian Couples Navigating Fertility Treatment: An Ecological Systems Perspective	Wrong country or specific country not specified
Rivet-Danon et al.[252] (2024)	[The revision of the Bioethics Act, two years on: major principles and consequences for practice in the reproductive biology laboratory]	No access to the full text
Ronan et al.[253] (2022)	The Lack of Ireland's Assisted Human Reproduction (AHR) Regulation Viewed under the Lens of the Patient's Experience	Wrong country or specific country not specified
Salazar et al.[254] (2023)	Third-party reproduction: a treatment that grows with societal changes	Wrong country or specific country not specified
Schaler et al.[255] (2023)	Assisted human reproduction legislation: Acknowledging the voice of health care professionals	Wrong country or specific country not specified
Shaw[256] (2022)	Introduction: Reproductive Citizenship and Meanings of Infertility	No access to the full text
Shenfield et al.[257] (2020)	EBCOG position statement on Ethical analysis of cross-border reproductive care	Not focused on DAHR services
Shufaro et al.[258] (2023)	Medical, Social, Legal, and Religious Aspects of Genetic Donation	Focused on initial gamete/embryo donation
Skiegal and Ravitsky[259] (2018)	Women With Mental Illness Seeking Assisted Reproduction Considerations in Ethical Candidate Selection	Not focused on DAHR services
Skedgel et al.[260] (2021)	Is the public supportive and willing to pay for a national assistive reproductive therapies programme? Results from a multicountry survey	Not focused on DAHR services
Soave and Marci[261] (2023)	Chapter 39 - Regulation, data management, informed consent, and legal issues for ART	No access to the full text
Tanderup et al.[262] (2024)	Permanently infertile couples and family building-a cross-sectional survey in Denmark	Not focused on DAHR services

Author(s) [Reference] (Year)	Title	Reason for exclusion
Theodoridis et al.[263] (2018)	Effects of the Sperm Donor Registry Act on extraction facilities and facilities of medical care	No mention of publicly-funded DAHR services
Tonkens[264] (2018)	Infertilitism: unjustified discrimination of assisted reproduction patients	Not focused on DAHR services
Viuff and Gravholt[265] (2019)	Care of adult women with turner syndrome: The state of affairs in Germany	Not focused on DAHR services
Volks et al.[266] (2025)	From clicks to creating kin: how Australian online egg donors craft relationships with recipients and donor-conceived children	No mention of publicly-funded DAHR services
Wurful[267] (2018)	Reproductive medicine: The current situation in Germany	No access to the full text
Wiecki and Dejewski[268] (2025)	Global Insights from Patients Seeking IVF Treatment Abroad	Not focused on DAHR services
Wilinska-Zelek[269] (2021)	Infertility treatment law making in Europe: the clash of knowledge, ethics and business	Wrong country or specific country not specified
Wilson-Nash et al.[270] (2025)	Beyond the rainbow bunting: examining the realities of UK fertility care for LGBTQ+ patients	No mention of publicly-funded DAHR services
Zweifel et al.[271] (2020)	Is it time to establish age restrictions in ART?	Not focused on DAHR services

Appendix C – Characteristics of included published literature

No.	Author(s) [Reference] (Year)	Title	Type of evidence source	Country(ies) of focus
1.	Adams et al.[129] (2016)	Does the removal of anonymity reduce sperm donors in Australia?	Journal Article	Australia
2.	Adrian and Kroløkke[272] (2018)	Passport to Parenthood: Reproductive Pathways In and Out of Denmark	Journal Article	Denmark
3.	Agopiantz et al.[273] (2025)	The donation of begetting in France: The proposal of a new model	Journal Article	France
4.	Applegren Engstrom et al.[162] (2018)	Mothers in Same-Sex Relationships Describe the Process of Forming a Family as a Stressful Journey in a Heteronormative World: A Swedish Grounded Theory Study	Journal Article	Sweden
5.	Armuand et al.[274] (2019)	Attitudes towards embryo donation among healthcare professionals working in child healthcare: A survey study	Journal Article	Sweden
6.	Asplund[275] (2019)	Use of in vitro fertilization-ethical issues	Journal Article	Sweden
7.	Baia et al.[120] (2021)	Priority of Access to Fertility Treatments Based on Sexual Orientation and Marital Status: the Views of Gamete Donors and Recipients	Journal Article	Portugal
8.	Bals-Pratsch and du Bois[276] (2022)	Doctors call for the modernization of the German Embryo Protection Act (ESchG)	Journal Article	Germany
9.	Bartholomaeus and Riggs[277] (2018)	Embryo donation and receipt in Australia: views on the meanings of embryos and kinship relations	Journal Article	Australia
10.	Bauer and Meier-Credner[124] (2024)	Intra-familial dynamics of knowledge and ignorance experienced by donor-conceived adults in Germany	Journal Article	Germany
11.	Beier et al.[125] (2018)	[A reproductive medicine law for Germany] Ein Fortpflanzungsmedizingesetz fur Deutschland	Journal Article	Germany
12.	Bracewell-Milnes et al.[127] (2018)	A systematic review investigating psychosocial aspects of egg sharing in the United Kingdom and their potential effects on egg donation numbers	Journal Article	UK
13.	Calhaz-Jorge et al.[13] (2024)	Survey on ART and IUI: legislation, regulation, funding, and registries in European countries: an update	Journal Article	Multiple countries
14.	Catalini et al.[278] (2023)	Assisted Reproductive Technology Results Using Donor or Partner Sperm: A Danish Nationwide Register-Based Cohort Study	Journal Article	Denmark
15.	Cavaliere and Fletcher[126] (2022)	Age-discriminated IVF Access and Evidence-based Ageism: Is There a Better Way?	Journal Article	UK

No.	Author(s) [Reference] (Year)	Title	Type of evidence source	Country(ies) of focus
16.	Compans[279] (2024)	Alignment, Anticipation, Adaptation, or Lagging Behind? Age-Based Regulations in Assisted Reproduction and Late Fertility	Journal Article	Multiple countries
17.	Cooper[280] (2023)	Assisted Reproductive Technologies	Book Chapter	UK
18.	Crawshaw et al.[281] (2022)	Counselling challenges associated with donor conception and surrogacy treatments - time for debate	Journal Article	UK
19.	de Melo[282] (2016)	How best to protect the vital interests of donor-conceived individuals: prohibiting or mandating anonymity in gamete donations?	Journal Article	Multiple countries
20.	Dempsey et al.[110] (2022)	A perfect storm of intervention? Lesbian and cisgender queer women conceiving through Australian fertility clinics	Journal Article	Australia
21.	Elenis et al.[283] (2020)	Access to infertility evaluation and treatment in two public fertility clinics and the reasons for withholding it: A prospective survey cohort study of healthcare professionals	Journal Article	Sweden
22.	Elenis et al.[284] (2025)	Perinatal outcomes and maternal health before and after single motherhood through assisted conception: A multiregistry study in Sweden	Journal Article	Sweden
23.	Fernandez et al.[123] (2025)	Trends in clinical encounters and management for infertility among women attending Australian general practice: a national longitudinal study using MedicineInsight, 2011 to 2021	Journal Article	Australia
24.	Galhardo[285] (2024)	From secrecy to transparency: The journey of donor identity in reproductive medicine in Portugal	Conference Abstract	Portugal
25.	Gianaroli et al.[286] (2016)	Current regulatory arrangements for assisted conception treatment in European countries	Journal Article	Multiple countries
26.	Gigstad et al.[287] (2023)	HIV and access to fertility treatment in the European and Swedish contexts	Journal Article	Multiple countries
27.	Gilman and Nordqvist[288] (2023)	The case for reframing known donation	Commentary	UK
28.	Goedeke and Rodino[289] (2023)	Embryo donation: Counselling practice issues and dilemmas within the context of identity-release donor programmes	Journal Article	Australia
29.	Goedeke et al.[290] (2022)	Fertility stakeholders' concerns regarding payment for egg and sperm donation in New Zealand and Australia	Journal Article	Australia
30.	Goedeke[291] (2025)	Donor Conception in the Interests of the Well-Being of Donor-Conceived Persons, and Other Parties Connected through Donor Conception - A Review	Journal Article	Multiple countries

No.	Author(s) [Reference] (Year)	Title	Type of evidence source	Country(ies) of focus
31.	Irwin[116] (2024)	Politics, law and a lack of sperm: single women and fertility treatment in the Swedish health system	Journal Article	Sweden
32.	Kentenich et al.[292] (2018)	Medical and psychosocial aspects of consultation	Journal Article	Germany
33.	Lemke and Ruppel[293] (2018)	Social dimensions of preimplantation genetic diagnosis: a literature review	Journal Article	Multiple countries
34.	Lind[112] (2023)	[The best interests of the child in assisted reproduction] Barnets bästa vid assisterad befruktning	Journal Article	Sweden
35.	Lind[122] (2025)	Child welfare assessments and the regulation of access to publicly funded fertility treatment	Journal Article	Sweden
36.	Lindell Pettersson et al.[294] (2023)	Perceived social support in solo women seeking treatment with donor gametes and in women in heterosexual couples seeking IVF-treatment with own gametes	Journal Article	Sweden
37.	Matorras et al.[295] (2023)	Evaluation of costs associated with fertility treatment leading to a live birth after one fresh transfer: A global perspective	Journal Article	Multiple countries
38.	McDermott et al.[151] (2022)	A comparison of assisted human reproduction (AHR) regulation in Ireland with other developed countries	Journal Article	Multiple countries
39.	Meads et al.[296] (2021)	Why Are the Proportions of In-Vitro Fertilisation Interventions for Same Sex Female Couples Increasing?	Journal Article	UK
40.	Mohr and Koch[297] (2016)	Transforming social contracts: the social and cultural history of IVF in Denmark	Journal Article	Denmark
41.	Mohr and Herrmann[298] (2022)	The politics of Danish IVF: reproducing the nation by making parents through selective reproductive technologies	Journal Article	Denmark
42.	Passet-Wittig et al.[299] (2025)	Social Disparities Across Different Stages of Medical Help Seeking to Have a Child in Germany	Journal Article	Germany
43.	Payne and Korolczuk[300] (2016)	Reproducing politics: the politicisation of patients' identities and assisted reproduction in Poland and Sweden	Journal Article	Sweden
44.	Pennings[301] (2025)	Donor sperm: only for the rich and straight	Commentary	UK
45.	Piek et al.[302] (2024)	Against age limits for men in reproductive care	Journal Article	Multiple countries
46.	Raperport et al.[303] (2022)	˜It takes a village‟ fertility treatment using donor gametes, embryos and/or surrogacy	Journal Article	UK
47.	Riggs and Bartholomaeus[304] (2020)	Formal and informal support and counselling for embryo donation and receipt: An Australian qualitative study	Journal Article	Australia

No.	Author(s) [Reference] (Year)	Title	Type of evidence source	Country(ies) of focus
48.	Rinehart[119] (2021)	Storage, transport, and disposition of gametes and embryos: legal issues and practical considerations	Journal Article	Multiple countries
49.	Rozee and de La Rochebrochard[305] (2023)	[Assisted reproductive technology (ART) in France: a reproduction of gender inequalities?] La PMA en France : une reproduction des inégalités de genre ?	Journal Article	France
50.	Rozee and de La Rochebrochard[306] (2021)	[Assisted reproduction outside the French legal and medical framework: what are the issues today?] L'aide à la procréation en dehors du cadre légal et médical français : quels enjeux aujourd'hui?	Journal Article	France
51.	Rozee and Malmanche[307] (2023)	[To be "alone in the driver's seat": MAR's solo journey in France] Pour être « seule aux manettes » : parcours solo de la PMA en France	Journal Article	France
52.	Siermann et al.[308] (2024)	Ready for polygenic risk scores? An analysis of regulation of preimplantation genetic testing in European countries	Journal Article	Multiple countries
53.	Silva et al.[309] (2019)	[Gamete donation: (un)answered social and ethical issues in Portugal]	Journal Article	Portugal
54.	Taylor et al.[103] (2023)	Accessing publicly funded donor insemination treatment in the UK: is funding information available on fertility clinic websites?	Journal Article	UK
55.	Taylor et al.[310] (2022)	Are UK Policies and Practices for Regulated Donor Insemination Forcing Women to Find Unregulated Sperm Donors Online? A Perspective on the Available Evidence	Journal Article	UK
56.	Thorn et al.[311] (2017)	[Mine, yours, our embryo] Mein, dein, unser Embryo	Journal Article	Germany
57.	Tippett[99] (2023)	Reproductive rights where conditions apply: an analysis of discriminatory practice in funding criteria against would-be parents seeking funded fertility treatment in England	Journal Article	England
58.	Tremellen et al.[94] (2017)	Should obese women's access to assisted fertility treatment be limited? A scientific and ethical analysis	Opinion	Australia
59.	Volgsten and Schmidt[312] (2023)	Exploring Swedish single women's decision to choose motherhood through medically assisted reproduction - a qualitative study	Journal Article	Sweden
60.	Volgsten and Schmidt[313] (2021)	Motherhood through medically assisted reproduction characteristics and motivations of Swedish single mothers by choice	Journal Article	Sweden
61.	Zagel[314] (2024)	Reproduction policy as life course policy: normative modelling of reproductive life courses in Germany	Journal Article	Germany

Appendix D – Summary tables

Table D 1 Summary of populations eligible for publicly-funded DAHR services in selected countries.

Country Relevant documents	DAHR interventions available and eligible populations
Australia ▪ Medicare Benefits Schedule[62] ▪ Services Australia: ○ ART services[63] ○ Item numbers for billing Assisted Reproductive Technology services[64] ▪ Tremellen et al.[94] ▪ Dempsey et al.[110]	**Donor-assisted human reproduction (DAHR) interventions offered:** A number of DAHR interventions are covered by Medicare reimbursement in Australia. Generally, to be eligible for Medicare a patient must permanently reside in Australia and be one of the following: ▪ an Australian citizen ▪ a permanent visa holder ▪ a New Zealand citizen ▪ (in certain circumstances) an applicant for a permanent residence visa. Medicare Benefits Schedule provide assisted human reproduction (AHR) treatment involving donated ova, when there is an identified infertile recipient. Medicare benefit applies only to services that are considered clinically relevant and medically necessary, therefore elective fertility is not covered. However, as of 2024 the definition of infertility was broadened to 'the inability to achieve a successful pregnancy based on a patient's medical, sexual, and reproductive history, age, physical findings, diagnostic testing, or any combinations of these factors" and "the need for medical intervention… to achieve a successful pregnancy'.[92] **Definition of a treatment cycle according to Medicare:** The treatment cycle for ART including DAHR is defined in terms of timing - "A treatment cycle that is a series of treatments for the purposes of ART services is defined as beginning either on the day on which treatment by superovulatory drugs is commenced or on the first day of the patient's menstrual cycle, and ending either; not more than 30 days later, or if [oocyte retrieval, transfer of embryos or both ova and sperm, or preparation of sperm for artificial insemination] is provided in connection with the series of treatments-on the day after the day on which the last of those services is provided. The date of service in respect of treatment covered by Items 13200, 13201, 13203, 13209 and 13218 is DEEMED to be the FIRST DAY of the treatment cycle." **Royal Australian and New Zealand College of Obstetricians (RANZCOG)** ▪ A body mass index (BMI) greater than or equal to 35 is a recognised risk factor in pregnancy and delivery and should be regarded as a contraindication to assisted fertility'. While discretion for accessing treatment is ultimately left to the treating doctor, this policy does create a significant barrier for morbidly obese women or birthing people accessing AHR. ▪ It would be more valid to limit in vitro fertilisation (IVF) for women over 43 because the chances of success are very low. This is a stronger argument than denying IVF to younger women or birthing people who are obese. However, Australian government policy and RANZCOG guidelines do not ban IVF for older women or birthing people with poor chances of success. Also, arguments about fair use of limited resources do not apply when women or birthing people pay for treatment themselves, yet RANZCOG does not separate public and private IVF in its policy.

	Interventions available: There are two main conception methods used by Australian LGBTQI+ women or birthing people accessing fertility clinics: ▪ In intrauterine insemination (IUI), thawed, cryopreserved sperm is placed in the intended mother's uterus at the time of ovulation. During a natural IUI cycle, patients may monitor ovulation themselves, or this may be done by ultrasound. Oral or injectable medications can also be used to induce ovulation such as a 'trigger shot' of hormones. ▪ IVF is a more complex and interventionist procedure. It requires that: the woman or birthing person's ovaries are stimulated through injected hormones; ova are surgically extracted from the woman or birthing person (who may be the intended birthing mother, or her partner, or an egg donor); fertilised with sperm in the laboratory; and the resultant embryo implanted in the uterus of the intended birthing mother. **Pre-implantation Genetic Diagnosis (PGD):** Couples with a high risk of having a child affected by a genetic disorder will be able to access PGD and receive a Medicare rebate. There are five items on the Medicare Benefits Schedule: ▪ an item to test the reproductive couple for pathogenic variants (73384) ▪ one surgical item for an embryo biopsy from an at risk couple as identified by the first test (13207) ▪ and a further three items for genetic testing of the biopsied embryo(s) (73385, 73386, 73387).[96] Eligibility for PGD items are restricted to patients and (if relevant) a reproductive partner with a recognised risk of having a child affected by a Mendelian or mitochondrial disorder, autosomal dominant disorder, or chromosome disorder, for which there is no curative treatment and there is a severe limitation of quality of life despite contemporary management.[96]
Denmark ▪ BEK no. 1452 of 01/12/2025 Executive Order on Assisted Reproduction[24] ▪ BEK no. 316 of 27/03/2019 Executive Order on assessment of parental unfitness in connection with assisted reproduction treatment[20] ▪ LBK nr 902 of 23/08/2019: Proclamation of the Act on Assisted Reproduction in Connection with Treatment, Diagnostics and Research, etc.[19] ▪ New agreement to help involuntarily childless people get pregnant (and implementation agreement)[41] ▪ New agreement provides twice as many fertility attempts for child number two[43]	In Denmark, AHR and or DAHR is available to couples and individuals. Assisted reproduction is understood to mean that pregnancy is sought to be established in a way other than through sexual intercourse. This includes both treatments where fertilised eggs are removed and or implanted from a woman or birthing person, as well as insemination, but does not include isolated follicle-stimulating and ovulation-inducing treatment with the aim of promoting pregnancy through subsequent sexual intercourse. Eligibility requirements for AHR: ▪ There must be a treatment indication. Patients are generally required to have attempted pregnancy for at least 12 months if they are under 30-35 years old and there are no obvious causes for the condition. This does not apply to individuals who want to be pregnant, couples consisting of two people who are assigned the female sex at birth, those where there is considered to be little chance of success in advance due to one or more significantly fertility-reducing biological factors in the couple or in the individual (including advanced age). The reason for waiting for at least the mentioned period is to ensure a sufficient strength of the treatment indication, to take into account that some couples achieve pregnancy naturally, and that it can be assumed that a treatment request made at the first consultation has been sufficiently clarified. ▪ Before treatment for involuntary infertility in couples is initiated, relevant investigations must be carried out to clarify the cause of possible biologically determined conception difficulties. The investigations usually include a gynaecological examination, ovulation determination, semen analysis and hysterosalpingography (HSG) or other examinations equivalent to this scope. These examinations will not necessarily be relevant to perform for individuals or same-sex couples. ▪ Before treatment is initiated, the infection marker status must be determined. ▪ The woman or birthing person cannot be older than 45 years. In public clinics, treatment is only offered to those referred before they are 40, and treatment is not provided after the age of 41. Women or birthing people over 41 can still receive a referral for fertility evaluation, However, if fertility treatment (for example, IVF-treatment) is initiated, it will be self-funded,

▪ ROAD No. 9351 of 26/05/2015 Guidance on the activities and obligations of healthcare professionals and tissue establishments in connection with assisted reproduction[45] ▪ Information from multiple sources on public funding: ○ Rigshospitalet: The Fertility Clinic[49] ○ Triangelen Fertility Clinic: Fertility treatment via a public health referral at Trianglen[46] ○ LGBT Familie: Access to assisted reproduction[47] ○ Fertility Clinic Skive: Fertility Treatment.[48]	▪ Regional councils at their hospitals may only provide treatment with AHR to individuals who do not have children and couples who do not have children together. An individual or a couple who has had a child through AHR and who, after the end of treatment, still have frozen eggs, are, however, offered egg freezing in the public hospital system with a view to the couple or individual being able to have more children. Treatment in addition to this may also be offered in the public hospital system if the situation is covered by risk-reducing treatment (PGD and patients with special diseases). Similarly, treatment of fertile and infertile couples where one or both parties are HIV, hepatitis B or C positive may be offered in the public sector as a highly specialised function in the speciality of gynaecology-obstetrics in collaboration with the speciality of infectious medicine. **Further assessments:** ▪ **Health requirements:** Prior to initiating AHR, a health assessment of the woman or birthing person must be carried out. In cases of doubt, the authorized healthcare professional must ensure, if necessary, by referring to another authority, a relevant health professional assessment of the health conditions. Based on the results of such a relevant health assessment, a woman or birthing person may be informed of the risk that may be assumed to be associated with treatment or with pregnancy and childbirth in the specific case. Where there is a significantly increased health risk, including special conditions that entail an imminent risk to the development of the fetus, this must be remedied before AHR is initiated. In special cases, the authorized health professional may refuse to initiate AHR ▪ **Parental unfitness:** When assessing whether there is doubt about an individuals or a couple's unfitness to be a parent, the following may be included: ○ any substance abuse problems in the individual or couple ○ the mental state of the individual or couple, which may affect the ability to care for a future child ○ circumstances that may result in the child being placed outside the home or ○ that one or both prospective parents already have a child who is placed outside the home because of family circumstances. If the healthcare professional responsible for AHR treatment of a person residing in this country assesses that there is doubt about the ability of an individual or a couple to provide the necessary care for a child after birth, the healthcare professional must, with the consent of the individual or couple, submit information to the regional council with a request that the regional council make a decision on whether assisted reproduction treatment can be initiated. In the absence of consent from the individual or couple to disclose information to the regional council, the healthcare professional must refuse to initiate assisted reproduction treatment. The Regional Council shall decide whether assisted reproduction treatment may be initiated. The Regional Council may, with the consent of the individual or couple, include other expertise in the assessment of parental suitability before treatment is initiated. In the absence of consent, the Regional Council shall refuse to initiate AHR treatment. AHR may not take place in: ▪ cases where the woman or birthing person is older than 45 years ▪ women or birthing people with a BMI over 35 ▪ those where a healthcare professional or a person under the responsibility of a healthcare professional is aware that the egg cell and sperm originate from genetically closely related or otherwise genetically more closely related persons ▪ those where a healthcare professional or a person under the responsibility of a healthcare professional is aware that either the egg cell or sperm originate from relatives of the same sex in the descending or ascending line. There is no age limit regarding the man or person with male reproductive organ's age. ▪ **Number of cycles offered for a first child at public fertility clinics:** 3 IUI and 6 IVF and or intracytoplasmic sperm injection (ICSI) treatments for patients where there is a reasonable chance of pregnancy by carrying out additional treatment. There is always

	an ongoing individual assessment of the treatment, and in some cases, fewer attempts may be offered if the chances of success are deemed very low. ▪ **Number of cycles offered for a second child at public fertility clinics:** up to 6 IVF and or ICSI treatments. **Cycle definition:** The use of frozen eggs is not counted as a new treatment attempt. If pregnancy has not been achieved in a usual treatment cycle, where excess suitable embryos were frozen for later transfer to the woman or birthing person, transfer of the frozen-thawed embryos in a natural and or substituted cycle should usually be advised before a new treatment cycle with hormone stimulation and egg retrieval, and so on, is considered. This minimizes the number of hormone-stimulated cycles. Frozen eggs can be stored for up to 5 years. The storage period may be extended in exceptional cases, such as when one partner in a couple has a serious illness. **Intrauterine insemination (IUI) with the partner's sperm:** the probability of achieving pregnancy decreases significantly after 3-4 stimulated IUI cycles, and further attempts are generally not professionally well-indicated. **Intrauterine insemination with donor sperm (IUI-D):** the same applies, although less pronounced. In IUI-D, if there are normal conditions in the tubae and a regular cycle, treatment with insemination in a spontaneous (unstimulated) cycle is offered from the start; if pregnancy is not achieved after 3 inseminations, up to 3 subsequent attempts with a stimulated cycle can be attempted. Further treatment attempts are generally not professionally well-indicated. Similarly, numerous studies have shown that there is no evidence that multiple insemination attempts in the same cycle increase the likelihood of pregnancy. Examples of those offered IUI in Skive Fertility Clinic: ▪ couples where the man or person with male reproductive organs has a normal/slightly reduced semen quality and the woman or birthing person has normal fallopian tube function ▪ individuals with normal fallopian tube function ▪ same-sex couples where the woman or birthing person has normal fallopian tube function. Examples of those offered IVF and or ICSI in Skive Fertility Clinic: ▪ couples with a medical reason to use IVF: ▪ the woman or birthing person's fallopian tubes are blocked or not functioning ▪ PCO and or PCOS ▪ endometriosis ▪ low semen quality and previous sterilisation ▪ unexplained infertility ▪ individuals ▪ same-sex couples. **Sperm donation:** sperm donation can take place with a known heterologous sperm donor (always non-anonymous) and with an unknown heterologous sperm donor (anonymous or non-anonymous). All authorized healthcare professionals can use sperm from a known donor in connection with AHR. With regard to the treatment of patients in the public hospital system who wish to use non-anonymous sperm, it is noted that it is expected that the regions will to a certain extent offer treatment with both anonymous and non-anonymous donated sperm. The specific product range will be determined regionally.

	Egg donation: May only take place if it is done for the purpose of to achieve a pregnancy in another woman or birthing person, or research. It will also be legal for a fertility clinic, or for several fertility clinics in association, to organize an egg donation program based on so-called crossed anonymous donation (see below). **Cross-donation of eggs:** The latest amendment to the law has introduced the possibility of "cross-donation". This means that an individual or a couple in need of receiving an egg for treatment finds a donor themselves who donates to a pool to which several other donors have also donated. The individual and or couple will then be guaranteed to be able to receive an egg from the pool, but from another donor whose identity they do not know. They will also be anonymous donors in the sense of the law if no other information can be obtained about them (from the recipients who receive their eggs) at the time of donation or later, other than that corresponding to the basic profile (information about the donor's skin colour, hair colour, eye colour, blood type, age, height and weight). **Double donation:** If the egg cell does not originate from the woman who is to give birth to the child, and the sperm does not originate from her partner, AHR may only be established where the use of both donated sperm and donated egg cell is justified on health grounds and either the sperm or the egg cell is donated in a non-anonymous form. The requirement for medical justification does not apply where the egg cell is donated by the partner of the woman or birthing person. **Embryo donation:** Only permitted for research purposes. **Pre-implantation genetic diagnosis (PGD):** Genetic testing of a fertilised egg may take place where there is a known and significantly increased risk of giving birth to a child with a serious hereditary disease. The risk may be known due to familial occurrence, previous birth of an affected child, pre-conceptional carrier diagnosis, and so on. In the case of a woman or birthing person and their possible spouse or partner, where such a risk is known and the possibility of PGD is being considered, counselling and examination must first be provided at a clinical genetics department. Pre-implantation genetic testing must therefore not be offered solely on the basis of carrier testing in the parents, without further genetic counselling of the couple. Many gene mutations manifest with different clinical severity. It is the severity of the disease in the affected family, and not the diagnosis alone, that is generally the decisive criterion for considering PGD. A "positive list" cannot be established, but will always be an in-depth, specific assessment, which must always involve genetic and or hereditary biology expertise at a clinical genetics department. Examples of chromosomal abnormalities that would be covered by this in principle: ▪ Trisomy-21 (Down syndrome) ▪ Trisomy-18 ▪ Trisomy-13 ▪ XXY (Klinefelter) ▪ any chromosomal change that is not compatible with long-term survival is included. Assisted reproduction with selection of sperm cells or fertilised eggs before implantation in a woman or birthing person's uterus with the aim of choosing the sex of the child may not be carried out unless this is done to prevent a sex-linked serious hereditary disease in the child. Genetic screening of fertilised eggs for hereditary diseases other than the serious hereditary diseases for which the known and significantly increased risk is directed in the treated woman or birthing person and couple may not be offered. **Reciprocal IVF:** It has become legal for same-sex couples to donate eggs to their partner without medical justification.

France ▪ Biomedicine Agency: Procreation-medical.fr[27] and associated webpages. ▪ L'Assurance Maladie: Assisted Reproductive Technology (ART)[26] ▪ Public Health Code: Title IV: Medically assisted procreation (Articles L2141-1 to L2143-9)[28] ▪ Service Public: Medically assisted genetic procreation 2025[25] ▪ Rozee and de la Rochebrochard[306] ▪ Rozee and de la Rochebrochard[305] ▪ Rozee and Malmanche[307]	**Criteria required to carry out AHR:** ▪ AHR is accessible to all women or birthing people, whether they are in a relationship or are in an individual. ▪ a medical evaluation of both members of the couple or the individual is mandatory before treatment. In addition, the age criteria for the removal and collection of gametes and their use in AHR, self-preservation with a view to the preservation of the fertility, or in the absence of medical reasons is: ▪ egg retrieval until the 43rd birthday for the woman or birthing person and sperm collection until 60th birthday for the man or person with male reproductive organs ▪ use of gametes and embryos until the day of the 45th birthday for women or birthing people and 60th birthday for men or people with male reproductive organs or the other member of the couple if it is a same-sex couple. **Proof of cohabitation:** The condition of stability of the couple (marriage or proof of living together for at least two years) has been abolished. The reality of the couple is an obligation to be able to access AHR care. If two people come to a centre as a couple to receive AHR, the donation centre must ensure that the couple is genuine. A couple is defined as any couple composed of a man or person with male reproductive organs and a woman or birthing person, or two women or birthing people. The members of the couple may or may not be married or bound by a civil solidarity pact. Indeed, it is important to remember that in the event of divorce (or divorce application), separation, death or revocation of the consent of one of the members of the couple, any transfer of embryos frozen or any artificial insemination is made impossible when the request for AHR coverage has been made by a couple. **Same-sex couples' marital status:** Every couple or individual has access to AHR. AHR is open to all couples, regardless of their marital status. The possible separation of the couple after AHR does not change anything: even if separated, women or birthing people can make a joint recognition before the notary provided that at the time of AHR, these two women or birthing people were in a couple (married, in a civil partnership or cohabiting) and that they had recourse to AHR as part of a joint parental project. The use of AHR is now conditional on the existence of a parental project. The new Article L. 2141-2 of the Public Health Code provides that AHR "is intended to respond to a parental project" and that "any couple consisting of a man and a woman or two women or any unmarried woman shall have access to AHR after the individual interviews of the applicants with the members of the multidisciplinary clinical-biological medical team carried out in accordance with the procedures provided for in Article L. 2141-10." **Social assessment of individuals and same-sex couples requesting AHR:** The law does not provide for an obligation to carry out a social assessment before an AHR, regardless of the applicants' marital status. All requests for AHR are subject to a medical evaluation by the multidisciplinary clinical-biological team of the AHR centres. In order to harmonise practices across the country and prevent any risk of discrimination, the composition of this team is now set by decree. The role of the medical team of the AHR centre is therefore to support couples or individuals in their parental project. To do this, the doctor at the AHR centre carries out an assessment to choose the most suitable solution for the couple or individual who wishes to benefit from AHR. After a clinical examination, the doctor prescribes the simplest and least invasive examinations to the couple or individual before considering more sophisticated examinations if necessary. In addition, French law requires that the implementation of AHR be preceded by several private meetings between the couple or individual and the members of the centre's multidisciplinary clinical-biological medical team. The implementation of AHR is preceded by individual interviews between the requesting individual or couple and one or more doctors and other health professionals from the centre's multidisciplinary clinical-biological medical team, which includes a psychiatrist, psychologist or nurse with expertise in psychiatry, if necessary from outside the centre. The doctors of the team mentioned must: 1. Check the motivation of both members of the couple or of the individual

	2. Carry out a medical evaluation of both members of the couple or of the individual 3. Inform both members of the couple or the individual, in the light of the state of scientific knowledge, of the possibilities of success or failure of medically assisted reproduction techniques, of their side effects and their short and long-term risks, as well as of their arduousness and the constraints they may entail 4. In the case of AHR with a third-party donor, inform both members of the couple or the individual of the terms and conditions of access to non-identifying data and the identity of the third-party donor by the donor-conceived person 5. In the case of a couple, inform the latter of the impossibility of carrying out a transfer of the stored embryos in the event of the couple's breakdown as well as of the provisions applicable in the event of the death of one of the members of the couple 6. Provide both members of the couple or the individual with a guide file including: a) A reminder of the legislative and regulatory provisions relating to medically assisted procreation b) A description of the techniques c) A reminder of the legislative and regulatory provisions relating to adoption as well as the addresses of associations and bodies likely to complete their information on this subject d) Information on access to non-identifying data and the identity of the third-party donor by the donor-conceived person, as well as the list of associations and bodies likely to supplement their information on this subject. The members of the couple or the individual are encouraged to anticipate and create the conditions that will allow them to inform the child, before he or she reaches the age of majority, of the result of a donation. The consent of the couple or the individual shall be confirmed in writing at the end of a reflection period of one month from the completion of the steps mentioned in 1 to 6. AHR may not be implemented by the doctor who has also participated in the interviews provided for in the first paragraph when the individual or the applicant couple do not meet the conditions laid down in this title. The multidisciplinary clinic-biological team considers that an additional period of reflection is necessary for the individual or the requesting couple, in the interest of the unborn child. A couple or individual who, in order to procreate, has recourse to medical assistance requiring the intervention of a third-party donor must first give their consent to a notary. The reasons for the postponement or refusal of AHR shall be communicated in writing to applicants upon request to the AHR centre. The following acts of AHR are 100% covered by the Health Insurance for a maximum of: ▪ 6 inseminations (only one artificial insemination per cycle) to achieve pregnancy ▪ 4 attempts at IVF to get pregnant. This care is the same for everyone (couples and individuals). **Recourse to AHR:** The general practitioner or gynaecologist who usually follows the patient will carry out an initial assessment and refer them if necessary to a specialized colleague or a multidisciplinary centre for AHR. Consult without too much delay: If a woman or birthing person is 35 years of age or older If a woman or birthing person has: ▪ cycles that are too long (more than 35 days) or too short (less than 22 days) ▪ known severe endometriosis or very painful periods ▪ previously had a tubal infection, a proboscis. If a man or person with male reproductive organs has:

	▪ ever had testicular torsion or any testicular involvement Whether a man or person with male reproductive organs or a woman or birthing person, has: ▪ ever had a genital infection ▪ ever had a sexually transmitted disease (chlamydia) ▪ already received medical treatment that could impact their fertility ▪ sexual difficulties, whatever the causes. **Artificial insemination can be done with one of the following techniques:** ▪ spouse's sperm (spouse, civil partner or cohabiting partner) ▪ frozen sperm from a donor. This artificial insemination is performed by a doctor specialized in fertility, in most cases without hospitalisation. Most often, the woman or birthing person undergoes hormonal treatment (ovarian stimulation) beforehand. **IVF can be performed:** ▪ with the woman or birthing person's egg and donor sperm ▪ or with the partner's sperm and a frozen egg from a donor ▪ or, in some cases, with donor sperm and donor egg. **When IVF is used:** It is the medical team that determines the most appropriate AHR technique for each case. It may be indicated in particular: ▪ in the event of an abnormality in the woman or birthing person's reproductive function (for example, when there is an abnormality of the fallopian tubes or severe endometriosis) ▪ and or in the event of an abnormality in the man or person with male reproductive organ's reproductive function (for example, too low sperm count) ▪ in case of failure of intrauterine insemination, even if no cause has been identified. **Gamete donation is proposed in the following cases:** ▪ risk of transmitting a genetic disease to the child ▪ infertility in either member of the applicant couple ▪ AHR in an individual. **Double gamete donation:** (sperm and egg) is allowed. Thus, an embryo can be conceived with gametes that do not come from either member of the couple. The recipient(s) must first give their consent to a notary. **Embryo donation may be offered in the following cases:** ▪ risk of transmitting a genetic disease to the child ▪ infertility in either member of the applicant couple ▪ AHR in an individual. **Embryo donation:** A couple or an individual meeting the eligibility, may receive an embryo. Both members of the couple or the individual must first give their consent, before a notary, to the reception of the embryo. The couple or the individual receiving the

	embryo and the couple or individual who consented to the reception of their embryo cannot know each other's identities. In the case of medical necessity, a doctor can access non-identifying medical information concerning the couple or the individual who has consented to the reception of their embryo, for the benefit of the child. This medical information may be updated with the establishments mentioned in this article. No compensation, in any form, may be granted to the couple or to the individual who has consented to the reception of their embryo. The reception of the embryo is subject to health safety rules. These rules include testing for infectious diseases. Only public or private non-profit establishments authorised for this purpose may store embryos intended for reception and implement the reception procedure. **Pre-implantation Genetic Diagnosis (PGD):** Pre-implantation genetic diagnosis (PGD) is offered to couples with "a high probability of giving birth to a child with a genetic disease of particular seriousness recognized as incurable at the time of diagnosis". Each request for PGD is studied by the multidisciplinary centre for prenatal diagnosis present in each region, which must validate the indication. PGD can be performed in one of 5 centres in France. **Same-sex couple, simultaneous embryo transfer in both members of the couple:** Yes, it is possible to transfer embryos in both women or birthing people in the couple. However, each woman or birthing person will only be able to benefit from the transfer of embryos conceived with donor sperm and her own oocytes or egg donation but in no case from an embryo conceived with the oocytes of their partner. Indeed, the so-called ROPA method (reception of oocytes from the partner) is not authorized in France. This prohibition is based on: ▪ on the one hand, on the principle of the anonymity of donation in France between the donor and the recipient ▪ on the other hand, on the fact that an oocyte retrieval, except for use in the context of IVF for the benefit of the person removed, immediately or subsequently (self-preservation), cannot have any other purpose than an anonymous donation. So, there are two distinct procedures of stimulation, IVF and embryos**:** a procedure for each of the women or birthing people. These are two separate parenting projects. For this reason, two separate consents and two separate RCAs are required**.**
Germany ▪ Federal Republic of Germany: Apply for cost coverage for measures to induce pregnancy[50] ▪ Social Code Book 5: Statutory Health Insurance: Section 27a – Artificial insemination[52] ▪ Act for the Protection of Embryos (Embryo Protection Act - ESchG)[53]	Two key representatives from Germany confirmed that DAHR services are not publicly-funded through the statutory health insurance in Germany. For men who have had themselves sterilized, the argument is that they did it voluntarily. For same-sex couples, there's no explicit justification. Under certain conditions, grants from the federal government and some federal states for DAHR services are available, for example if for those in a same-sex relationship or those that are unmarried. This is the exception, rather than the rule and is outlined in Section 3.2.2, Funding. The main requirements for access publicly-funded AHR treatment in Germany are: ▪ when someone cannot become pregnant naturally ▪ from a medical point of view, when artificial insemination measures are suitable for bringing about a pregnancy ▪ a couple must be married and use their own egg and sperm cells. The statutory health insurance funds cannot cover artificial insemination with sperm or egg donation from a third party. ▪ the woman or birthing person must be 25 to 39 years old; the man or person with male reproductive organs must be 25 to 49 years old. Additionally, in Germany, while sperm and embryo donation are legally permitted, egg donation is not.

	Pre-implantation genetic diagnosis (PGD): PGD is legally allowed if parents have a predisposition to a serious genetic illness. However, even in cases in which artificial insemination is allowed and publicly reimbursed (see above), PGD is not publicly-funded.[98]
Portugal ▪ National Council for Medically Assisted Reproduction[60]Law No.32/2006: Medically assisted procreation (Consolidated Legislation currently in force)[56] ▪ Law No. 12/2009: Establishes the legal framework for quality and safety relating to the donation, collection, analysis, processing, preservation, storage, distribution and application of tissues and cells of human origin, transposing into national law (Consolidated Legislation currently in force)[57] ▪ Baia et al.[120] ▪ Silva et al.[309]	AHR techniques can also be used by all women or birthing people regardless of the diagnosis of infertility. Couples and individuals, regardless of marital status and sexual orientation, may use AHR techniques. The legal minimum limit is 18 years old. The maximum limit is, for women or birthing people, 50 years. There is no maximum limit for men or people with male reproductive organs. However, AHR treatments are only publicly-funded if they are carried out before the woman or birthing person's 40th birthday (for IVF and ICSI) or before the woman or birthing person's 42nd birthday (in the case of artificial insemination). For private treatment, AHR can be carried out until the woman or birthing person's 50th birthday and the man or person with male reproductive organ's 60th birthday. **Limit to the number of AHR treatments:** Beyond clinical reasonableness, there is no definitive limit. However, it is generally agreed that after 4 unsuccessful embryo transfers, the likelihood of further treatments resulting in pregnancy is very low. In public centres, each couple (or individual) is entitled to undergo 3 artificial inseminations and 3 cycles of IVF and or ICSI as long as the beneficiary's age limit is not exceeded. Cryopreserved embryo transfers are not included in the count of this 3-cycle limit. In the case of same-sex couples, the decision regarding the member of the couple who undergoes artificial insemination or in vitro fertilisation rests with the couple, unless there is a weighty clinical reason that does not advise the performance of the ART technique on that woman or birthing person. **Artificial Insemination:** Main indications: ▪ ovulation problems ▪ slight changes in sperm number and motility ▪ sexual dysfunctions ▪ infertility of unexplained cause of short duration (situation in which after the couple's study there is no explanation for infertility) ▪ need to resort to sperm donation due to lack of sperm production (secretory azoospermia). ▪ insemination using donated sperm is also an indication for individuals or same-sex couples. **In Vitro Fertilisation (IVF):** The use of IVF has a much broader scope than that of AI. The most frequent indications are: ▪ bilateral obstruction or absence of the fallopian tubes ▪ endometriosis ▪ failure of simpler treatments such as ovulation induction and IUI. **Intracytoplasmic Sperm Microinjection (ICSI):** ICSI has the following main indications: ▪ severe infertility in the man or person with male reproductive organs. ▪ cases of zero or very low fertilisation in a previous IVF. **Sperm, oocyte and embryo donation:** Oocytes, sperm or embryos donated by third parties may be used when, in view of the objectively available medical and scientific knowledge, it is not possible to obtain pregnancy or pregnancy without a serious genetic disease through the use of any technique that uses the gametes of the beneficiaries and provided that effective conditions are ensured to guarantee the quality of gametes. Donors may not be considered as parents of the child to be born.

	Treatment with sperm donation: A treatment with sperm donation can be justified in several situations: ▪ in situations of absence of sperm production (azoopermia) ▪ surgical removal of the testicles ▪ severe situations of poor sperm quality ▪ in treatments of same-sex couples or individuals. **Treatment with oocyte donation:** Despite the advances in reproductive medicine and fertility treatments, which solve a very significant part of infertility situations, many cases will only be solved by donation. A treatment with oocyte donation can be justified in several situations: ▪ early ovarian failure ▪ absence or congenital insufficiency of the ovaries ▪ in situations of repeated failure in fertility treatments using the woman or birthing person's own oocytes, usually due to their poor quality, or a number considered insufficient ▪ in situations of late motherhood, from the age of 38, in addition to the decrease in the number of oocytes, a large number of them may have genetic alterations, which can make a normal pregnancy unfeasible. **Treatment with embryo donation:** In situations where it is impossible to obtain a pregnancy because there is a problem with both oocytes and sperm, a double donation of these cells can be used or, alternatively, an embryo donation. The donation of embryos is only possible with the express consent of the beneficiaries holding the rights over such embryos. These are invariably the result of AHR treatments, in which viable surplus embryos are obtained which, by legal obligation, will have to be cryopreserved. In the event of non-use, and after a period that can vary between 3 and 6 years, they can be donated, as long as this option has been foreseen by the respective beneficiaries. **Pre-implantation genetic diagnosis (PGD):** The performance of PGD for monogenic diseases (PGT-M) and structural chromosomal abnormalities (PGT-SR) is only possible after the guidance and opinion of a physician specialized in Medical Genetics and the recognition of the scientific value of the techniques used for pre-implantation genetic testing for diagnosis, treatment or prevention of serious genetic diseases, as such considered by the National Council for Medically Assisted Reproduction (CNPMA). In the absence of a legal definition of serious illness, the CNPMA understands that the concept applies to illnesses that cause significant distress and or premature death. The CNPMA also outlines a list of situations for which the prior application for authorization for Pre-implantation Genetic Testing of Monogenic Diseases (PGT-M) is waived. The PGD is intended for people from families with alterations that cause early death or serious illness, when there is a high risk of transmission to their offspring. The specific medical indications for possible PGD are determined by current good practice and are included in the recommendations of national and international professional organisations in the area, and are periodically reviewed. The CNPMA decided that PGT-A does not require prior authorization as long as the technique used allows the study of all chromosomes and at least one of the following indications is verified: ▪ advanced age in the woman or birthing person (39 years or older) ▪ repeated embryo implantation failures after IVF and or ICSI (three or more transfers) ▪ recurrent clinical abortions (two or more) of unknown cause (excluding biochemical pregnancy) ▪ previous pregnancy with chromosomal number abnormality or unbalanced structural anomaly

	▪ performed an embryonic biopsy already authorized for PGT-M. **Aneuploidy screening and PGD:** 1. PGD aims to identify embryos that do not have a serious anomaly, before their transfer to the woman or birthing person's uterus, using AHR techniques. 2. The application, under the guidance of a responsible specialist doctor, of genetic screening for aneuploidies in the embryos to be transferred is permitted in order to reduce the risk of chromosomal alterations and thus increase the chances of success of ART techniques. 3. The application, under the guidance of a specialist physician in charge, of PGD techniques that have recognised scientific value for the diagnosis, treatment or prevention of serious genetic diseases, as such considered by the CNPMA, is permitted. 4. AHR centres that wish to apply PGD techniques must have or articulate with a multidisciplinary team that includes specialists in reproductive medicine, embryologists, medical geneticists, cytogeneticists and molecular geneticists. ROPA: In the Portuguese health system, a members of a same-sex couple are not allowed to undergo AHR treatment at the same time.
Sweden ▪ Act (2006:351) on Genetic Integrity, etc.[30] ▪ SOSFS 2009:32 Use of tissues and cells in healthcare and clinical research etc.,[31] and amendment[61] ▪ National Board of Health and Welfare: Assisted fertilisation with donated gametes guidelines[33] ▪ Recommendations for homogeneity in county councils' and regions' publicly funded assisted reproduction offers[35] ▪ Asplund et al.[275] ▪ Elenis et al.[283] ▪ Elenis et al.[284] ▪ Volgsten et al.[313] ▪ Irwin[116] ▪ Lind[122] ▪ Lind[112] ▪ Gunnarsson and Korolczuk[300]	**Investigation and treatment:** ▪ couples who have difficulty having children can seek help from the health care system for an investigation of involuntary infertility ▪ if opposite-sex couples have tried to have a child for a year without a pregnancy, they can receive help with investigation and treatment from the health care system. If it is known that there are medical reasons for the infertility, the couple does not need to wait a year for an investigation ▪ individuals who want a child can also seek help from the health care system. The investigation is carried out at a gynaecological clinic, a woman or birthing person's clinic at a hospital or a private fertility clinic. The investigation regarding assisted reproduction shall include an examination to assess whether, for opposite-sex couples, there is a reasonable possibility of having children naturally and, for opposite-sex, same-sex couples and individuals, whether they have the medical conditions to become pregnant**.** After the investigation, it is decided individually for each couple and or individual which treatment the healthcare system offers, and the choice of treatment depends on which causes have been found for the infertility. <u>County council-funded assisted reproduction is offered to couples without joint or adopted children and to individuals who are not previously registered guardians of a child.</u> **In the case of donation treatment, assisted fertilisation with donated gametes**: a special assessment must be made of whether it is appropriate for the treatment to take place, taking into account the medical, psychological and social conditions of the spouses, cohabitants or the individual. Treatment may only be carried out if it can be assumed that the future child will grow up under good conditions. The assessment should take into account the couple's or individuals: ▪ **Age:** The assessment should take into account the age of the couple or individual. This means at least an 18-year perspective, when applicants must function as parents at least until the child reaches adulthood (but in practice also into young adulthood). Advanced age of applicants is an example of one of the risk factors that the health and medical services have to consider in the assessment, but it is not possible to specify any specific age limit based on the research.

	▪ **Health status and any functional impairments:** Physical or mental illness or extensive functional impairment, which can mean reduced capacity and parental ability during a child's upbringing, risky use, abuse of alcohol, drugs, medicines are, according to research, examples of risk factors for children coming to harm. Other forms of abuse and dependence can also constitute risk factors. An illness that is well managed through, for example, adequate medication or treatment does not necessarily mean that parenting ability is negatively affected. Society's support efforts to compensate for any limitations that come with the illness need to be considered in the assessment. The assessment also takes into account how any assistive devices compensate for any functional impairment, as well as what help and support the person receives. The applicant needs to be able to have close and continuous physical and psychological contact with the child and be able to provide for the child's needs for care and safety. ▪ **Living conditions:** If previous children have been exposed to a lack of care or have been taken into care, if there are serious deficiencies in the ability to provide for themselves and or the housing situation, as well as if there is serious crime, these are risk factors for children to come to harm. ▪ **Attitude towards telling the child about its biological origin:** The reason why this aspect is included as one of the factors in the general advice is that the legislation gives donor-conceived people the right to know their genetic origin and to receive information about the donor. A donor-conceived person in Sweden who has reached sufficient maturity has the right to access information about the donor in the healthcare system. ▪ **Previously neglected or children taken into care by society:** Known deficiencies in parental ability, such as previous children of the applicant having been neglected or exposed and or taken into care by society, are an obvious risk that a new child will be at risk of exposure. ▪ **Serious crime:** Crime such as violent crimes, assaults, and crimes that indicate impulsiveness, poor judgment, lack of empathy and lack of respect for integrity, or other serious crimes, pose a clear risk of lack of parental capacity, of children being exposed to neglect, violence or abuse, or of witnessing violence in the family. ▪ **Relational aspects:** Signs of violence, control or other difficult problems in close relationships, uncertainty about the relationship and if the request for donation treatment is not well thought out are risk factors for children being harmed. ▪ **Uncertainty about relationship:** An important prerequisite for someone to undergo donation treatment as an individual is that the person is neither married, has a registered partner or cohabitant. There may be reasons why a person living in a relationship chooses to seek donation treatment as a single person, for example if there is conflicts in the relationship (for example, about parenthood), or whether there are risk factors in the partner or in the relationship that could result in a negative decision if they came to the attention of the healthcare provider. If such a relationship is suspected, the investigation may need to be further investigated in this regard. If a single applicant has recently separated, there may be reasons to go into more depth in the investigation into what this means for the decision about donation treatment and parenthood. A prerequisite for couples applying for donation treatment is that the relationship is stable and lasting. ▪ **Request for donation treatment not well thought out:** Couples undergoing donation treatment must be able to handle the fact that one of the parents will have no genetic connection to the potential child. The person must also be able to handle the fact that the child may have a genetic connection to another family, where there may also be genetic half-siblings. A single parent needs to have thought through how to address the child's questions about why they only have one parent. If the applicant has not decided what this means or is ambivalent, given these circumstances, the desire to undergo donation treatment does not appear to have been sufficiently processed and thought out. ▪ **Social networks:** A well-functioning social network is an important aspect of the life situation and thus the social conditions in the investigation for both couples and individuals. Lack of a well-functioning social network and thus lack of opportunity for sufficient support and relief are examples of a risk factor to take into account.

	▪ **Assessment of the applicant's insight and attitude:** A person who becomes a parent through donation and who thus lacks a genetic connection to the potential child must be able to deal with this fact. The applicant must also be able to deal with the fact that the child has a different genetic origin with a genetic connection to other people. If the applicant has not taken a position on what this means or is ambivalent about these circumstances, there is a risk that a potential child will not receive knowledge of his or her origin from his or her parent. In examining the psychological and social well-being of the couple or the individual, a professional with behavioural science expertise should participate. In this investigation, conversations should be held with the individual, with the couple together and with each spouse, cohabitant or registered partner separately. In the psychological and social part of the special assessment, it may sometimes be necessary, especially in cases of doubt, to have several conversations with each applicant. **Registry information:** To support the special assessment, information may need to be obtained from various registers or other healthcare institutions. This requires consent from the applicant for the information to be released, and certain information can only be requested by the applicant themselves. The purpose of obtaining information from registers is to ensure that existing information about some of the most serious risk factors for children being harmed is not missed, such as convictions for violent crimes or abuse or documentation of previous serious shortcomings in parenting. Information can be obtained either on indication or routinely. **Medical assessment**: What is usually included in the basis for the medical assessment in connection with donation treatment is the following: ▪ medical history for applicants (both partners in pairs) including medical history (somatic and mental), medication, surgeries, sick leave, vaccinations, hereditary factors, previous pregnancies and births ▪ health declarations ▪ weighing and measuring ▪ infection samples. If necessary, additional measures are sometimes taken, such as: ▪ chromosome cultivation ▪ consultation with the patient's treating physician ▪ ordering medical records and reports ▪ genetic counselling. Other elements may also be included. The purpose of the medical assessment is, among other things, to ensure that the treatment or pregnancy does not endanger the health of the potential child and the person who will carry it. Insemination: If the woman or birthing person is married or in a cohabiting relationship, insemination may only be performed if the spouse or cohabiting partner has consented to it in writing. **Special conditions for treatment with a donated fertilised egg:** An egg that has been fertilised for insertion into a woman or birthing person's body may be inserted into the body of another woman or birthing person only if: 1. the first woman or birthing person treated, and, if married or cohabiting, also their spouse or cohabiting partner, has consented to it in writing, 2. the first woman or birthing person treated, and, if married or cohabiting, also their spouse or cohabiting partner, is the parent of at least one child, and

	3. it is the first woman or birthing persons own egg that has been fertilised or, if married or cohabiting, the egg has been fertilised with sperm from their spouse or cohabiting partner. During the same menstrual cycle, a woman or birthing person may not be inseminated with sperm from more than one donor. Eggs from more than one woman or birthing person may not be placed at the same time into another woman or birthing person's body after fertilisation outside the body. After fertilisation outside a woman or birthing person's body, as a rule, only one fertilised egg may be introduced into the woman or birthing person's body. If the risk of twin pregnancy is assessed as low, two fertilised eggs may be introduced. The couple should be informed about the risks that a twin pregnancy may pose and be offered a conversation with a paediatrician. Assisted fertilisation in cases of HIV, HTLV I/II, hepatitis B/C and syphilis is carried out in accordance with SOSFS 2009:32. The Swedish National Board of Health and Welfare's regulations and general advice on the use of tissues and cells in healthcare and clinical research. **Upper age limits:** ▪ AHR should be started before the woman or birthing person's 40th birthday, any remaining frozen embryos can be transferred until the treated woman or birthing person's 45th birthday. **Lower age limits:** The regional counties believe that the lower age limit for applying for assisted reproduction should be on par with the age limit that applies for applications for adoption, as in 25 years. **Current family constellation:** 'The recommendation states that county council-funded assisted reproduction should be offered to couples without joint or adopted children or to individuals who are not registered guardians of any children. If the family constellation changes, a new assessment is made based on the new situation. As an alternative, it has been discussed that the number of attempts should be personal. SKL believes that this is not a suitable alternative for several reasons. First, that it would disadvantage both the woman or birthing person and a new partner. Another reason against such a solution is that with today's record management, it is not possible for the county councils to follow up on whether individuals in a different family constellation have undergone assisted reproduction. Even if this were to become technically feasible in the future, the option to block their record information will in all likelihood remain, which means that healthcare will also not be able to check the individuals' information in the future.' **Conditions for Pre-implantation Genetic Diagnosis (PGD):** Pre-implantation genetic diagnosis may only be used if the man or person with male reproductive organs or the woman or birthing person carries a predisposition for a serious monogenic or chromosomal hereditary disease, which entails a high risk of having a child with a genetic disease or injury. The treatment must not be used to select a trait but must only be aimed at ensuring that the child does not inherit a predisposition for the disease or injury in question. Pre-implantation genetic diagnosis may not be used without permission from the National Board of Health and Welfare to try to have a child with such a gene set that the child could become a donor of blood stem cells for a seriously ill sibling. Permission may only be granted if there are exceptional reasons to allow use.
UK ▪ National Institute for Health and Care Excellence (CG156)	**The National Institute for Health and Care Excellence (NICE) Guidelines recommends:**

Fertility problems: assessment and treatment[69] ▪ Human Fertilisation and Embryology Authority[70] ▪ Fertility Network UK[71]	**Intrauterine insemination:** consider unstimulated intrauterine insemination as a treatment option in the following groups as an alternative to vaginal sexual intercourse: ▪ people who are unable to, or would find it very difficult to, have vaginal intercourse because of a clinically diagnosed physical disability or psychosexual problem who are using partner or donor sperm ▪ people in same-sex relationships ▪ for people in recommendation above who have not conceived after 6 cycles of donor or partner insemination, despite evidence of normal ovulation, tubal patency and semen analysis, offer a further 6 cycles of unstimulated intrauterine insemination before IVF is considered. **Indications for donor insemination (DI):** the use of donor insemination is considered effective in managing fertility problems associated with the following conditions: ▪ obstructive azoospermia ▪ non-obstructive azoospermia ▪ severe deficits in semen quality in couples who do not wish to undergo intracytoplasmic sperm injection (ICSI). Donor insemination should also be considered in conditions such as: ▪ where there is a high risk of transmitting a genetic disorder to the offspring ▪ where there is a high risk of transmitting infectious disease to the offspring or woman or birthing person from the man or person with male reproductive organs ▪ severe rhesus isoimmunisation. **Assessments to offer the woman or birthing person**: ▪ before starting treatment by DI, it is important to confirm that the woman or birthing person is ovulating ▪ women or birthing people with a history that is suggestive of tubal damage should be offered tubal assessment before treatment ▪ women or birthing people with no risk factors in their history should be offered tubal assessment after 3 cycles of treatment by DI ▪ women or birthing people who are ovulating regularly should be offered a minimum of 6 cycles of DI without ovarian stimulation to reduce the risk of multiple pregnancy and its consequences. **Eligibility criteria for IVF and or ICSI:** **Women or birthing people aged < 40:** ▪ who have not conceived after 2 years of regular unprotected intercourse or 12 cycles of artificial insemination (where 6 or more are by IUI), offer 3 full cycles of IVF, with or without ICSI ▪ if the woman or birthing person reaches the age of 40 during treatment, complete the current full cycle but do not offer further full cycles ▪ any previous full IVF cycle, whether self- or NHS funded, should count towards the total of 3 full cycles that should be offered by the NHS. **Women or birthing people aged 40 to 42 years:** ▪ who have not conceived after 2 years of regular unprotected intercourse or 12 cycles of artificial insemination (where 6 or more are by IUI), offer 1 full cycle of IVF, with or without ICSI, provided the following 3 criteria are fulfilled: ○ they have never previously had IVF treatment ○ there is no evidence of low ovarian reserve

	○ there has been a discussion of the additional implications of IVF and pregnancy at this age. **Woman or birthing person's BMI:** should ideally be in the range 19 to 30 before commencing AHR. **Indications for oocyte donation:** The use of donor oocytes is considered effective in managing fertility problems associated with the following conditions: ▪ premature ovarian failure ▪ gonadal dysgenesis, including Turner syndrome ▪ bilateral oophorectomy ▪ ovarian failure following chemotherapy or radiotherapy ▪ certain cases of IVF treatment failure. Oocyte donation should also be considered in certain cases where there is a high risk of transmitting a genetic disorder to the offspring. **Donor conception eligibility (HFEA):** a clinic is likely to recommend donor conception if: ▪ someone is not producing eggs or sperm of their own ▪ someone's own sperm or eggs are unlikely to result in a pregnancy ▪ there is a high risk of passing on an inherited disease ▪ it is a same-sex couple, or ▪ it is an individual.
England Integrated Care Board (ICB) polices by National Health Service (NHS) Region and Integrated Care System: 1. East of England Region ▪ NHS Cambridgeshire & Peterborough: Assisted Conception[73] 2. London Region ▪ North East London: Fertility Policy[74] 3. Midlands Region ▪ NHS Staffordshire and Stoke on Trent ICB Commissioning Policy Assisted Conception for Infertility[75] 4. North East and Yorkshire Region ▪ Yorkshire and Humber Access to Infertility Treatment Commissioning Policy Document[76]	In Cambridgeshire and Peterborough ICB the following applies: **Intrauterine insemination (IUI) (Unstimulated):** Due to poor clinical evidence, IUI will only be offered under exceptional circumstances. A maximum of 3 cycles of IUI will only be offered if prior approval for funding is obtained from the CCG. **Couples will be eligible to receive IVF/ICSI where they meet the specified referral criteria:** ▪ women or birthing people aged 23 to less than 43 years at the start of treatment. For women or birthing people >40 years, there must be a discussion of the additional implications of IVF and pregnancy at this stage ▪ paternal age is 23 years up to and including 55 years of age ▪ number of cycles is one full or abandoned cycle. There should be shared decision making between patients and providers to agree the funding for this cycle. If the choice is made to count the abandoned cycle as NHS-funded, no further cycles will be NHS funded. ▪ NHS funding is not available (whether self-funded or NHS funded) if couples have received 3 or more cycles and the woman is <40 years. If the woman or birthing person is >40 and they have received 1 cycle then NHS funding is not available ▪ couples are ineligible if previous sterilisation has taken place (either partner), even if it has been reversed ▪ women or birthing people must have a BMI of between 19 and 30 and the man or person with male reproductive organs in the couple (where appropriate) must have a BMI of less than 35. Patients outside of this range will not be added to the waiting list and should be referred back to their referring clinician and or general practitioner for weight management advice and support if required. In same-sex couples, BMI criteria should only apply to the partner undergoing fertility treatment ▪ couples who smoke will not be eligible for NHS-funded specialist assisted reproduction assessment or treatment and should be informed of this criterion at the earliest possible opportunity. They should be provided with information about the impact of smoking on their ability to conceive naturally, the adverse health impacts of passive smoking on any children and smoking cessation support should be provided as necessary.

5. North West Region ▪ NHS Lancashire and South Cumbria ICB Policy for Assisted Conception Services[77] 6. South East Region ▪ Schedule of policy statements for ART for Kent and Medway ICB[78] 7. South West Region ▪ NHS Devon Assisted Conception Commissioning Policy[79]	▪ both partners must be non-smoking at the time of referral from secondary care to specialist IVF services and maintained during treatment. This applies equally for same-sex couples as passive smoking may affect the fertility of the partner undergoing fertility treatment. Smoking status should be ascertained by carbon monoxide testing in secondary care and specialist IVF services. ▪ couples are ineligible for treatment if there are any living children from the current or any previous relationships, regardless of whether the child resides with them. This includes any adopted child within their current or previous relationships. ▪ providers must meet the statutory requirements to ensure the welfare of the child. This includes HFEA's Code of Practice which considers the 'welfare of the child which may be born' and takes into account the importance of a stable and supportive environment for children as well as the pre-existing health status of the parents. ▪ both partners must be registered with a GP Practice within the CCG and be eligible for NHS care for at least 12 months prior to referral from primary care to secondary care. ▪ to be eligible, the patient should have an Anti-Mullerian Hormone level of more than 5.4pmol/l or Antral Follicle Count of ≥ 4 measured in the last 3 months of referral from secondary care to the specialist IVF provider. If both tests are done, both criteria must be met. Treatment may be denied on other medical grounds not explicitly covered in this document. **Same-sex couples:** Same-sex couples are entitled to treatment on the NHS following at least 12 cycles of unsuccessful artificial insemination over 3 years (this is self-funded or 3 IUI may be NHS-funded if they have gained Exceptional Case Panel approval). However, BMI eligibility criteria only apply to the woman or birthing person undergoing fertility treatment. As for opposite-sex couples, couples with a diagnosed cause of absolute infertility will have immediate access to services. Donor semen is used for same-sex couples as part of IVF and or ICSI treatment. **Egg donation:** Available to women or birthing people who have undergone premature ovarian insufficiency (amenorrhoea >6 months and a raised FSH >25 on 2 occasions >1 month apart) due to an identifiable pathological or iatrogenic cause before the age of 40 years or to avoid transmission of inherited disorders to a child where the couple meet the other eligibility criteria. The patient may be able to provide an egg donor; alternatively, the patient can be placed on the waiting list, until an altruistic donor becomes available. If either of the couple exceeds the age criteria prior to a donor egg becoming available, they will no longer be eligible for treatment. **Treatments excluded from this policy:** ▪ Pre-implantation Genetic Diagnosis and associated IVF/ICSI. This service is commissioned by NHS England. ▪ A maximum of 3 transfers of embryos (one fresh, plus two frozen). **Number of embryos per transfer:** Embryo transfers should be as per HFEA guidance and generally this would be: ▪ Women or birthing people aged 23 to 39 years – ONE embryo may be transferred per procedure. ▪ Women or birthing people aged between 40 to less than 43 years – TWO embryos may be considered for transfer per procedure. In Devon ICB the following applies: **Intrauterine insemination (unstimulated):** IUI will only be funded under the circumstances below. Consider up to 12 cycles of unstimulated IUI as a treatment option in the following groups as an alternative to vaginal sexual intercourse: ▪ people who are unable to, or would find it very difficult to, have vaginal intercourse because of a clinically diagnosed physical disability or psychosexual problem who are using partner **or donor sperm**

	▪ people with conditions that require specific consideration in relation to methods of conception (for example, after sperm washing where the man or person with male reproductive organs is HIV positive) ▪ people in same-sex couples who have not conceived after six cycles of **privately funded donor or partner insemination**, despite evidence of normal ovulation, tubal patency and semen analysis, the NHS will offer six cycles of unstimulated intrauterine insemination procedures before IVF is considered. ▪ people with unexplained infertility, mild endometriosis or 'mild male factor infertility', who are having regular unprotected sexual intercourse: ○ do not routinely offer intrauterine insemination, either with or without ovarian stimulation (exceptional circumstances include, for example, when people have social, cultural or religious objections to IVF ○ advise them to try to conceive for a total of two years (this can include up to one year before their fertility investigations) before IVF will be considered. **Donor insemination is** funded for: ▪ azoospermia ▪ severe deficits in semen quality in couples who do not wish to undergo ICSI ▪ where there is a high risk of transmitting a genetic disorder to the offspring ▪ where there is a high risk of transmitting infectious disease to the offspring or woman or birthing person from the man or person with male reproductive organs, and ▪ severe rhesus isoimmunisation. ▪ Also following IVF egg retrieval when no living sperm produced on day of treatment. **The tariff covers transport of sperm; and storage for the NHS-funded cycle only**. ○ donor sperm required for a clinical indication may be used for: ○ 1 cycle of IVF or ○ unstimulated IUI followed by 1 cycle of IVF, if IUI is unsuccessful. There will be no requirement for a couple to undergo a specified number of cycles of unstimulated IUI before receiving IVF. Up to 6 cycles of unstimulated IUI may be offered dependent on the availability of donor sperm, or ○ 3 cycles of stimulated IUI followed by 1 cycle of IVF, if IUI is unsuccessful. ▪ before starting treatment by donor insemination it is important to confirm that the woman or birthing person is ovulating. Women or birthing people with a history that is suggestive of tubal damage should be offered tubal assessment before treatment. If the woman or birthing person is **aged under 40**, they should be offered one cycle of IVF if: ▪ they have been trying to get pregnant through regular unprotected sexual intercourse for a total of two years or ▪ they are using artificial insemination to conceive and have not become pregnant after 12 cycles – at least 6 of these cycles should have been using IUI ▪ they **require donor sperm** for a clinical indication. However, if tests show that there appears to be no chance of the woman or birthing person conceiving naturally, and that IVF is the only treatment that is likely to help, they should be referred straightaway for IVF. No woman or birthing person may receive an NHS-funded IVF cycle if they have previously received a total of three cycles, whether self- or NHS-funded. The woman or birthing person's doctor should also take into account how they have responded to any previous IVF treatment and what the outcome was when deciding how effective and safe further IVF would be for that individual. If a woman or birthing person turns 40 during a cycle of IVF,

	they can finish the current cycle. They will still be able to have up to one frozen embryo transfer episode from their most recent episode of ovarian stimulation since this counts as part of the same cycle. A 'cycle' of IVF is defined in this policy as one fresh and one frozen implantation of embryos. A frozen embryo transfer episode will only be available if there are embryos generated from the fresh cycle suitable for freezing. **Eligibility criteria:** ▪ BMI: women or birthing people must have a BMI of more than 19 and less than 30; Men or people with male reproductive organs must have a BMI of less than 30. ▪ smoking: both partners should be objectively confirmed non-smokers. ▪ welfare of the child: in order to take into account the welfare of the child, the clinician should consider factors which are likely to cause serious physical, psychological or medical harm, either to the child to be born or to any existing children of the family ▪ previous children: ○ there should be no living children from the current relationship, and ○ at least one partner must have no living children from previous relationships ○ this includes biological and legally adopted children and offspring who are adults. ▪ relationship: the stability of the relationship is very important for the welfare of children; couples must be in a stable relationship for at least two years to be entitled to receive NHS-funded assisted reproduction techniques ▪ previous assisted conception: the couple has not previously received NHS funded assisted reproduction techniques. This applies unless failure of NHS-funded IUI is required to access IVF. The use of egg donation is funded for: ▪ premature ovarian failure ▪ gonadal dysgenesis including Turner Syndrome ▪ bilateral oophorectomy ▪ ovarian failure following chemotherapy or radiotherapy, and ▪ where there is a high risk of transmitting a genetic disorder to the offspring. <u>In Kent and Medway ICB the following applies:</u> Patients need to fulfil the eligibility criteria to access **NHS-funded IUI using donor sperm**: ▪ Up to 6 cycles of unstimulated IUI using donor sperm is funded for eligible couples or individuals where there is evidence of normal ovulation and tubal patency and one of the following: ○ obstructive or non-obstructive azoospermia ○ severe deficits in semen quality in couples who do not wish to undergo ICSI ○ a high risk of transmitting a genetic disorder or infectious disease to the child and or partner ○ severe rhesus isoimmunisation ○ individuals, same-sex couples, and other couples trying to conceive through donor insemination who have not conceived after 6 cycles of artificial insemination (AI). NHS funded assisted conception treatment should not be undertaken concurrently in both partners of a couple, or in one partner where the other is pregnant. IVF using donor sperm will be funded for the above groups, where investigations show IVF is the only effective treatment option or patients have undergone 12 unsuccessful cycles of AI, where 6 or more are by IUI.

	▪ funding is only available where the woman or birthing person receiving fertility treatment is aged **under 40 years**. Women or birthing people must start medication with the ART provider before their 40th birthday; women or birthing people must only be referred to fertility clinics if there is adequate time to complete work up ▪ if the woman or birthing person reaches the age of 40 during treatment, the current full IVF cycle may be completed but no further fresh cycles will be available. A full cycle of IVF treatment is defined as one episode of ovarian stimulation and the transfer of resultant fresh and frozen embryo(s). ▪ women or birthing people receiving fertility treatment must have a **BMI between 19-30**. The **partner** providing sperm for treatment must have a BMI of below **30** ▪ treatment will not be funded if the woman or birthing person **undergoing treatment smokes tobacco** ▪ treatment will not be funded if the partner providing sperm for treatment smokes tobacco. People who use e-cigarettes will not be excluded from accessing NHS funded ART on that basis. ▪ **couples:** neither partner in a couple should have a living child from their relationship or any previous relationship. In addition, a partner in a couple will not be eligible for treatment if their partner is pregnant or attempting to become pregnant through NHS funded ART ▪ **single persons: individuals should not have a living child**. An adopted child is considered to have the same status as a biological child ▪ neither partner in a couple or an individual should have undergone sterilisation, even if reversal was attempted unsuccessfully. ▪ women or birthing people receiving fertility treatment should have an AMH level of more than 5.4 pmol/l Patients need to fulfil the eligibility criteria outlined to access **NHS funded IVF using donor eggs**. Patients undergoing IVF using donor eggs **do not** need to meet the ovarian reserve criterion outlined in fertility preservation. ▪ IVF using donor eggs will be funded for eligible patients who have one of the following: ○ premature ovarian insufficiency ○ gonadal dysgenesis including Turner syndrome (pre-treatment screening should have excluded phenotypic manifestations of Turner syndrome that might jeopardise successful pregnancy, including aortic dilation and cardiac lesions) ○ undergone bilateral oophorectomy ○ ovarian failure following chemotherapy or radiotherapy ○ a high risk of transmitting a genetic disorder to the offspring. Patients may be able to provide an egg donor, alternatively the patient can be placed on a waiting list until an altruistic donor becomes available. If during their time on the waiting list the couple no longer fulfil the eligibility criteria, funding will not be available. <u>In Lancashire and South Cumbria ICB the following applies:</u> Donor gametes: ▪ the scope of this policy is limited to the commissioning of tertiary fertility services and includes IUI, ICSI and IVF. This may also include the provision of donor sperm and donor eggs and the storage of gametes and embryos. ▪ specific patient subgroups (in line with NICE guidelines): ○ women or birthing people in same-sex relationships who have unexplained infertility after donor insemination ○ individuals who have unexplained infertility after donor insemination.

	Sperm and Egg Donation: will be funded if: ○ it is required as part of an approved treatment unit and ○ the **eligibility criteria** are fulfilled and ○ the patient, or for couples one of the partners, is able to make a contribution to the **child's genome**. Assisted conception to create an **embryo** entirely from third party gametes will **not be funded.** <u>The eligibility criteria for accessing AHR includes:</u> ▪ the patient, and their partner in the case of couples, must not have a living biological or adopted child from their current or any previous relationship ▪ neither partner has previously had a treatment unit or part of a treatment unit of assisted conception irrespective of the source of funding of that treatment unit, unless it can be clearly demonstrated that: ○ the unit of treatment was undertaken to demonstrate the presence of clinical infertility. ○ the unit of treatment was in a different relationship. AND EITHER ○ the cause of the infertility was attributable predominantly to the other partner in that relationship. OR The treatment was not related to clinical infertility. ▪ the woman or birthing person receiving treatment is between 18 years and 42 years of age. Treatment must commence before the woman or birthing person's 43rd birthday. ▪ additionally, if the **funding package includes harvesting of eggs from a donor**, then the donor has not yet reached the age of 40 years and has no evidence of infertility ▪ neither partner has been previously sterilised ▪ the woman or birthing person seeking to become pregnant has a body mass index between 19 and 30 ▪ the woman or birthing person receiving treatment is a non-smoker and commits to remain so throughout the treatment and until the completion of any resulting pregnancy. For the purposes of this policy the use of an e-cigarette is considered equivalent to non-smoking status. the other partner (when applicable) is a non-smoker and commits to remain so throughout the treatment unit ▪ if the woman or birthing person receiving treatment is aged 40-42, a treatment unit will be offered provided the following two additional criteria are fulfilled (in line with NICE guidelines): ○ there is no evidence of low ovarian reserve ○ there has been a discussion of the additional implications of pregnancy and IVF at this age. <u>In North East London ICB the following applies:</u> **Intrauterine insemination (IUI) and IVF using donor sperm:** Up to 6 cycles of unstimulated IUI using donor sperm is funded for eligible patients where there is evidence of normal ovulation and tubal patency and either: ▪ obstructive or non-obstructive azoospermia ▪ severe deficits in semen quality in couples who do not wish to undergo ICSI ▪ a high risk of transmitting a genetic or infectious disorder to the child and or partner ▪ severe rhesus isoimmunisation ▪ individuals, or couples trying to conceive using donor insemination who have not conceived after 6 self-funded IUI cycles. <u>The eligibility criteria for accessing AHR includes:</u> ▪ the woman or birthing person trying to get pregnant who are aged < 43 years ▪ the woman or birthing person trying to get pregnant must have a BMI of between 19 and 30 at the time treatment begins

	▪ the woman or birthing person or individual trying to get pregnant must be a non-smoker and continue to be a non-smoker throughout treatment. The partner providing sperm for assisted conception treatment must be a non-smoker ▪ AHR treatment will not be offered to couples who have a child together or people who are trying to have a baby on their own who already have a child. ▪ AHR treatment will be offered to eligible couples where neither partner has a child, or where one of the partners has a child from a previous relationship, but the other does not ▪ couples: neither partner in a couple should have undergone sterilisation. People who are trying to have a baby on their own: should not have undergone sterilisation. The above still applies if sterilisation reversal has unsuccessfully been attempted. ▪ ovarian reserve is considered low where: ○ antral follicle count is less than or equal to 4 ○ anti-Müllerian hormone is less than or equal to 5.4 pmol/l ○ follicle-stimulating hormone is greater than 8.9 IU/l If two or three of the above measures show low ovarian reserve, AHR will not be offered. If one of the above measures show low ovarian reserve, treatment may be offered if appropriate. Where appropriate, IVF using donor sperm will be funded for the above groups. ICB will fund the cost of the IUI and or IVF, but the donor sperm will need to be sourced and paid for by the patient. **Provision of IVF:** patients need to fulfil the eligibility criteria outlined in sections above. For the purposes of this policy, a full IVF cycle is defined as one episode of ovarian stimulation and the transfer of any resultant fresh and frozen embryo(s). The cycle may be with or without intracytoplasmic sperm injection (ICSI). All frozen embryos should be transferred before starting the next NHS funded fresh IVF cycle. Embryo transfer strategies outlined in NICE CG156 should be followed to minimise the number of multiple births. Storage of cryopreserved supernumerary embryos will be funded for a maximum of two years following each fresh cycle. Natural cycle IVF is not routinely funded. **For >40 years:** For eligible patients requiring IVF where the woman or birthing person is aged under 40, NEL ICB will fund up to three full IVF cycles. If the patient reaches the age of 40 during treatment, the current full cycle will be completed but no further full cycles will be available. Treatment will not be funded for patients aged under 40 years old who have previously had three fresh cycles of IVF, including privately funded cycles. This means if a patient has had one previous fresh IVF cycle, up to two NHS funded full IVF cycles will be funded. If a patient has had two previous fresh IVF cycles, one NHS funded full IVF cycle will be funded. **Between 40 – 42 years:** For eligible patients requiring IVF where the woman or birthing person is aged 40–42, NEL ICB will fund one full IVF cycle. Treatment will not be funded for patients aged 40–42 years old who have previously had any IVF treatment, including privately funded cycles. Before starting treatment, patients aged 40–42 years old should be made aware of the additional implications of IVF and pregnancy at this age. **Abandoned cycle:** One abandoned cycle (defined as a cycle where an egg collection procedure has not been undertaken) does not count towards the number of cycles funded. However, further cycles will not be started if the treating doctor thinks it would be clinically inappropriate. **IVF using donor eggs:** will be funded for eligible patients who have: ▪ premature ovarian failure

	▪ gonadal dysgenesis including Turner syndrome ▪ undergone bilateral oophorectomy ▪ a high risk of transmitting a genetic disorder to the offspring. The ICB will fund the cost of the IVF, but the donor eggs will need to be sourced and paid for by the patient. There are significant practical and logistical issues relating to NHS-funding of donor sperm and eggs. The ICB intends to fund donor sperm and eggs for use in NHS funded AHR treatments in the future once arrangements have been put in place to resolve these issues. In Staffordshire and Stoke-on-Trent the following applies: **Eligibility Criteria for infertility service:** ▪ **Woman or birthing person's age:** Any treatment cycle will not be commenced if the patient is less than 23 years of age but a referral into tertiary care must be made before the woman or birthing person reaches her 39th birthday. Women or birthing people aged 35 – 39 years will be offered treatment provided their predicted ovarian reserve is found to be satisfactory, since this provides useful information regarding likely response to treatment**.** Although there is continuing debate around the most effective test, AMH is the test of choice for many providers since it has been found to be reliable and can be performed at any stage of the cycle. An AMH >3 will be required for all women or birthing people 35 years or over for access to IVF treatment. ○ > 39 years old at the point of entering tertiary care may be referred for tests and or investigations in secondary care but should be advised that it is unlikely they will be eligible for NHS funded IVF and or ICSI in tertiary care due to the time required for any secondary care tests and or treatments. ○ It is the responsibility of service providers to ensure that couples meeting the eligibility criteria have been referred into tertiary care for their IVF ICSI treatment before the 39th birthday of the woman or birthing person undergoing treatment. If the patient does not undergo their treatment within the 6 months following their 39th birthday they will no longer be eligible for NHS funding. ▪ **BMI:** The woman or birthing person should have a BMI between 19 and 30 (measured in a clinical setting) at the time of commencing treatment within tertiary care. Those who are overweight or underweight will be offered referral to dieticians and or lifestyle interventions in order to improve their BMI. Those with a BMI of less than 19 and greater than 30 will not be funded. ▪ **Men or people with male reproductive organ's age:** There is no upper age limit for the man or person with male reproductive organs, in the couple (where appropriate) as there is limited evidence to suggest sperm quality deteriorates with age. ▪ **Infertility:** Couples who have an identified medical cause for their fertility problems OR have unexplained infertility of at least 1 year duration. Infertility is defined as the failure of a woman or birthing person of reproductive age to conceive after 1 year of regular unprotected vaginal intercourse, in the absence of any known medical cause of infertility. The above definition cannot be applied in: ○ same-sex couples ○ those unable to have vaginal intercourse due to a clinically diagnosed physical disability. Infertility may be demonstrated by the failure to conceive after 6 cycles of self-funded donor insemination IUI during the previous 12 months, undertaken at a Human Fertilisation and Embryology Authority (HFEA) licensed clinic, in the absence of any known reproductive pathology. ▪ **Same-sex male couples:** will not be able to access fertility treatment within their relationship but may be eligible for some assistance if there are medical infertility issues in both partners and both partners fit the above criteria for funding. These cases will be considered via the Individual Funding Request process on the basis of exceptionality.

	▪ **Couples who previously paid for fertility treatment privately** can receive 1 NHS-funded cycle if they haven't had more than 2 complete private cycles. Once a partner completes NHS-funded fertility treatment (regardless of outcome), they've used their NHS entitlement and cannot receive additional NHS-funded cycles with their current or any future partners. ○ This is not applicable where same–sex couples or couples with a physical disability have self-funded **donor insemination/IUI** for the purpose of demonstrating infertility in line with above. ▪ Couples are ineligible if previous sterilisation has taken place in either partner, even if it has been reversed. ▪ Couples should be in a stable relationship of at least two years duration and should be married, or cohabiting, with each other. Couples should also be seen together within primary, secondary and tertiary services as fertility treatment concerns both partners. ▪ Couples must not have a living child from their current or any previous relationships, regardless of whether the child resides with them. This includes any adopted child within their current or previous relationship. Once accepted for treatment, should a child be adopted or a pregnancy leads to a live birth the couple will no longer be eligible for treatment. Foster children are **not included** within this criterion. ▪ Where couples smoke, only those who agree to take part in a supportive programme of smoking cessation will be accepted on any assisted conception or IVF waiting list and should be non-smoking for at least 28 days at the time of commencing investigations within secondary care. ▪ Consideration should be given to any alcohol or substance misuse by the couple. The above are a requirement of the HFEA and the following HFEA guidance should be used when making these decisions. The ICB will **not routinely fund donor sperm** but will fund the associated IVF and or ICSI treatment in line with the eligibility criteria within this policy providing the sperm meet the criteria set out by the treating provider unit. Patients wishing to access donor sperm treatments must make their own arrangements but are advised to check with the treating provider unit to ensure HFEA guidelines before accessing donated sperm. **Donor Eggs:** Oocyte donation may be commissioned as part of a cycle in cases where it is clinically appropriate: ▪ premature ovarian failure ▪ gonadal dysgenesis including Turner Syndrome ▪ bilateral oophorectomy Ovarian failure following chemotherapy or radiotherapy NHS-funding would not normally be available for women or birthing people outside these groups who do not respond to follicular stimulation. Oocyte donations will be sourced by the provider. <u>In Yorkshire and Humber ICBs the following applies:</u> **Eligibility Criteria at the point of referral to, and throughout, specialist care:** ▪ women or birthing people aged between 40–42 will need further assessment within specialist care to ascertain whether they are eligible ▪ neither partner should have any living children (this includes adopted children but not fostered) from their relationship together or any previous relationship ▪ women or birthing people intending to become pregnant must be between the ages of 18 – 42 years. Referrers should be mindful of the woman or birthing person's age at the point of referral and the age limit for new cycles. **Pre-Referral Requirements for Specialist Care**

	▪ The woman or birthing person receiving treatment's **BMI should be between 19 and 30** prior to referral to specialist services and throughout treatment. In the case of same-sex couples, the BMI range applies to the patient(s) intending to undergo fertility procedures. Patients with a higher BMI should be referred for healthy lifestyle interventions including weight management advice. Patients should not be re-referred to specialist services until their BMI is within the recommended range. ▪ GP should discuss smoking with couples prior to referral to secondary care and support their efforts to stop by referring to a **smoking cessation programme**. Smoking adversely affects the success rate of the treatment and the pregnancy outcome. Couples must be **non-smoking for 28 days** to access any fertility treatment and must continue to be non-smoking throughout treatment. Currently there is limited and uncertain evidence around the safety of vaping and nicotine products, but sole use of e-cigarettes, without the concurrent use of tobacco, is classified as non-smoking for the purposes of this policy. If it is suspected that patients continue to smoke then carbon monoxide testing may be considered. ▪ Couples must give assurances that **their alcohol intake** is within current Department of Health guidelines and that they are not currently using recreational drugs. ▪ The ICB will not fund IVF treatment for patients who have been sterilised, including those who have undergone reversal of sterilisation. ▪ The chance of pregnancy decreases with successive cycles so all previous self-funded or NHS funded cycles will be taken into consideration when assessing a couple's ability to benefit from treatment and will count towards the total number of cycles that may be 15 offered by the NHS. This includes where either person has had a previous cycle with a previous partner. ▪ Couples must have been co-habiting in a stable relationship for a minimum of 2 years at the same address. ▪ Welfare of the Child HFEA guidance concerning the welfare of the child should be followed. **Intrauterine insemination (IUI) and donor insemination (DI):** IUI and DI are separate from IVF treatment; however, the couple may then access IVF treatment if appropriate. ▪ People who are unable to, or would find it very difficult to, have vaginal intercourse because of a clinically diagnosed physical disability or psychosexual problem or people in same-sex couples or other specific conditions with infertility who are using partner or donor sperm (as per the definition of infertility): up to 6 cycles of IUI may be funded where clinically appropriate, followed by further AHR if required. In some circumstances, IUI may be impractical or not desired and so is not a requirement to access further fertility treatment. IUI will not be funded as a treatment after IVF treatment. ▪ Couples with unexplained infertility, who are having regular unprotected sexual intercourse: IUI either with or without ovarian stimulation will not be funded routinely (exceptional circumstances may include, for example, when people have social, cultural or religious objections to IVF), instead couples should try to conceive for a total of 2 years (this can include up to 1 year before their fertility investigations) before IVF will be considered, in keeping with current NICE guidance. ▪ Women or birthing people with anovulatory infertility: ovulation induction with gonadotrophin therapy may be funded for up to 6 cycles, followed by further assisted conception if required. In some circumstances, IUI may be impractical or not desired and so is not a requirement to access further fertility treatment. IUI will not be funded as a treatment after IVF treatment. ▪ **Donor gametes including azoospermia:** patients who require donor gametes will be placed on the waiting list for an initial period of up to 3 years, after which they will be reviewed to assess whether the fertility policy eligibility criteria are still met. If it is anticipated that there will be difficulty finding a suitable donor and there is evidence of exceptionality the clinician may consider an IFR application to source from alternative providers. **Donor Sperm**:

	▪ where **clinically indicated up to six cycles of donor** insemination will be offered. The cost of **donor sperm is included in the funding of treatment for which it is required**, to be commissioned in accordance with this policy and the funding policy of the ICB ▪ couples who request the use of a known clinically appropriate sperm donor will be responsible for all costs associated with the donor, including transportation costs. The ICB will fund the IUI, IVF and or ICSI treatment at an accredited provider in line with the criteria in this policy, providing it meets the criteria defined by the HFEA. **IVF cycles funded by South Yorkshire ICB:** ▪ women or birthing people aged between 18-39 years who meet the eligibility criteria for infertility will receive 1 full cycle of IVF treatment with their own eggs, with or without ICSI ▪ women or birthing people aged 40–42 years who meet the eligibility criteria for infertility will receive 1 full cycle of IVF treatment with their own eggs, with or without ICSI. The following eligibility criteria must also be fulfilled: ○ they have never previously had IVF treatment ○ there is no evidence of low ovarian reserve using one of the following measures AFC of less than or equal to 4, AMH of less than or equal to 5.4 pmol/l, FSH greater than 8.9 IU/l ○ there has been a discussion of the additional implications of IVF and pregnancy at this age. Where IVF is the only effective treatment, women or birthing people aged between 40-42 should be referred directly to a specialist team for IVF treatment. Where an individual feels that they have exceptional circumstances that would merit consideration of an additional cycle being funded by the NHS they should speak to their doctor about submitting an Individual Funding Request to the ICB. **Donor Eggs**: ▪ patients eligible for treatment with donor eggs, in line with NICE recommendations, will be placed on the waiting list for treatment. Unfortunately, the availability of donor eggs remains severely limited in the UK. There is, therefore, no guarantee that eligible patients will be able to proceed with treatment ▪ couples who request the use of a known clinically appropriate egg donor will be responsible for all costs associated with the donor, including transportation costs. The ICB will fund the associated IUI, IVF and or ICSI treatment at an accredited provider in line with the criteria in this policy, providing it meets the criteria defined by the HFEA. NHS England are responsible for the commissioning of PGD. The following eligibility criteria must be met to be eligible for three full NHS funded cycles of PGD:[100] ▪ the couple must be at risk of having a child with a serious genetic condition ▪ the couple must have been referred to the PGD provider by an NHS Clinical Genetics Service ▪ the risk of conceiving a pregnancy affected by a serious genetic condition must be 10% or more ▪ the couple must have received genetic counselling from a clinical geneticist or a registered genetic counsellor ▪ the woman or birthing person receiving treatment must be under 40 years of age at the time of treatment ▪ the woman or birthing person receiving treatment must have a BMI of more than 19 and less than 30 ▪ both partners must be non-smokers ▪ there must be no living unaffected child from the current relationship ▪ the HFEA must have licensed the indication for PGD

	▪ the test must be included in the list of UK Genetic Testing Network (UKGTN) approved tests or be suitable for inclusion. ▪ the couple must not be seeking PGD primarily because they are infertile or for any other reason be unable to have children on their own.
Northern Ireland ▪ Eligibility for HSC (Health and Social Care Trust) funded IVF and related treatments effective from 1st June 2019[81] ▪ Belfast HSC Trust. Regional Fertility Centre[82] ▪ Taylor et al.[103]	In the absence of any known cause of infertility, a woman or birthing person of reproductive age should be offered further clinical assessment and investigation (along with her partner, where appropriate) where: ▪ she has not conceived after one year of unprotected vaginal sexual intercourse, or ▪ if using artificial insemination (with either partner or donor sperm), she has not conceived after four cycles of artificial insemination. Earlier referral for specialist consultation should be made where clinically indicated. Unless otherwise clinically indicated, women or birthing people trying to conceive using artificial insemination, who have not conceived after four cycles of donor or partner insemination, should be offered four cycles of unstimulated intrauterine insemination (IUI) before referral for IVF is considered. **Provision of IVF where:** ▪ a fertility problem has been demonstrated at investigation ▪ or a woman or birthing person has not conceived after 2 years of regular unprotected vaginal intercourse (including the year prior to being referred for investigation) ▪ or eight cycles of artificial insemination (where at least four are by IUI). One cycle of IVF, with or without ICSI, and one frozen embryo transfer, should then be offered for: ▪ women or birthing people aged under 40 or ▪ women or birthing people aged between 40 and 42 who have never previously had IVF treatment and where there is no evidence of low ovarian reserve and there has been a discussion of the additional implications of IVF and pregnancy in this age group. However, in 2024 the Minister in Northern Ireland announced that if a woman or birthing person meets the access criteria for IVF and has been placed on the waiting list for publicly funded IVF/ICSI treatment on or after 1 October 2022, and they do not achieve a live birth with either their fresh or first frozen embryo transfers, and still has frozen embryos, they will be entitled to further treatment until they either have a live birth or have transferred all their frozen embryos.[315] **Further eligibility criteria for the provision of IUI and IVF and or ICSI are:** ▪ the woman or birthing person must have a BMI of at least 19.0 kg/m^2 and up to and including 30.0 kg/m^2. Women or birthing people with a BMI over 30.0 kg/m^2 and who are not ovulating should be informed that losing weight is likely to increase their chance of conception. Women or birthing people with BMI over 30.0 kg/m^2 should be referred to a group program involving exercise and dietary advice to lose weight. ▪ neither the woman or the birthing person, nor her partner, must have had three or more IVF cycles previously (including both publicly funded and private treatment) ▪ neither the woman or the birthing person, nor her partner, have undergone a voluntary sterilisation procedure, even if reversed. This does not include conditions where sterilisation occurs as a result of another medical problem. ▪ Women or birthing people who smoke should be informed this is likely to reduce their fertility. They should be encouraged to abstain from smoking for 3 months prior to IVF

	▪ Women or birthing people who are trying to become pregnant should be informed that drinking no more than 1 - 2 units of alcohol once or twice per week and avoiding intoxication reduces the risk of harming a developing foetus. Men should be advised that excessive alcohol intake is detrimental to semen quality ▪ treatment will only be provided to people who have been assessed by the clinic as meeting HFEA requirements on the welfare of any child who may be born as a result and of any other child who may be affected by the birth. The decision on whether IVF or ICSI is more suitable will depend on certain medical criteria and best clinical practice. While the above eligibility criteria applies to both opposite-sex and same-sex couples, the ability to meet the criteria is harder for same sex couples who do not necessarily have an infertility diagnosis, and more significantly, are unable to try to conceive naturally with their partner.[103] **Donor gametes:** There is a shortage of egg and sperm donors in the UK. This can result in waiting a longer time before treatment. A key representative from Northern Ireland confirmed that for: ▪ Donor sperm: this is provided by the Regional Fertility Centre (RFC) for publicly funded treatment if clinically indicated ▪ Donor eggs: the RFC does not have a bank of donor eggs but will advise on how a person can attempt to identify someone who may be able to donate an egg. **Embryo donation:** for some couples who have both an egg and sperm problem, treatment using embryos (fertilised eggs) from another couple may be the only appropriate treatment. A couple who has had treatment at the Regional Fertility Centre and have stored embryos they no longer intend to use in treatment may consider donating embryos to another couple. **Pre-implantation genetic diagnosis:[105]** if couples fit the below criteria, they will generally be offered up to three cycles of PGD on the NHS. This funding ceases if they have a healthy child, are not responding to treatment or no longer fit the eligibility criteria: ▪ treatment to start before the woman or birthing person in the couple is 40 yrs of age ▪ the woman or birthing person in the couple must have a BMI of more than 19 and less than 30 ▪ both partners must be nonsmokers ▪ testing for condition occurred in an accredited genetic laboratory ▪ couples have had genetic counselling locally ▪ couples are in a year long relationship and co-habiting. Funding is applied for from the health board usually by the couple's genetic counsellor. If approval is granted the cost of treatment, travel and accommodation will be covered. Couples will likely attend 4-5 appointments.
Scotland ▪ Access Criteria for: ○ NHS IVF Treatment in Scotland[83] ○ NHS-Funded Donor Insemination[84] ▪ NHS Scotland: Right Decision Service: Infertility[86] ▪ National Infertility Group Report (March 2016)[87]	**Who should be referred to an infertility clinic:** couples with no obvious cause for fertility problems who have been having unprotected intercourse for a year or more. Couple with an obvious cause for infertility oligo or amenorrhea, known tubal block or abnormal semen analysis should be referred straight away, and should not have to wait for a year. Same-sex couples can be referred to the infertility clinic. **Donor Insemination:** Donor insemination is one of the treatments of choice when the man or person with male reproductive organs in the couple is unable to produce sperm or where a known genetic defect exists. Wherever possible, the donor's physical characteristics (for example. hair and eye colouring, height) are matched to those of the receiving couple. **To receive NHS-funding for donor insemination the following eligibility criteria must be met:**

▪ NHS Scotland Assisted Conception Units (ACUs): ○ Edinburgh Fertility Centre – NHS Lothian[88] ○ Glasgow Royal Infirmary Assisted Conception Service[38] ○ Aberdeen Fertility Centre[39] ○ Assisted Conception Unit | Ninewells Dundee | Dundee ACU[40]	▪ be in a couple and live in Lothian or the Borders ▪ stable relationship (have been co-habiting (at the same address) in a stable relationship for a minimum of two years) ▪ neither partner had voluntary sterilisation nor who have undertaken reversal of sterilisation, even if reversal has been self-funded ▪ have one partner with no living biological child. Same-sex couples who have previously conceived through AHR and are both named on the resulting child's birth certificate are not eligible for future treatment. ▪ the prospective birth mother must have a Body Mass Index (BMI) above 18.5 and below 30. Couples should be aware that a normal BMI is best for both partners ▪ both partners must not smoke, vape or use nicotine for at least three months before referral for treatment and couples must continue to be non-smoking and nicotine free during treatment ▪ both partners must abstain from illegal and abusive substances ▪ both partners must be methadone free for at least one year prior to referral for treatment ▪ neither partner should drink alcohol prior to or during the period of treatment ▪ treatment must start before the prospective birth mother's 40th birthday ▪ must satisfy the requirements of a Welfare of the Child Assessment. **Number of cycles:** Up to **six cycles of donor insemination** may be undertaken where there is a reasonable expectation of a live birth. Clinical judgement should be applied to determine this. After three to six unsuccessful cycles of donor insemination, the couple can be referred for IVF with donor sperm. If the prospective birth mother is referred at 38 or 39 years old, the couple will be provided with the option to start IVF treatment with donor sperm instead of starting donor insemination treatment. If a couple is referred when the female partner is 39, the couple will most likely receive one NHS IVF cycle. Once a couple has started IVF treatment, they are no longer eligible for donor insemination treatment. No individual can access more than six NHS-funded donor insemination cycles, under any circumstances, even if they are in a new relationship. **To receive NHS-funding for IVF treatment the following eligibility criteria must be met:** Meet one of the following definitions of infertility: ▪ subfertility with an appropriate cause of any duration (all couples) ▪ unexplained subfertility of 2 years (opposite-sex couples) ▪ unexplained subfertility following 6 cycles of NHS-funded donor insemination (same sex couples). Further eligibility criteria for all couples are the same as that for NHS-funded donor insemination however it is not outlined that the couple must satisfy the requirement of a Welfare of the Child assessment. Also, it does not state that same-sex couples who have previously conceived through AHR and are both named on the resulting child's birth certificate are not eligible for future treatment. The following access criteria also applies: ▪ NHS funding will not be provided to couples where either partner has already received the number of NHS-funded IVF treatment cycles supported by NHS Scotland regardless of where in the UK they received treatment ▪ no individual (male or female) can access more than the number of NHS-funded IVF treatment cycles supported by NHS Scotland under any circumstances, even if they are in a new relationship

	▪ fresh cycles of treatment must be initiated by the date of the women or birthing person's 40th birthday and all subsequent frozen embryo transfers must be completed before their 41st birthday. If the woman or birthing person during their first fresh cycle of treatment, no further fresh cycles will be offered. Each individual treatment cycle, including all frozen transfers, must be completed within 12 months of starting treatment, or (as set out above) before the date of the female partners 41st birthday if this is reached first NHS treatment may be given to those patients who have previously paid for IVF treatment, if in the treating clinician's view, the individual clinical circumstances warrant further treatment. Intracytoplasmic Sperm Injection (ICSI) is offered to couples with male factor infertility after investigation and assessment, if clinically appropriate. 'The Scottish Government expects NHS Boards to meet the needs of couples who are eligible for NHS fertility treatment and require donor gametes (eggs and sperm) for that treatment. We have always been clear that couples who are eligible for NHS fertility treatment should not pay for any aspect of their treatment, and this includes the purchase and use of donor gametes.'(106) **Definition of one full cycle of IVF:** One fresh cycle includes ovarian stimulation, egg retrieval, fertilisation, and transfer of fresh embryo (if appropriate), followed by the freezing of suitable embryos and the subsequent placement of these, provided the couple still fulfil all access criteria. If suitable embryos are frozen these must be transferred before the next NHS-funded stimulated treatment cycle. Transfer of frozen embryos is not counted as a separate cycle for NHS-funded patients. **Single embryo transfer**: Patients with a good prognosis are always expected to have single embryo transfer and this will be discussed with patients at clinic appointments. The single biggest risk of fertility treatment is a multiple pregnancy. **Number of cycles of IVF and or ICSI:** Those meeting the eligibility criteria are entitled to up to **3 treatment cycles**. Following each cycle, a full review of the outcome will be discussed. If it is decided that treatment is unlikely to be of benefit, further treatment will not be offered, and NHS entitlement will be withdrawn. In specific circumstance, for couples where the woman or birthing person is aged from the day after her 40th birthday, who meet all other criteria, one cycle of treatment may be funded. Couples must have been screened for treatment by the time of the female partners 42nd birthday at the latest, and all treatment including any subsequent frozen embryo transfers must be completed by the time the female partner reaches 42 + 364 days. All of the following criteria must additionally be met: ▪ they have never previously had IVF treatment (NHS or private) ▪ there is no evidence of poor ovarian reserve and if, in the treating clinician's view it is in the patients' interest ▪ there has been a robust discussion of the additional implications of IVF and pregnancy at this age. **Egg sharing:** There is a great shortage of egg donors so the waiting time for this treatment (involving donated eggs) can be very long. For that reason, we are able to ask women or birthing people undergoing IVF and ICSI to consider sharing their eggs; in exchange for this, they receive subsidised treatment. This is called egg-sharing. Only certain women or birthing people are suitable to be egg-share donors, equally not all women or birthing people are suitable to be egg-share recipients. In order to become an **egg share recipient,** the female must be (if receiving NHS-funded treatment): ▪ under the age of 42 years. Requests from women or birthing people over 42 years will be considered on an individual basis ▪ in good health ▪ within a healthy weight range, with a BMI of less than 30 ▪ a non-smoker.

	Egg donation from a friend or relative is allowed and will reduce the waiting time. **Pre-implementation genetic diagnosis (PGD):**[107, 108] couples who fulfil the PGD eligibility criteria are eligible for up to three NHS-funded PGD cycles. The couple must have: 1. A known genetic condition in the family which conveys a 'significant risk of a serious genetic condition'. 2. No living, unaffected child, or untested child (for an adult-onset disorder) as a couple or, if one partner has no living biological child. 3. Female hormone level (anti mullerian hormone) of 7.5 pmol/L or greater (or an adequate ovarian scan). 4. Female age < 39 years. 5. Female body mass index < 30. 6. Both partners should be non-smokers for at least 3 months, living at same address for at least 2 years and both must be eligible for NHS treatment. Individuals who have an unaffected child from PGD are not entitled to any further NHS-funded cycles.
Wales ▪ NHS Wales. Specialised Services Commissioning Policy: CP38 Specialist Fertility Services[89] ▪ Wales Fertility Institute[90, 109]	**Subfertility must be demonstrated before there can be access to NHS-funded IVF treatment:** ▪ subfertility for opposite-sex couples is defined as inability to conceive after 2 years unprotected intercourse or a fertility problem demonstrated at investigation ▪ subfertility for same-sex couples, and individuals is defined as no live birth following insemination at or just prior to the known time of ovulation on at least 6 non-stimulated cycles or a fertility problem demonstrated at investigation. For same-sex couples, and individuals, the non-stimulated cycles may be achieved through a private arrangement or through NHS-provided IUI with donor sperm. Intra-uterine insemination is not funded by Wales Health Specialised Services Committee (WHSSC). Funding for IUI is the responsibility of the Health Boards. Where donor sperm is needed to undertake IUI, the donated sperm will be funded by WHSSC, but not the IUI procedure. **Donor insemination:** The use of donor insemination is considered effective in managing fertility problems associated with the following conditions: ▪ obstructive azoospermia ▪ non-obstructive azoospermia ▪ severe oligospermia ▪ infectious disease in the man or person with male reproductive organs (such as HIV) ▪ severe rhesus isoimmunisation ▪ severe deficits in semen quality in couples who do not wish to undergo intracytoplasmic sperm injection. Donor insemination should also be considered in certain cases where there is a high risk of transmitting a genetic disorder to the offspring. Donor insemination is also used for same-sex couples and individuals. **Further Eligibility criteria for IVF treatment** ▪ **The woman or birthing person's age:** ○ Women or birthing people must be at least 20 years old to access IVF treatment. Those who are aged less than 40 years and who meet the access criteria are entitled to 2 cycles of IVF with or without ICSI. However, if the woman or birthing person reaches the age of 40 during the first cycle of treatment they will **not** be entitled to a second cycle of IVF

	○ women or birthing people aged between 40 and 42 years (up to their 43rd birthday), who meet the access criteria, are entitled to one cycle of IVF with or without ICSI provided the following 3 criteria are also fulfilled: — they have never previously had IVF treatment — there is no evidence of low ovarian reserve — there has been a discussion of the additional implications of IVF and pregnancy at this age. ▪ **The man or person with male reproductive organ's age:** 55 years or younger ▪ **Existing children:** the following will be allowed - couples where one of the partners does not have any living children (biological or adopted), and or individuals who do not have any living children (biological or adopted) ▪ **Body Mass Index (BMI):** Women or birthing people must have a BMI of between 19 and 30. Those with a BMI below 19 that are ovulating normally may be treated at the discretion of the treating clinician. Men who have a BMI of 30 or over should be informed that they are likely to have reduced fertility ▪ **Sterilisation**: Subfertility is not the result of a sterilisation procedure in either partner, or the individual (this does not include conditions where sterilisation occurs as a result of another medical problem). Couples and individuals who have undertaken a reversal should not be referred for treatment ▪ **Smoking:** couples and individuals who smoke are not eligible. Only patients who agree to take part in a supported programme of smoking cessation will be accepted on the IVF treatment waiting list and must be non-smoking at time of treatment ▪ **History of previous treatment:** for single patients, three or more IVF cycles by the patient will exclude any further NHS IVF treatment. For couples, three or more IVF cycles by either partner will exclude any further NHS IVF Treatment. Previous cycles whether NHS or privately funded will be taken into account. **Definition of one full cycle of IVF:** A full cycle of IVF treatment, with or without ICSI, should comprise 1 episode of ovarian stimulation and the transfer of any resultant fresh and frozen embryos. This will include the storage of any frozen embryos for 1 year following egg collection. Patients will need to be advised at the start of the treatment that this is the level of service that is available on the NHS and that the NHS will not fund storage following this period. Patients must be counselled, and agree that storage of any frozen embryos following this period will need to be funded by themselves, or allowed to perish. **Change of partner whilst waiting for IVF treatment:** if a couple consent to treatment but during the waiting period for treatment the couple break up then treatment cannot commence. If one or both of the partners wish to proceed with treatment with either a new partner or by themselves then the clinic that is providing the treatment needs to be notified. The new couple and or individual will need to attend a consultation where the fertility history of the couple and or individual needs to be reviewed, treatment options explained and discussed and if the couple and or individual still meet the eligibility criteria consent to proceed with treatment. **Use of donor eggs:** egg donation may be offered where no other treatment is available. Egg donation may be available to women or birthing people who have undergone premature ovarian failure due to an identifiable pathological or iatrogenic cause or to avoid transmission of inherited disorders to a child where the couple meet the other access criteria. The patient must be able to identify and provide a donor, either through altruistic egg donation or through an individual agreement (for example, with a friend or relative). WHSSC will not fund IVF for patients participating in the egg sharing schemes that may operate within fertility clinics. **Pre-implantation genetic screening (PGD):** The NHS does not routinely fund PGD, and only funds PGT-A (aneuploidies) and PGT-SR (structural rearrangements) where patients meet the criteria. The Department of Health issued "Guiding Principles for

	Commissioners of NHS Services or PGD" to inform Health Authorities about the benefits of the technique, with indications for PGD including patients with chromosomal disorders and couples at risk of transmitting serious genetic disorders to their offspring.

Key: AHR = assisted human reproduction; ART = assisted reproductive technology; BMI = body mass index; CNPMA = National Council for Medically Assisted Reproduction; DAHR = donor-assisted human reproduction; HFEA = Human Fertilisation and Embryology Authority; ICB = Integrated Care Board (England); ICSI = intracytoplasmic sperm injection; IUI = intrauterine insemination; IUI-D = intrauterine insemination with donor sperm; IVF = in vitro fertilisation; NHS = National Health Services; NICE = the National Institute for Health and Care Excellence; PGD = pre-implantation genetic diagnosis; PGT = pre-implantation genetic testing; PGT-M = PGT for monogenic diseases; PGT-SR = PGT for structural chromosomal abnormalities; RANZCOG = Royal Australian and New Zealand College of Obstetricians; RFC = Regional Fertility Centre (Northern Ireland); UK = United Kingdom; WHSSC = Wales Health Specialised Services Committee.

Table D 2 Summary of funding information for publicly-funded DAHR services in selected countries.

Country Relevant documents	Funding
Australia ▪ Medicare Benefits Schedule Book Operating from 1 March 2024 and Services Australia[62, 64] ▪ Understanding Medicare Provider Handbook[111] ▪ Assisted Reproductive Technology Storage Funding Program Guidelines[66] ▪ Assisted reproductive technology services[63] ▪ Dempsey et al.[110]	[See Table D 1 for detailed information on what is covered and for who] A number of DAHR services are covered by Medicare reimbursement. A person can enrol in Medicare if they live in Australia and are any of the following: ▪ an Australian citizen ▪ a New Zealand citizen ▪ an Australian permanent resident ▪ applying for permanent residency ▪ a temporary resident covered by a ministerial order. A person can also enrol if they are a citizen or permanent resident of any of the following: ▪ Norfolk Island ▪ Cocos (Keeling) Islands ▪ Christmas Island ▪ Lord Howe Island. A person may be able to enrol if they are visiting from a Reciprocal Health Care Agreement country. The major elements of Medicare are contained in the Health Insurance Act 1973, as amended, and include the following: a. Free treatment for public patients in public hospitals. b. The payment of 'benefits', or rebates, for professional services listed in the Medicare Benefits Schedule. The relevant benefit rates are: i. 100% of the Schedule fee for services provided by a general practitioner to non-referred, non-admitted patients, or for general practitioner attendances specified as not being hospital treatments ii. 100% of the Schedule fee for services provided on behalf of a general practitioner by a practice nurse or Aboriginal and Torres Strait Islander health practitioner; iii. 75% of the Schedule fee for professional services rendered to a patient as part of an episode of hospital treatment (other than services provided to public patients), including services provided in hospital outpatient settings. iv. 75% of the Schedule fee for professional services rendered as part of a privately insured episode of hospital-substitute treatment such as 'hospital in the home', but generally not including certain services listed below. v. 85% of the Schedule fee for all other services. The Health Insurance Act 1973 stipulates that Medicare benefits are payable for professional services. A professional service is a clinically relevant service which is listed in the MBS. A medical service is clinically relevant if it is generally accepted in the medical profession as necessary for the appropriate treatment of the patient.

	Medicare Benefits Schedule (MBS) - The preparation of frozen or donor embryos, or donor eggs (oocytes), for placement in the female reproductive organs (uterus/womb or fallopian tubes). The treatment also includes pathology tests and counselling. This is for one treatment cycle. This item is used to provide fertility treatments, for example, IVF. **Fee 13200** Assisted reproductive technologies superovulated treatment cycle proceeding to oocyte retrieval, involving the use of drugs to induce superovulation and including quantitative estimation of hormones, ultrasound examinations, all treatment counselling and embryology laboratory services but excluding artificial insemination, transfer of frozen embryos or donated embryos or ova or a service to which item 13201, 13202, 13203 or 13218 applies, being services rendered during one treatment cycle—initial cycle in a single calendar year Fee: $3,543.85 Benefit: 75% = $2657.90 85% = $3445.15 Extended Medicare Safety Net Cap: $1,996.80 **Fee 1202** Assisted reproductive technologies superovulated treatment cycle that is cancelled before oocyte retrieval, involving the use of drugs to induce superovulation and including quantitative estimation of hormones and ultrasound examinations, but excluding artificial insemination, transfer of frozen embryos or donated embryos or ova or a service to which item 13200, 13201, 13203 or 13218 applies, being services rendered during one treatment Fee: $530.35 Benefit: 75% = $397.80 85% = $450.80 Extended Medicare Safety Net Cap: $77.30 **Fee 13207** Biopsy of an embryo, from a patient who is eligible for a service described in item 73384 under clause 2.7.3A of the pathology services table (see PR.7.1), for the purpose of providing a sample for preimplantation genetic testing—applicable to one or more tests performed in one assisted reproductive treatment cycle (See para PR.7.1 of explanatory notes to this Category) Fee: $125.90 Benefit: 75% = $94.45 85% = $107.05 **Fee 13209** Planning and management of a referred patient by a specialist for the purpose of treatment by assisted reproductive technologies or for artificial insemination—applicable once during a treatment cycle Fee: $98.75 Benefit: 75% = $74.10 85% = $83.95 Extended Medicare Safety Net Cap: $13.60 **Fee 13212** Oocyte retrieval for the purpose of assisted reproductive technologies—only if rendered in connection with a service to which item 13200 or 13201 applies (Anaes.) (See para TN.1.4 of explanatory notes to this Category) Fee: $403.80 Benefit: 75% = $302.85 85% = $343.25 Extended Medicare Safety Net Cap: $83.70 **Fee 13215** Transfer of embryos or both ova and sperm to the uterus or fallopian tubes, excluding artificial insemination—only if rendered in connection with a service to which item 13200, 13201 or 13218 applies, being services rendered in one treatment cycle Fee: $129.70 Benefit: 75% = $97.30 85% = $110.25 Extended Medicare Safety Net Cap: $61.40 **Fee 13218** Preparation of frozen or donated embryos or donated oocytes for transfer to the uterus or fallopian tubes, by any means and including quantitative estimation of hormones and all treatment counselling but excluding artificial insemination services rendered in one treatment cycle and excluding a service to which item 13200, 13201, 13202, 13203 or 13212 applies. Fee: $925.70 Benefit: 75% = $694.30 85% = $821.20 Extended Medicare Safety Net Cap: $888.30 **Fee 13221** Preparation of semen for the purpose of artificial insemination—only if rendered in connection with a service to which item 13203 applies

Fee: $57.85 Benefit: 75% = $43.40 85% = $49.20 Extended Medicare Safety Net Cap: $25.80

Note TN.1.4: *Refers to ART list items 13200 – 13221. The treatment cycle for art including donor-assisted reproduction is defined in terms of timing - "A treatment cycle that is a series of treatments for the purposes of AHR services is defined as beginning either on the day on which treatment by superovulatory drugs is commenced or on the first day of the patient's menstrual cycle, and ending either; not more than 30 days later, or if a service mentioned in item 13212, 13215 or 13221 is provided in connection with the series of treatments-on the day after the day on which the last of those services is provided.*
The date of service in respect of treatment covered by Items 13200, 13201, 13203, 13209 and 13218 is DEEMED to be the FIRST DAY of the treatment cycle."

It should be noted that Medicare reimbursement can be following patient payment or bulk billing.

- **Patient payment:** The quickest way to claim Medicare benefit is at the doctor's office straight after the patient pays. To do this the patient and doctor need to both be enrolled in Medicare and the patient must show their Medicare card. The doctor's office can make an electronic claim for the patient on the spot. Services Australia will process the claim as soon as possible and pay the Medicare benefit into either the account for the EFTPOS card used to pay or the registered bank account registered. Medicare benefits can be claimed online, in the post, at a service centre or for someone else.
- **Bulk billing:** Bulk billing means the patient doesn't have to pay for their medical service from a health professional.[316] They bill Services Australia instead and accept the Medicare benefit as full payment for the service.

Medicare rebates can reduce the cost of a typical IVF cycle from USD 10,000 to approximately USD 4,000, with unlimited rebated cycles available if the parent(s) are medically diagnosed as infertile. A standard IVF cycle typically costs USD/AUD 10,000, while a single IUI procedure costs around USD/AUD 2,500.
For fertility clinics, government reimbursement differs significantly by procedure type:

- The government pays approximately USD 5,500 to a clinic for performing one IVF cycle.
- The government pays approximately USD 500 for performing one IUI (artificial insemination) cycle.[110]

Key information on Medicare benefits and billing practices
The *Health Insurance Act 1973* stipulates that Medicare benefits are payable for professional services. A professional service is a clinically relevant service which is listed in the MBS. A medical service is clinically relevant if it is generally accepted in the medical profession as necessary for the appropriate treatment of the patient. Medical practitioners are free to set their fees for their professional service. However, the amount specified in the patient's account must be the amount charged for the service specified. The fee may not include a cost of goods or services which are not part of the MBS service specified on the account.

Billing practices contrary to the Act
A *non-clinically relevant service* must not be included in the charge for a Medicare item. The non-clinically relevant service must be separately listed on the account and not billed to Medicare. Goods supplied for the patient's home use (such as wheelchairs, oxygen tanks, continence pads) must not be included in the consultation charge. Medicare benefits are limited to services which the medical practitioner provides at the time of the consultation - any other services must be separately listed on the account and must not be billed to Medicare. Charging part of all of an episode of hospital treatment or a hospital substitute treatment to a non-admitted consultation is prohibited. This would constitute a false or misleading statement on behalf of the medical practitioner and no Medicare

	benefits would be payable. An account may not be re-issued to include charges and out-of-pocket expenses excluded in the original account. The account can only be reissued to correct a genuine error. **Potential consequence of improperly issuing an account** The potential consequences for improperly issuing an account are (a) no Medicare benefits will be paid for the service (b) the medical practitioner who issued the account, or authorised its issue, may face charges under sections 128A or 128B of the *Health Insurance Act 1973* (c) Medicare benefits paid as a result of a false or misleading statement will be recoverable from the doctor under section 129AC of the *Health Insurance Act 1973*. Providers should be aware that Services Australia is legally obliged to investigate doctors suspected of making false or misleading statements and may refer them for prosecution if the evidence indicates fraudulent charging to Medicare. If Medicare benefits have been paid inappropriately or incorrectly, Services Australia will take recovery action.
Denmark ▪ BEK No. 1452 of 01/12/2025[24] ▪ New agreement to help involuntarily childless people get pregnant[41] (and implementation agreement[42]) ▪ New agreement provides twice as many fertility attempts for child number two[43] (and implementation agreement[44]) ▪ ROAD No. 9351 of 26/05/2015 (Current) Guidance on the activities and obligations of healthcare professionals and tissue establishments in connection with assisted reproduction[45] ▪ Triangelen Fertility Clinic: Fertility treatment via a public health referral at Trianglen[46]	[See Table D 1 for detailed information on what is covered and for who] From 2026 onward, the Finance Act provides DKK 35 million annually to expand IVF and or ICSI capacity. Regions must use these funds to increase the number of IVF and or ICSI attempts so that individuals and couples can be offered up to 6 IVF and or ICSI treatments for a second child. Fertility treatment is free at public hospitals. However, individuals and couples will need to pay for medication for both the first and second attempt. Individuals and couples do not have the right to use a private fertility clinic without paying for it themselves, even if there is a waiting time for treatment at a public fertility clinic. However, it is possible to receive AHR in the form of insemination treatment from a private specialist with public funding. At the regional hospitals, AHR treatment in the form of IVF and or ICSI for the first and second child is available free of charge. This applies to both individuals and couples. This means that IVF and or ICSI for the purpose of having a second child can be carried out free of charge at the regional hospitals if couples and individuals have frozen fertilised eggs from previous treatment, Frozen Embryo Replacement, or if it is in the case of intrauterine insemination treatment (IUI). **Donor sperm:** If an individual or couple brings their own chosen sperm donor to a regional hospital, the hospital may require that sperm donation, including testing and evaluation, be carried out through an approved tissue centre (sperm bank). All costs associated with the tissue centre's testing and evaluation must be paid by the individual or couple.
France ▪ Biomedicine Agency: Procreation-medical.fr[27] and associated webpages. ▪ Procreation: Questions and testimonials[27]	[See Table D 1 for detailed information on what is covered and for who] **Funding for providers of fertility preservation services (and AHR services in general):** An activity-based pricing system is used that has 2 complementary components: ▪ financing the diagnostic, treatment and care activity through service rates and national packages: resources are allocated to establishments according to the volume and nature of their activity

▪ Medically assisted procreation (ART)[25]	▪ compensation for expenses linked to the accomplishment of missions of general interest, through specific grants called MIG (missions of general interest) or MIGAC (missions of general interest and assistance with contracting). The national MIG and or MIGAC funding allocation finances missions and actions which the legislator has deemed should not be subject solely to variations in activity. The MIG and or MIGAC allocations aim to compensate for observed additional costs, which are potentially different depending on the establishment given the disparities in activities and results. Only health establishments can receive MIG grants. For AHR, additional costs have been identified for AHR activity in general and for certain specific treatments. These missions are therefore compensated – subject to valid authorisation of the activities – by structural and annual funding of the MIG type based on quantitative indicators, and allocated by establishment. The AHR MIG is one of the rare MIG allocations awarded to both the public and private sectors according to identical rules. It is made up of 2 complementary components: a billable part (clinical, biological, imaging procedures, consultations, hospitalisation stays) and a non-billable part (linked to the execution of different missions). The non-billable component, or MIG allocation, is intended to finance personnel and equipment costs. **Financial coverage from health insurance in the context of AHR carried out abroad**: Clinical and biological AHR care carried out outside France is scheduled subject to prior authorisation by the health insurance fund in order to be able to benefit from financial coverage. It is important to note that not all countries, including those belonging to the European Union, impose the same rules and standards on practices related to AHR, which can have consequences on the quality and safety of care. In France, these activities are strictly regulated. AHR centres and the practitioners who practise there are issued with an authorisation that attests to the good quality of care and compliance with the rules of good practice. The activities of the centres are evaluated annually by the Biomedicine Agency. **Note:** the vitrification of gametes without AHR care is not subject to prior authorisation and is covered according to French tariffs, after advance payment of the costs on the patient's part. To be covered by the Health Insurance, the patient has to take steps before AHR. **Financial support of AHR:** AHR procedures are 100% covered by the Health Insurance within the limit of: ▪ 6 inseminations (only one artificial insemination per cycle) to achieve pregnancy ▪ 4 attempts at IVF to achieve pregnancy. The onset of pregnancy resets the counters. This care is the same for everyone. Individuals living in France may access AHR even if their spouse resides abroad. The French health insurance fund provides 100% reimbursement for AHR performed in France following approval by the relevant primary health insurance fund, Caisse Primaire d'Assurance Maladie directly (CPAM). Couples in which one partner lives abroad should contact their CPAM for guidance.
Germany ▪ D.I.R. Annual 2023 – The German IVF-Registry[55] ▪ Apply for cost coverage for measures to induce pregnancy[50] ▪ Fertility Information Portal[51]	[See Table D 1 for detailed information on what is covered and for who] AHR cost coverage is regulated by 27a of the German Social Code (SGB V). Statutory health insurance covers 50% of approved treatment plan costs. Treatments are billed to each partner's own insurer. Normally, the procedure is as follows: ▪ gynaecologist referral to fertility centre ▪ fertility centre prepares treatment plan ▪ treatment plan submitted (post or online or in person) to each partner's insurer

	▪ insurer reviews and issues cost coverage certificate (paper form) ▪ certificate given to doctor ▪ billing occurs via e-health card ▪ couple receives invoices for their personal contribution. The potential subsidies may cover up to 25% of the couple's remaining out-of-pocket costs after statutory health insurance reimbursement. For married couples, out-of-pocket costs are typically reduced by 25% for the first three treatment cycles and by up to 50% for the fourth cycle, which is usually not covered by health insurance. For unmarried cohabiting couples, subsidies are lower, generally 12.5% for the first three cycles and up to 25% for the fourth cycle. This difference arises because statutory health insurance benefits under § 27a SGB V are available only to married couples. Federal initiative "Help and Support for Unwanted Childlessness" varies across states: ▪ no state support is provided in Baden-Württemberg, Bavaria, Brandenburg, Hamburg, North Rhine-Westphalia, and Schleswig-Holstein, as they do not participate in the federal programme. ▪ in Mecklenburg-Western Pomerania, Lower Saxony, Saxony, Saxony-Anhalt, Saarland) and Hesse: funding is limited to married and unmarried opposite-sex couples and usually restricted to treatments using the partners' own gametes. Donor gametes are excluded in line with § 27a SGB V. Berlin, Bremen, Rhineland-Palatinate, and Saarland offer broader access, allowing same-sex couples to apply for state funding, though conditions and administrative processes apply: ○ Bremen: in the case of same-sex married couples, civil partnerships or same-sex couples living in a non-marital cohabitation in which at least one person has female reproductive organs, Bremen grants up to 50% of the couples' remaining co-payment for the first to fourth treatment cycles after settlement with the health insurance company and, if applicable, the aid office, but no more than for the 1st to 3rd attempt: ○ € 1,200.00 for in vitro fertilisation and ○ € 1,300.00 for an intracytoplasmic sperm injection; at most, however, for the 4th attempt: ○ € 1,600.00 for in vitro fertilisation and ○ € 1,700.00 for an intracytoplasmic sperm injection The average cost of one AHR cycle with fresh embryo transfer in Germany: €5,051.
Portugal ▪ Law No. 32/2006 of 26 July Medically assisted procreation[56] ▪ Ordinance No. 300/2024/1, of 25 November[58]	[See Table D 1 for detailed information on what is covered and for who] The legal framework establishes that centres authorized to provide AHR cannot assign any monetary value to donated genetic material or embryos when determining remuneration for treatment, ensuring that donation remains altruistic. AHR provided within the National Health Service is governed by conditions set out in a specific legal diploma, taking into account the opinion of the National Council for Medically Assisted Procreation. Infertility-related medicines, particularly those used in AHR, are reimbursed at a high rate of 90% under Step A of the national reimbursement scheme. This scheme covers a wide range of pharmacological groups essential for AHR. The inclusion of these medicines in the exceptional reimbursement scheme depends on applications from marketing authorisation holders as defined in relevant legislation, and approval by the government member responsible for health area. The list of reimbursable active substances may be updated by resolutions of the Board of Directors of

	National Authority of Medicines and Health Products (Public Institute), ensuring that reimbursement criteria remain aligned with clinical and regulatory developments.
Sweden ▪ Recommendations for homogeneity in county councils' and regions' publicly funded assisted reproduction offers[35] ▪ Payne and Korolczuk[300] ▪ Irwin[116]	[See Table D 1 for detailed information on what is covered and for who] DAHR services in Sweden are publicly-funded through the tax-funded healthcare system. The care fee for the patient in connection with assisted reproduction is determined by the County Councils in accordance with Section 26 and Section 26a of the Health and Medical Services Act. Although IVF is available in both public and private settings in Sweden, treatments involving donated gametes may only be provided at university hospitals, effectively excluding private providers from the provision of sperm and egg donation.[300] In the public sector the costs of the visits and medicine are capped at 3 500 SEK (US$413). In the private sector, a round of IVF is around 45 000 – 50 000 SEK (US$5158 - US$5757) but medicine costs are subsidized and capped at 2 350 SEK (US$278) (amounts from 2020).[116]
UK ▪ Gilman and Nordqvist[288] ▪ Pennings[301] ▪ Taylor et al.[310] ▪ Meads et al.[296]	[See Table D 1 for detailed information on what is covered and for who] There is currently no UK-wide funding policy for DAHR. Although sperm banking is widely available (though not necessarily funded), provision of the other techniques is patchy or absent. It is noted that sperm banking is usually available on the NHS and NHS funding may be available for embryo storage. However, this is not always the case and so services may only be available in the private sector. NHS funding for DAHR treatment costs varies across the country <u>Average Private Costs</u> **Intra-uterine insemination (IUI) with Donor Sperm** ▪ Typical private cost: £2,000 per cycle (approx. £800–£1,600 for IUI + ~£1,000 donor sperm). ▪ Donor sperm alone may cost £1,000 per vial, varying by: ○ preparation method (IUI-ready vs. unprepared) ○ screening intensity ○ motility ○ whether the donor is traceable (required for some imports). **In vitro fertilisation:** Approximately £5,000 per cycle (private clinic cost). **Donor eggs**: A cycle of treatment with donor eggs costs at least £9000.
England ▪ Guidance: NHS-funded IVF in England[80] ▪ Taylor et al.[103]	[See the UK and Table D 1 for detailed information on what is covered and for who] Integrated Care Boards (ICBs) provide NHS funding for assisted conception only when individuals meet the specific eligibility criteria. Where a patient does not meet the policy criteria or the intervention is not normally funded by the NHS, an application for clinical exceptionality can be considered via the ICB's Individual Funding Request (IFR) Policy and Process. The IFR is a request received from a provider or a patient with explicit support from a clinician, which seeks exceptional funding for a single identified patient for a specific treatment on the basis of their clinical individuality.[80, 317]
Northern Ireland	[See the UK and Table D 1 for detailed information on what is covered and for who]
Scotland	[See the UK and Table D 1 for detailed information on what is covered and for who]

▪ Assisted Conception Unit | Ninewells Dundee | Dundee ACU[40] ▪ Edinburgh Fertility Centre – NHS Lothian[88]	**Ninewells Dundee Assisted Conception Unit and Edinburgh Fertility Centre: Private cost Information** 1. Donor Egg Recipient Treatment (Known Donor) Cost: £8,500 Includes: Full consultations, screening, treatment planning, implications counselling, donor & recipient preparation, scans, monitoring, medication, egg collection, semen analysis, sperm preparation, embryo transfer, freezing of surplus embryos, human chorionic gonadotropin (hCG) test, pregnancy scan, one follow-up, first year embryo storage. Additional charge: sperm freezing (if required). 2. Screening of Known Egg Donor Cost: £1,900 Includes: Initial consultation, all screening tests, two sessions of counselling. 3. IVF and or ICSI with Donor Sperm Cost: £7,050 (+ £500 non-refundable deposit before first consultation) Includes: Full clinical pathway—consultation, blood tests, treatment planning, counselling, scans, monitoring, medication, egg collection, semen analysis, freezing/storage of donor sperm, preparation on treatment day, embryo transfer, freezing of surplus embryos, HCG test, pregnancy scan, one follow-up, first year embryo storage. Excludes: Donor sperm cost (price on request). 4. Shared Motherhood Cost: £8,100 Includes: Full pathway for both partners—consultations, blood tests, planning, counselling, scans, monitoring, medication, egg collection, sperm preparation, embryo transfer, freezing of surplus embryos, HCG test, pregnancy scan, one follow-up, first year embryo storage. Excludes: Donor sperm. 5. Donor IUI Cost: £1,010 Includes: Consultation, consents, scans, screening tests, bloods, sperm preparation, pregnancy scan, one follow-up consultation. Excludes: Donor sperm. Eligible groups: individuals, same-sex couples, sibling-use cycles. 6. Donor Embryo Recipient Treatment Cost: £4,500 Includes: Consultation, planning, full donor & recipient screening, scans, blood tests, medication, embryo transfer, pregnancy scan, implications counselling, one follow-up. 7. Storage Costs (After First Year) Renewal charges: 1 year: £275

	2 years: £525 5 years: £1,275
Wales	[See the UK and Table D 1 for detailed information on what is covered and for who]

Key: AHR = assisted human reproduction; DAHR = Donor assisted human reproduction; CNPMA = National Council for Medically Assisted Reproduction; CPAM = Caisse Primaire d'Assurance Maladie (France); GP = general practice; hCG = human chorionic gonadotropin; ICB = Integrated Care Board (England); IFR = Individual Funding Request (England); IVF = in vitro fertilisation; IUI = intrauterine insemination; MBS = Medicare Benefit Schedule (Australia); MIG = Municipal Infrastructure Grant (France); MSAC = Medical Services Advisory Committee (France); NHMRC = National Health and Medical Research Council (Australia); NHS = National Health Services (UK); SGB V = 27a of the German Social Code (Germany); UK = United Kingdom.

Table D 3 Summary of organisational information for publicly-funded DAHR services in selected countries.

Country Relevant documents	Organisational aspects
Australia ▪ Medicare Benefits Schedule[62] ▪ Services Australia: ART services[63] Item numbers for billing Assisted Reproductive Technology services[64] ▪ Dempsey et al.[110] ▪ Fernandez et al.[123] ▪ Tremellen et al.[94]	**Referral pathways for Medicare:** The general practitioner (GP) is the gatekeeper for referred services, in recognition that GPs play a major role in the primary care of their patients and should generally be the first point of contact in determining the treatment a patient receives. In relation to fertility service the GPs initiate investigations, manage early reproductive health concerns, and determine the need for referral to fertility specialists such as gynaecologists or AHR clinics. GPs may order early investigations (for example, pathology, imaging) and identify when specialist skills are required for diagnosis or treatment of infertility. The referral system was introduced to allow medical practitioners to refer patients to specialists where their specific skills and expertise are required to assist with the diagnosis and treatment of the patient. It is not intended to allow medical practitioners to refer patients to themselves. For a valid referral, a referring practitioner must: ▪ consider the need for the referral ▪ identify themselves as the referring practitioner ▪ explain the reason for the referral, including providing relevant clinical information about the patient's condition for investigation/opinion/treatment ▪ and/or management, and ▪ sign and date the referral. To claim Medicare refund for fertility services, including AHR and DAHR, patients must follow the same referral rules as for other specialist services as described above: ▪ a referral from a GP or a specialist gynaecologist and or obstetrician is required to initiate Medicare claims ▪ GPs issue 12-month referrals; specialist referrals are valid for 3 months when referring to a fertility clinic ▪ the referral must include all mandatory patient details and meet documentation requirements to qualify for Medicare payment. **Provider eligibility for Medicare:** To be eligible to provide a medical service which will attract Medicare benefits, or to provide services for or on behalf of another practitioner, practitioners must meet one of the following criteria: (a) be a recognised specialist, consultant physician or general practitioner; or (b) be in an approved placement under section 3GA of the Health Insurance Act 1973; or (c) be a temporary resident doctor with an exemption under section 19AB of the Health Insurance Act 1973 and working in accord with that exemption. **Timelines to access services:** A treatment cycle begins on either: ▪ The day super ovulatory drugs are started, or ▪ The first day of the menstrual cycle. A cycle ends either: ▪ No more than 30 days after it starts, OR ▪ The day after completion of the: ○ oocyte retrieval ○ embryo transfer

	○ sperm preparation for artificial insemination. **Patient level factors affecting timelines:** BMI ≥ 35 is identified as a contraindication to assisted fertility, recognising increased pregnancy and delivery risks and can add potential delay to access fertility treatment, particularly for women or birthing people with obesity. Clinics may require LGBTQI+ women to complete 2 or more IUIs before they can be classified as clinically infertile and eligible for further AHR. This imposes an additional timeline prior to accessing IVF or other advanced interventions.[110]
Denmark ▪ Trianglen Fertility Clinic: Fertility Treatment via a public health referral at Trianglen[46] ▪ LBK no. 902 of 23/08/2019: Executive Order on the Act on Assisted Reproduction in Connection with Treatment, Diagnostics and Research, etc.[19] ▪ BEK No. 316 of 27/03/2019[20] ▪ New agreement provides twice as many fertility attempts for child number two[43] (and implementation agreement[44] ▪ New agreement to help involuntarily childless people get pregnant[41] (and implementation agreement[42])	**Referral pathways:** In Denmark, the man within the couple (where appropriate) must obtain a referral from his GP before beginning fertility evaluation or treatment. For same-sex couples, the referral requirements depend on who is undergoing assessment: ▪ If both partners wish to be evaluated, each partner must have an individual referral from her GP. ▪ If only one partner will begin fertility treatment, only that partner needs a referral. However, regardless of who receives treatment, the future co-parent must attend the initial consultation at the clinic. During this visit, both partners complete the required consent forms and receive information about the planned treatment process and responsibilities. In connection with the health professional assessment and decision on treatment with assisted reproduction, the treating health professional must consider whether there is any doubt about the ability of an individual or a couple to care for a child after birth. ▪ If the responsible healthcare professional assesses that there is doubt about the ability of an individual or a couple to care for a child after birth, the healthcare professional must, with the consent of the individual or couple, submit information to the Regional council with a request that the regional council make a decision on whether assisted reproduction treatment can be initiated. ▪ For the regional council's case processing, the treating healthcare professional must submit an explanation of the health professional's doubts about the individual's or couple's suitability for parenthood. In the event of a lack of consent from the individual or couple to the disclosure of information to the regional council must refuse to initiate treatment with assisted reproduction. The Regional Council shall decide whether assisted reproduction treatment may be initiated. The Regional Council may, with the consent of the individual or couple, involve other expertise in the assessment of parental suitability before making a decision. Other expertise may be the general practitioner, the social authorities or others. **Service provider characteristics:** The Government and the Danish Regions have agreed that, where regional needs indicate a capacity or resource gap, the regions may explore opportunities for collaboration with private fertility clinics. This may include entering into tender-based agreements or other formal partnership arrangements to ensure sufficient service availability and timely access to treatment. **Any other organisational aspects:** **Pre-implantation genetic diagnosis (PGD)** In Denmark, PGD is centralised and performed exclusively at two specialised public facilities: ▪ the Fertility Department at Rigshospitalet, and ▪ the Fertility Clinic at Aalborg University Hospital. In close collaboration with the Departments of Clinical Genetics at both locations. This centralisation ensures uniform national standards, genetic expertise, and quality assurance in PGD procedures. **Reporting requirements:** The healthcare professional responsible for treatment must report the outcome of assisted reproduction involving donated sperm or eggs to the relevant distributing tissue establishment within 14 days after a confirmed viable pregnancy is achieved.

	The report must include: ▪ The country of residence of the treated individual. ▪ An indication of whether the viable pregnancy is a sibling pregnancy conceived using the same donor previously used by the individual or couple. These reporting requirements support donor tracking, legal compliance, and monitoring of donor-related sibling limits. Women or birthing people treated with donated eggs should be informed that they should inform the prenatal diagnostic service that they are egg donors if pregnancy is achieved. This allows the risk assessment to be adapted to the donor's age.
France ▪ L'Assurance Maladie: Assisted Reproductive Technology (ART)[26] ▪ Biomedicine Agency: Procreation-medical.fr[27] and associated webpages. ▪ Public Health Code: Chapter IV: Donation and use of gametes (Articles L1244-1 to L1244-9)[29] ▪ Rozee and de La Rochebrochard[306]	**Referral pathways:** People likely needing AHR should first consult their general practitioner or usual gynaecologist. This clinician performs an initial assessment and, if necessary, provides a referral to a specialised fertility doctor or a multidisciplinary AHR centre. The assisted reproduction technique proposed by the medical team depends on the results of the clinical-biological assessments carried out by the couple or the individual. French law requires that the implementation of AHR treatment be preceded by several private interviews between the couple or the individual and the members of the centre's multidisciplinary clinical-biological medical team (Art. L.2141-10 of the Public Health Code). It provides for a reflection period of 1 month before signing the consent to AHR treatment. Doctors in the assisted reproduction centres must, in particular: ▪ check the motivation of both members of the couple or the individual ▪ conduct a medical evaluation of both members of the couple or the individual ▪ fully inform both members of the couple or the individual, in the light of the state of scientific knowledge, of the possibilities of success or failure of assisted reproduction techniques, their side effects and their short- and long-term risks. The couple or the individual may then be offered either artificial insemination or in vitro fertilisation (classic or with micro injection of sperm– ICSI, possibly with gametes from a third-party donor), or an embryo reception. Applications may be refused if age criteria (Decree of 28 September 2021) are not met or if treatment is deemed medically inappropriate. Reasons for refusal must be provided in writing upon request (Bioethics Act). **Required Documentation:** During an initial consultation for medical assistance, the following should be provided: ▪ an identity document ▪ a health card ▪ the entire medical file, containing all the examinations previously carried out: operative reports, hospitalisation reports and blood test results. **The France Biomedicine Agency outlined the following steps before contacting the sperm donation centre:** The AHR process with sperm donation involves several stages, in any order. The professionals to meet are the: ▪ doctor specialising in reproductive medicine ▪ practitioner of the AHR centre ▪ psychologist at the AHR centre, whose one-off consultation is highly recommended. His role is to accompany the patient in their parental project ▪ notary, for the signing of the consent (and advance recognition, if applicable).

	Psychological Support: A psychologist appointment is not mandatory; however, French law requires that the implementation of AHR be preceded by several private interviews between the couple or the individual and the members of the centre's multidisciplinary clinical-biological medical team. The doctors of the AHR centre must: ▪ check the motivation of both members of the couple or the individual ▪ carry out a medical evaluation of both members of the couple or the individual ▪ to fully inform, in the light of the state of scientific knowledge, both members of the couple or the individual of the possibilities of success or failure of medically assisted reproduction techniques, of their side effects and their short and long-term risks, as well as of their arduousness and the constraints they may entail. From the beginning of the treatment, an interview with a psychologist and or psychiatrist is offered to the couple or the individual and can be repeated throughout the process. Psychologists or psychiatrists in AHR centres are available to listen to couples or individual and can provide them with support. **Service provider characteristic:** Registration with multiple AHR centres is legally permitted; however, not recommended because registering at several centres simultaneously slows down waiting lists for both the patient and others. Patients may choose to receive treatment in private assisted reproduction centres, as this is fully allowed within the French AHR system. **Timelines to access services:** The time taken to cover medically assisted reproduction for couples or individual depends on many specific criteria such as: ▪ the results of the Fertility carried out by the Centre for Assisted Reproduction, ▪ the technique proposed by the centre's medical team, the use of a third-party donor, the centre's human resources, the centre's infrastructure, and so on. **The deadlines for sperm donation in the different donation centres:** Sperm donation includes a medical check-up as well as several sperm collections (the number of sperm collections will depend on the sperm characteristics: sperm count and motility). The centre organises appointments according to the availability of the candidate donor. The course can thus be completed in a few weeks or months. For people who have recourse to medically assisted reproduction with sperm donation, it takes an average of between 6 and 12 months between the start of the procedure at the donation centre and the allocation of the sperm to the couple or the individual. However, these delays may vary depending on the region and the requests for matching with recipient persons for which donors with the same physical characteristics are rarer. In order to reduce these delays, the Biomedicine Agency is conducting a vast national communication campaign on gamete donation in order to raise awareness among the public of donor age and thus recruit new donors. **The deadlines for egg donation in the different CECOS:** Egg donation takes place in 5 stages, and it takes on average less than 6 months for the entire procedure. For people who have recourse to ART with egg donation, it takes an average of between 12 and 30 months between the start of the procedure in the donation centre and the allocation of the eggs to the recipients. However, these delays may vary in the case of matching with recipient persons for whom donors with the same physical characteristics are rarer. This is why the Biomedicine Agency is conducting a national communication campaign on gamete donation in order to raise awareness among the public of donor age and thus recruit new donors.

	The location of the AHR: Clinical or biological activities of AHR may only be carried out in authorised establishments. Authorisations are issued by the director general of the regional health agency (ARS). ART is led by a multidisciplinary team: ▪ a gynaecologist-obstetrician or a gynaecologist or endocrinologist for oocytes and embryo transfer ▪ a urologist or a general surgical surgeon or an obstetrician-gynaecologist for sperm retrieval ▪ a medical biologist and a laboratory technician for AHR or AHR laboratory activities ▪ a psychiatrist, psychologist or nurse with expertise in psychiatry, if necessary if necessary, outside the centre, asked for the preliminary interview ▪ a social worker if necessary. **Waiting time:** Severe unmet need for egg donation: At the end of 2019, around 4,000 couples were waiting for egg donation, with 1,300 new registrations that year but fewer than 400 births achieved via egg donation—highlighting a major supply–demand imbalance. Increasing demand following the 2021 Bioethics Law as of 31 December 2022, nearly 5,600 people were waiting for AHR with donor sperm; 36% were same-sex couples and 38% individuals (74% representing the new legal public). The average wait time for sperm donation was 14.4 months, with large variations between centres due to uneven geographical distribution, service capacity differences, and reluctance from some providers to accept new patient groups.(306) **Any other organisational aspects** Couples and individuals can continue their medically assisted reproduction course in France when it has been initiated abroad if: ▪ the donation procedure has respected the principles of free of charge and anonymity (couples and individuals will have to obtain an authorization to import gametes or to move embryos issued by the Biomedicine Agency) ▪ the use of gametes is done in an authorized centre and in compliance with the age conditions specified by Decree No. 2021-1243 of September 28, 2021.
Germany Passet-Wittig et al.(299)	**Referral pathways** Fertility treatments are performed at specialized fertility clinics. Before going to a specialized clinic, it is common for women or birthing people to see a gynaecologist and men or people with male reproductive organs a urologist.
Portugal ▪ Law No.32/2006: Medically assisted procreation (Consolidated Legislation currently in force)(56) ▪ Law No. 12/2009: Establishes the legal framework for quality and safety relating to the donation, collection, analysis, processing, preservation, storage, distribution and application of tissues and cells of human origin, transposing into national law (Consolidated Legislation currently in force)(57)	**Referral pathways** ▪ Physicians are responsible for recommending the most appropriate AHR technique based on scientific evidence, especially when other treatments have failed or are unsuitable. ▪ Health professionals are not required to participate in ART procedures if they have medical or ethical objections, but must specify their reasons, such as conscientious objection. ▪ Referral to National Health Service (SNS) ART centres for couples or individuals is managed by primary health care or hospital entities within the SNS referral network. **Service provider characteristic** **Authorised ART centres** ART techniques (including those used in surrogacy) may only be carried out in public or private centres explicitly authorised by the Minister of Health. An authorised centre is defined as the set of human, material, and organisational resources required to perform AHR procedures, and must hold formal authorisation under Law No. 32/2006, as amended. Centres may be authorised to perform: ▪ all ART techniques,

▪ Ordinance No. 300/2024/1, of 25 November: Reimbursement of medicines intended for the treatment of infertility.[58] ▪ Regulatory Decree No. 6/2016, of 29 December: Regulates medically assisted procreation[59]	▪ artificial insemination only, or ▪ donor selection and gamete preservation. No activity relating to the collection of human reproductive cells and embryonic stem cells or other cells and tissues collected within the scope of the application of medically assisted reproduction techniques may be carried out outside authorised centres in accordance with the conditions established by the CNPMA under the provisions of article 5 and paragraph 2 b) of article 30 of Law no. 32/2006, of 26 July. **Timelines to access services:** The existence of different waiting times for AHR treatments is prohibited; this means public and private AHR centres may not differentiate waiting lists for: ▪ opposite-sex couples ▪ same-sex couples or ▪ individuals. Exceptions are permitted only when based on objective clinical-severity criteria, allowing prioritisation strictly for medical reasons. **Any other organisational aspects** **Importing reproductive cells:** The importation of reproductive cells can only be done by centres authorised to administer PMA techniques and with express authorisation from the CNPMA. To apply for authorization for the import of reproductive cells, the centres must submit the request to the CNPMA, by filling in the specific model created by the Council for this purpose. Centres must submit a formal request, including: ▪ A declaration of compliance with legal requirements (Law No. 12/2009). ▪ Proof of authorisation from the originating Tissue and Cell Bank. Import authorisations are valid for one year. Due to Portugal's non-anonymous donor legislation, the authorisation to import reproductive cells is limited to countries where access to the donor's civil identity is not legally impeded. As a result of the above, the CNPMA decided as follows: ▪ AHR centres may only request the import of gametes from European Union countries where there is a regime of non-anonymity of the donor(s) ▪ the effects of gamete import authorizations already granted are restricted to the import of gametes from non-anonymous donors. **Exporting reproductive cells:** The export of reproductive cells can only be done by centres authorized to administer PMA techniques and with express authorisation from the CNPMA. Although the shortage of reproductive cells has always been a reality of the PMA in Portugal (a panorama that, moreover, unfortunately has not undergone significant changes), export rules must align with the principle of national self-sufficiency and follow procedures outlined in Resolution No. 02/IV (27 October 2023). Centres must publicly notify all national ART centres of available gametes before exporting. If a national centre lacks compatible gametes, the exporting centre must supply them domestically. The distribution or export of reproductive cells shall contain the express identification of the institution of destination for inspection purposes. The receiving institution (in the case of European Union countries) must be registered in the Compendium of Tissue and Cell Banks of the European Union. **Transport of gametes and embryos between national centres:** In accordance with the provisions of the "Requirements and Parameters for the Operation of AHR Centres", the transport of gametes, gonadal tissue and embryos from one Centre to another must be carried out in a container suitable for the transport of biological materials and that guarantees the safety and quality of the material transported. The identification of the content must be accurate and in such a way as to prevent unauthorized alterations. The

	material transported must be accompanied by the information listed in the above-mentioned document. The receiving Site shall establish a procedure for receiving gametes, gonadal tissue or embryos from another Centre to ensure that: ▪ the requirements for specific information regarding the products received are met ▪ the products arrive in conditions suitable for their safety and quality. If the beneficiary chooses to transport the gametes and or embryos between Centres, in order to ensure the requirements of quality, safety and traceability, they will have to sign the Term of Responsibility prepared by the CNPMA. **Traceability:** AHR centres that select, evaluate and harvest reproductive cells from third donors and apply AHR techniques using third-party donation, shall have a system for assigning a unique number to each donation and to each product associated with it, integrated into the donor register; beneficiaries and children born using a third-party donation, created and managed by the CNPMA under the provisions of paragraph p) of paragraph 2 of article 30 of Law no. 32/2006, of 26 July, amended by Law no. 25/2016, of 22 August, in accordance with the provisions of Annex X of this law. All tissues and cells shall be identified by a label containing information or references that allow a link to the information referred to in Annex VIII to this Law, which forms an integral part thereof. **Medical teams** ▪ the director is responsible for the centre authorised to provide ART techniques, hereinafter referred to as the AHR centre ▪ the director of the PMA centre is a doctor specialized in gynaecology or obstetrics, medical genetics, endocrinology or urology, recognised by the Portuguese Medical Association, with a minimum of three years' experience in the area of PMA ▪ AHR centres shall have at least two doctors specialising in gynaecology or obstetrics, preferably with the sub-speciality of reproductive medicine, one of whom may be the director ▪ the experience of the director of the PMA centre is proven through the curriculum and measured by the CNPMA ▪ the provisions shall not apply to centres authorised exclusively for artificial insemination, nor to centres authorised exclusively for the selection of donors and the preservation of gametes. **Other health personnel** PMA centres shall have staff with experience and skills compatible with PMA, comprising at least two technicians holding a bachelor's degree or higher degree in the areas of medicine, biology, biochemistry or pharmacy. The provisions of the preceding paragraphs shall not apply to centres authorised exclusively for artificial insemination, nor to centres authorised exclusively for the selection of donors and the preservation of gametes. Centres dedicated exclusively to artificial insemination must have a team consisting of at least one gynaecologist or obstetrician and a licensed technician with experience and skills compatible with AHR.
Sweden ▪ National Board of Health and Welfare: Assisted fertilisation with donated gametes guidelines[33] ▪ Recommendations for homogeneity in county councils' and regions' publicly funded assisted reproduction offers[35]	**Referral pathways** To undergo publicly funded donor-assisted reproduction (donor sperm, donor oocytes, or double donation) at Swedish public fertility clinics, individuals must obtain a referral from a gynaecologist within the regional health system. For donor gametes or embryos, Swedish law requires a special assessment. This includes: ▪ Medical suitability ▪ Psychological and social assessment of the intended individual or couple ▪ Verification that the clinic and donor eligibility requirements are met. **Service provider characteristic**

▪ Act (2006:351) on Genetic Integrity, etc.[30] ▪ SOSFS 2009:32 Use of tissues and cells in healthcare and clinical research etc.,[31] and amendment[61] ▪ Elenis et al.[283] ▪ Volgsten and Schmidt[313] ▪ Lind[112]	**Psychosocial assessment:** A professional with behavioural science expertise should participate in the assessment of the couple's or individuals psychological and social conditions. The assessment should include interviews with the individual, the couple together, and each spouse, cohabitant or registered partner separately. **Insemination**: Insemination with sperm from a man or person with male reproductive organs to whom the woman or birthing person is not married or cohabiting may not, without permission from the Health and Social Care Inspectorate, be carried out other than at publicly funded hospitals. Such insemination shall be carried out under the supervision of a physician with specialist competence in gynaecology and obstetrics. **Fertilisation outside the body:** Fertilisation of eggs from a woman or birthing person, into whose body the egg is to be inserted, with sperm from the woman or birthing person's spouse or cohabitant may not be carried out except in publicly funded hospitals without permission from the Health and Social Care Inspectorate. This also applies to the insertion of the egg into the woman or birthing person's body. If the egg does not come from the woman or birthing person or the sperm does not come from the woman or birthing person's husband or partner, fertilisation and implantation of eggs may not be carried out without permission from the Health and Social Care Inspectorate, except at hospitals that have healthcare units where higher education for medical degrees and research is conducted. **Assisted fertilisation permission:** Private healthcare facilities performing assisted fertilisation for couples or individuals using donor gametes must obtain permission from the National Board of Health and Welfare Applications for permission must be submitted by the healthcare provider and include: ▪ purpose of the planned activity ▪ scope ▪ organisation ▪ management system. Name and qualifications of the medically responsible doctor. If the facility handles gametes under the Tissues and Cells Act (2008:286), a separate permit under that Act is also required. **Timelines to access services** Under the Patient Act (2015), patients may seek publicly funded outpatient MAR in any county and care must be prioritised by medical need, not residency. Public fertility clinics must start investigation within 3 months of first contact (Healthcare Guarantee). Access to donor assisted reproduction depends on donor gametes availability therefore, waiting times may be variable. **Any other organisational aspects** ▪ Open (identity-release) donation has been practiced for more than 30 years in Sweden and, until 2019, applied to treatments using either donor oocytes or donor sperm. ▪ A special assessment is required only for treatments involving donated gametes. When patients use their own gametes, no special assessment is carried out, and the child's future upbringing conditions are not evaluated. ▪ Only patients who have been denied treatment with donor gametes have the right to request review by the National Board of Health and Welfare as stipulated in SFS 2006:351. ▪ Applicants may be denied publicly funded donor-assisted treatment for various reasons, including: ○ Medical risks to the woman or birthing person, or the intended child ○ Lack of legitimate medical or psychosocial grounds for the treatment.
UK	**Referral pathways:** GPs is the first point of contact for couples struggling to conceive. The initial investigation of the infertile couple can be performed in general practice and is essential to ensure appropriate management and onward referral. These include

▪ Human Fertilisation and Embryology Authority[70] ▪ Fertility Network UK[71] ▪ Taylor et al., 2023	assessment of ovulation with mid-luteal progesterone and/or Anti-Müllerian Hormone (AMH) and day 2–5 Follicle-Stimulating Hormone (FSH), male factor with semen analysis and tubal status with Hysterosalpingography (HSG). Management strategies for primary care include obesity management and may include ovulation induction for a small cohort of infertile couples. Watchful waiting is appropriate for women or birthing people aged less than 36 years and where no cause for infertility has been identified following initial investigations described above. Following initial assessment couples with male factor infertility or tubal infertility should be referred to specialist units that can deliver IVF/ICSI treatments. **Service provider characteristic:** In the UK, donors cannot be paid beyond reimbursement for reasonable expenses. In 2022, the HFEA licensed 104 fertility clinics, 60% of which were privately owned, though most clinics, public or private, treat both NHS-funded and privately funded patients, with the NHS also contracting services from private clinics. Responsibility for determining access criteria historically lay with ICBs in England and similar roles are performed by Health Boards in Scotland and Wales and Local Commissioning Groups (LCGs) in Northern Ireland. The UK fertility sector has shifted from predominantly NHS-provided services to an increasingly private sector-level landscape, with many private companies owning multiple clinics. While NHS commissioning, including eligibility criteria, applies only to NHS-funded patients treated in either NHS or private clinics, privately funded patients are subject to contracts set directly between themselves and the clinic, all still operating within the national regulatory framework. Before pursuing donor conception, people are encouraged to explore the Donor Conception Network, a support community for people who have used donor gametes. Clinics typically offer counselling to help prospective patients work through the ethical, emotional, and practical aspects of donor treatment, and once a clinic is chosen, treatment options such as intrauterine insemination (IUI) or in vitro fertilisation (IVF) are discussed.
England ▪ NHS Cambridgeshire & Peterborough: Assisted Conception[73] ▪ North East London: Fertility Policy[74] ▪ NHS Staffordshire and Stoke on Trent ICB Commissioning Policy Assisted Conception for Infertility[75] ▪ Yorkshire and Humber Access to Infertility Treatment Commissioning Policy Document[76] ▪ NHS Lancashire and South Cumbria ICB Policy for Assisted Conception Services[77]	**Referral pathway:** Across the ICBs, referrals are typically made on a couple-based basis, and all commissioned fertility services must be delivered by approved providers operating within national legal and regulatory frameworks. **NHS Staffordshire and Stoke on Trent ICB:** Referrals to fertility treatment to have followed 2 years of regular unprotected intercourse (in the absence of any known cause of infertility) for opposite-sex couples or following 6 rounds of artificial insemination for same-sex couples. **NHS Yorkshire and Humber ICB**: For infertility treatment the care pathway begins in primary care, where the first stage of treatment is general lifestyle advice and support to increase a couple's chances of conception without the need for medical intervention. If primary care interventions are not effective, initial assessment such as semen analysis and female hormone profile will take place. Following these initial diagnostics, it may be appropriate for the couple to be referred to secondary care services where further investigation and potential treatments will be carried out, such as hormonal therapies to stimulate ovulation. It may be appropriate at this stage for the primary care clinician to consider and discuss the care pathway and potential eligibility for IVF. It may also be appropriate for healthy lifestyle interventions to be further discussed. If secondary care interventions are not successful and the couple fulfils the eligibility criteria, they may then be referred through to specialist care for assessment for assisted conception techniques such as IVF, DI, IUI, and ICSI. All clinically appropriate individuals or couples are entitled to medical advice and investigation, with referrals made as a couple and including demographic information for both partners in opposite-sex and same-sex relationships. **NHS North East London ICB:** Patients with a known clinical cause of infertility or relevant risk factors may be referred directly for specialist consultation, while others can be referred after 6 self-funded IUI cycles, or 3 cycles if the person trying to conceive is aged 36 or over. Where investigations demonstrate that expectant management cannot result in pregnancy and IVF is the only effective option, eligible patients may be referred immediately for NHS-funded IVF. Otherwise, IVF may be offered after 12 IUI cycles, or after 6 cycles for those aged 36 or over. The policy also notes that up to 6 NHS-funded IUI cycles may be available for eligible patients under

	sections 12 and 13 of the documents. Treatment limits are per couple and per individual. Referrals should be as a couple and include demographic information for both partners in opposite-sex and same-sex relationships. **<u>Timelines to access services</u>** **NHS Staffordshire and Stoke on Trent ICB:** Referrers must ensure patients are aware of the requirements for initial investigations and potential secondary care treatment and the implications of these. These stages may take up to 12 months before a referral to tertiary services can be completed. Referrers must be aware that if these early stages are not initiated with sufficient time prior to the woman or birthing person's 39th birthday, patients may be ineligible for tertiary services **NHS Cambridgeshire and Peterborough ICB:** Couples should be referred from primary care after 12 months of unexplained infertility, to be eligible for NHS-funded IVF requires at least three years of unexplained infertility (or two years for women or birthing people aged 36+) consisting of regular ovulatory cycles with unprotected intercourse or 12 cycles of AI within three years. Following miscarriage, a further three years of unexplained infertility (or two years for women or birthing people 36+) is required before IVF eligibility. However, couples with a diagnosed cause of absolute infertility—including significant tubal damage not amenable to surgery, premature menopause (amenorrhea >6 months with FSH >25 before age 40), male-factor infertility based on WHO semen reference values, endometriosis where IVF is advised, or infertility resulting from cancer treatment are granted immediate access to NHS-funded assisted reproduction. **NHS Lancashire and South Cumbria ICB:** Where there is a lack of donor eggs available patients who are eligible for treatment with donor eggs, in line with NICE recommendations, will be placed on a hospital waiting list, where these exist. Patients will be placed on the waiting list for an initial period of 3 years, after which they will be reviewed to assess whether the fertility policy
Northern Ireland ▪ Belfast HSC Trust. Regional Fertility Centre[82]	**<u>Referral pathways:</u>** The person needs to be referred by a GP or hospital consultant to access NHS services in the Regional Fertility Centre. There are 4 stages of fertility treatment (generally): ▪ Consultation – the referral from the GP or consultant is received, the person is contacted to arrange an initial consultation. ▪ Investigations – after the consultation, some further investigations are arranged to get more information. ▪ Review – once the results of these investigations are received, the RFC team will meet with the person to discuss the results and possible treatment options. ▪ Treatment – if treatment is appropriate, the person's name will then be placed on a waiting list. Referral for Medically Required Fertility Preservation (Female): Information to be provided: ▪ Clinical reason for referral (We do not accept referrals for social reasons) ▪ Age and parity ▪ Likelihood of infertility ▪ Date of commencement of treatment or surgery. If the patient has a long-term partner, they should also attend the appointment. Please provide Partner details (if applicable).
Scotland ▪ National Infertility Group Report (March 2016)[87] ▪ Edinburgh Fertility Centre – NHS Lothian[88] ▪ Glasgow Royal Infirmary Assisted Conception Service[38]	**<u>Referral pathways:</u>** Upon referral, clinics such as the Edinburgh Fertility Centre require previous test results and medical summaries, followed by an initial appointment involving assessments such as AMH testing, BMI and health checks, and review of cervical screening status. At Glasgow Royal Infirmary, first consultations are often conducted by phone, during which medical histories and BMI are taken, with follow-up in-person visits including scans and blood tests when necessary. Eligibility for NHS-funded treatment is determined by Scottish Government criteria, with patients generally able to access up to three cycles of IVF/ICSI. Referral for treatment can only be made if all access criteria are fulfilled, as noted below. Should the first cycle of treatment be unsuccessful all access criteria must be met before a subsequent cycle can commence. ▪ Infertility with an appropriate cause, of any duration ▪ Unexplained infertility of 2 years – opposite-sex couples

▪ Assisted Conception Unit | Ninewells Dundee | Dundee ACU[40]	▪ Unexplained infertility following six cycles of donor insemination All referrals must be GP led, supported by required investigations including cervical smear, chlamydia screening, ovulation testing, and semen analysis before specialist treatment can begin. **<u>Timelines to access services</u>** Couples should ideally be seen in secondary care within 12 weeks from referral from GP. Baseline investigations should be completed and simple treatment in secondary care ideally commenced, (for example, ovulation induction for ovulatory problem, ideally within 18 weeks). Examples of when the clock should be stopped include: ▪ diagnosis of unexplained infertility when treatment may be deferred until duration of infertility 2 years ▪ when access criteria not met ▪ when referred to tertiary care. **<u>Any other organisational aspects</u>** **Number of Attempts at IVF/ICSI:** Patients may undergo further IVF/ICSI attempts if the first cycle is unsuccessful, provided additional treatment is still considered beneficial. Those eligible for NHS-funded care are entitled to up to two cycles, or up to three cycles for patients referred from 1 April 2017, as long as they continue to meet eligibility criteria. After each cycle, a full review of outcomes is completed, and if clinicians determine that further treatment is unlikely to offer benefit, no additional cycles will be offered and NHS entitlement will be withdrawn. Notably, frozen embryo transfers do not count as separate cycles for NHS-funded patients. Transfer of frozen embryos is not counted as a separate cycle for NHS-funded patients. **How the eggs are shared:** If 12 or more eggs are collected, then they are shared between the donor and the recipient. If an even number of eggs is collected, each will receive half; if an odd number of eggs are collected, the extra egg is given to the donor. If less than 12 eggs are collected, splitting the number will not give a good chance of success to either the donor or the recipient. In this case the donor will keep all the eggs, in which case there would be no charge to the recipient. On the day of egg collection, the partner must provide a semen sample, and both individuals must ensure all consent forms are completed. Fertilisation results are confirmed the following day, with further updates provided on Day 3 and Day 5 of embryo development. Any embryos that reach suitable quality are frozen on Day 5 for potential future treatment through a Frozen Embryo Transfer cycle. Although clinicians aim to achieve an optimal number of eggs, this cannot be guaranteed. Importantly, a donor retains the right to withdraw consent to donate their eggs at any time before embryo transfer, and this includes any surplus embryos that have been frozen.[40] **Pre-implantation Genetic Diagnosis (PGD)** service is centrally funded by National Services Division (NSD) and was designated as a national service in 2005. The PGD service carries out genetic testing for foetal chromosome abnormalities at two Centres in Scotland – Glasgow Royal Infirmary, and the Royal Infirmary of Edinburgh. Approximately 30 NHS-funded PGD treatment cycles are carried out in both Edinburgh and Glasgow annually.[87]
Wales ▪ NHS Wales. Specialised Services Commissioning Policy: CP38 Specialist Fertility Services[89] ▪ Wales Fertility Institute[90]	**<u>Referral pathways:</u>** Patients who experience problems with fertility will attend their GP practice to discuss their options. The patients will normally be assessed within primary and secondary care. A woman or birthing person of reproductive age who has not been conceived after 1 year of unprotected vaginal sexual intercourse, in the absence of any known cause of infertility, should be referred to secondary care fertility services for further clinical assessment and investigation along with her partner. Patients with unexplained infertility who have not conceived after two years (this can include up to 1 year before their fertility investigations) should be referred for IVF treatment. However, there are a number of situations where referral before two years may be appropriate. Where investigations show there is no chance of pregnancy with expectant management and where specialised fertility services are the only effective treatment, refer the patient directly to a specialist team for IVF treatment.

This can include:
Pre-disposing factor: Where a woman or birthing person is 36 years or over, or there is a history of predisposing factors or disability for example, amenorrhoea, oligomenorrhoea, pelvic inflammatory disease or with men undescended testes. In these circumstances earlier investigation should be offered. A decision to refer a patient for specialised fertility services will be based on:

- The access criteria contained in this policy and the NICE guidelines which underpin them.
- Individual clinical assessment against clinical guidelines and patient suitability. The generic referral form, which assesses the patient's eligibility against the access criteria must be used by the referring clinician and countersigned by the tertiary centre.

Referrers should:

- discuss all the alternative treatment with the patient
- advise the patient of any side effect and risks of the potential treatment
- inform the patient that treatment is not routinely funded outside of the criteria in the policy and
- confirm that there is contractual agreement with WHSSC for the treatment.

Service provider characteristic
There are three providers of specialist fertility services for Welsh patients. These are:

- Liverpool Women's NHS Foundation Trust (The Hewitt Centre at the Liverpool Women's Hospital)
- The Shrewsbury and Telford Hospital NHS Trust (Shropshire and Mid Wales Fertility Centre at Shrewsbury Hospital)
- Abertawe Bro Morgannwg University Health Board (Wales Fertility Institute at Neath Port Talbot Hospital and Wales Fertility Institute at University Hospital for Wales).

Second cycle: Patients presenting for their second cycle will not be treated as a new referral. IVF, with or without ICSI, treatment is specifically excluded from the referral to treatment targets for clinical reasons, however any patient who is seen in clinic and deemed to be suitable for a second IVF cycle will be treated in line with the referral to treatment guidance for planned procedures, as in a maximum wait of 26 weeks following the new decision to treat being communicated to the patient. These waiting times are applied by all the providers providing a service to Welsh patients.

Timelines to access services
Waiting time Following referral into specialised fertility services patients should be offered an outpatient appointment within the 26-week referral to treatment target. As the normal waiting times targets do not apply to IVF treatment for clinical reasons the referral to treatment clock is stopped at the first attended outpatient consultation. Couples with unexplained infertility will only be listed for IVF, with or without ICSI, treatment if it is demonstrated that the couple has not conceived after 2 years (this can include up to a 1 year before their fertility investigations) of regular unprotected sexual intercourse. Couples must have been cohabiting in a stable relationship for a minimum of 2 years.
Same-sex couples and individuals with unexplained infertility will only be listed for IVF, with or without ICSI, treatment if it is demonstrated that they have not conceived following insemination at or just prior to the known time of ovulation on at least 6 non-stimulated cycles.
Patients should be treated in the order they were placed on the waiting list. However, patients can be expedited for treatment if there is clinical justification for doing so. Patients with the following clinical indications may be expedited: Endometriosis, tubal disease, infertility in the man or person with male reproductive organs or if the woman or birthing person is over 36 years of age. Clinics should have a robust documented process for expediting treatment. Patients presenting for their first IVF/ICSI cycle must wait for a minimum

	of 12 months before treatment as many will conceive normally during this period. This is applied by all the Clinics providing a service to Welsh patients. Couples can be expedited before the 12-month waiting time if there is a clinical justification for doing so.

Key: AHR = assisted human reproduction; AMH = Anti-Müllerian Hormone (UK); ARS = Regional Health Agency (France)**;** BMI = Body Mass Index; CECOS = Center for the Study and Conservation of Human Eggs and Sperm (France); CNPMA = National Council for Medically Assisted Reproduction; DI = Donor Insemination (England); FSH = Follicle-Stimulating Hormone (UK); HSG = Hysterosalpingography (UK); ICB = Integrated Care Board (England); ICSI = Intracytoplasmic Sperm Injection (England); IVF = in vitro fertilisation; IUI = Intrauterine Insemination; LCGs = Health Boards in Scotland and Wales and Local Commissioning Groups (UK); NHS = National Health Services (UK); NSD = National Services Division (England); PGD = Pre-implantation Genetic Diagnosis; PGT = Preimplantation genetic testing; PMA = Procriação Medicamente Assistida (Portugal) SNS = National Health Services (Portugal); UK = United Kingdom; WHSSC = Wales Health Specialised Services Committee

Table D 4 Summary of donor material management information for publicly-funded DAHR services in selected countries.

Country Relevant documents	Donor material management
Australia ▪ National Health and Medical Research Council: Ethical guidelines on the use of assisted reproductive technology in clinical practice and research[65] ▪ Medicare Benefits Schedule[62] ▪ Services Australia: ○ ART services[63] ○ Item numbers for billing Assisted Reproductive Technology services[64] ▪ ART Storage Funding Program and Guidelines[66] ▪ Rinehart[119]	**Arrangements for obtaining donated gametes or embryos** The National Health and Medical Research Council (NHMRC) ethics outline that treatment in Australia using gametes donated by persons living in another country must not take place unless it can be established that the gametes were obtained in a manner consistent with any Commonwealth legislation and any relevant state or territory legislation, accreditation body guidelines and the NHMRC Guidelines. Where a recipient has had a child born before the introduction of the Ethical Guidelines and gametes or embryos are in storage, within Australia, for the recipient's future use, the gametes or embryos may be used in the treatment of the recipient provided that the relevant requirements are satisfied. Some Australian states must approve the import or export of donor gametes and or embryos, and some centres refuse to accept commercially obtained donor gametes. **Storage of donated gametes or embryos** The NHMRC ethical guidelines outline a number of responsibilities for clinics when storing gametes or embryos (in general): ▪ **Maintain the safe storage and accurate identification of all gametes and embryos:** ○ clinics must have procedures in place to ensure all reasonable efforts are taken to maintain the safe storage and accurate identification of all gametes and embryos. All procedures should be consistent with current best practice. ○ clinics must ensure that all reasonable efforts are made to keep gametes and embryos in safe storage for the period of storage specified in the consent form. After this time, if the individual or couple responsible for the stored gametes and embryos cannot be contacted to provide further direction and consent, clinics may discard the gametes or embryos, in accordance with the clinic's policy. ▪ **Assess the suitability for continued (long term) storage of gametes and embryos:** clinics should have policies that guide the clinical determination for continued storage of gametes and embryos. ▪ **Stored gametes or embryos following death:** clinics must have clear policies for managing disputes that may arise between individuals for whom an embryo is stored. Unless prohibited by law, if a clinic receives confirmation that a gamete provider has died, the gametes or embryos should remain stored and made available for use, or be discarded, in accordance with the wishes of the deceased expressed in the consent for storage. **The Assisted Reproductive Technology (ART) Storage Funding Program** aims to reduce eligible patient's costs for preserving eggs, sperm, or embryos through cryostorage (freezing). The purpose of this program is to support patients from two population groups who face extra costs associated with fertility preservation: ▪ hold a valid Medicare card, and ▪ seek cryostorage of up to two cryostorage services of different material types as in, eggs, or sperm and embryos for fertility preservation due to a cancer diagnosis as evidenced by medical documentation, or of embryos for fertility preservation when there is a risk of passing on genetic conditions, and they have undergone pre-implantation genetic testing funded by the Medicare Benefit Schedule and

	▪ consent to their AHR clinic sharing their relevant personal information with the Department of Health and Aged Care and Services Australia in order to facilitate their participation in the program. Under this program, the federal Government will make a payment to subsidise the cost of cryostorage of eggs, sperm, and embryos for eligible patients for a maximum of ten years per patient and per material stored. This payment will be made directly to eligible AHR clinics using a payment system managed by Services Australia. Patients will not receive any payment directly. Patients may not be charged out of pocket costs for cryostorage subsidised by the program. **NOTE:** If an eligible patient's eggs, sperm, or embryos are donated to another individual, reproductive partnership or organisation, then from the date of transfer the cryostorage service is no longer eligible for subsidies under this program and cannot be claimed by the ART clinic unless the other individual is also eligible for the program. **However:** If a patient dies with embryos, sperm or eggs in cryostorage and legal arrangements are in place for transfer of ownership to another person, subsidies may continue until the first of the below takes place: a. ownership has been transferred, or b. for a grace period of up to 2 years, or c. until the material is donated or destroyed at the person's request, or d. until the original ten-year limit that applied to the deceased patient's cryostorage service is reached. ▪ Maximum storage times for frozen gametes exist in a few areas and are growing as egg freezing becomes more prevalent. In the Australian states of Victoria and Western Australia, gametes may be frozen for up to 10 years and 15 years, respectively. **<u>Access to and or disposal of stored donated gametes or embryos</u>** Where a donated embryo (including one created using donated gametes) is no longer required by the individual or couple to whom the embryo was donated, the embryo may be reallocated to another individual or couple, subject to any directions or limitations expressed as part of the consent from the embryo donors or imposed by law. **Responsibility for use, storage and discard of donated gametes** Recipients of donated gametes need to know who is responsible for the gametes and resulting embryos used in their treatment. At the same time, the right of the gamete donor to withdraw their consent for donation also needs to be protected. Clinics must maintain clear procedures for the transfer of responsibility for gametes and the resulting embryos at each stage: ▪ when the gamete donor has not specified a recipient for their gametes (unknown donation), the clinic has responsibility for decision-making about the allocation, storage and discard of the gametes, subject to any directions or limitations expressed in the consent of the donor. Once allocated, the responsibility for decision-making is transferred to the recipient. ▪ when the gamete donor has specified a recipient for their gametes (known donation), and consent for treatment has been given by the recipient, the recipient has responsibility for decision-making about the use, storage and discard of the gametes or resulting embryos, subject to any directions or limitations expressed in the consent of the donor. ▪ the clinic is responsible for maintaining the appropriate storage of donated gametes. **Responsibility for donated embryos** Recipients of donated embryos need to know who is responsible for decision-making about the embryos used in their treatment. At the same time, the rights of the embryo donors to place limitations on the use, storage and discard of the donated embryos and to

	withdraw their consent for donation also need to be protected. Clinics must have clear procedures for the transfer of responsibility for embryos at each stage: ▪ the embryo donors are responsible for decision-making about the use, storage and discard of an embryo whilst it is in storage awaiting donation to an identified individual or couple (known donation), or to another individual or couple (unknown donation) ▪ the clinic is responsible for maintaining the appropriate storage of an embryo ▪ in circumstances involving unknown donation, the clinic is also responsible for the allocation of an embryo to an individual or couple. ▪ once a recipient individual or couple has accepted a donated embryo, they are responsible for decision-making about its use, storage and discard, including decisions about the reallocation of an embryo, subject to any directions or limitations expressed in the consent of the donors or imposed by law. ▪ when an embryo is reallocated to a subsequent individual or couple, and they have accepted an embryo, that individual or couple is responsible for decision-making about its use, storage and discard, including decisions about the reallocation of embryos, subject to any directions or limitations expressed in the consent of the embryo donors or imposed by law. **Manage the discard of stored gametes and embryos** ▪ Clinics must have policies and procedures in place for discarding stored gametes and embryos. These policies should provide for the responsible parties to determine the means of removal or discard of the embryos from the clinic, including those which are legal, but are not available at the particular clinic. ▪ Clinics may, in limited circumstances, and in line with the clinic's policy, discard stored gametes or embryos without the consent of the individual or couple for whom the gametes or embryos are stored. Before a clinic may discard stored gametes or embryos without the consent of the responsible parties, clinics must make all reasonable efforts, and document all attempts, to notify the responsible parties and allow reasonable time for the responsible parties to take action.
Denmark ▪ ROAD no 9351 of 26/05/2015: Guidance on the activities and obligations of healthcare professionals and tissue establishments in the field of assisted reproduction[45] ▪ LBK no. 902 of 23/08/2019: Executive Order on the Act on Assisted Reproduction in Connection with Treatment, Diagnostics and Research, etc.[19] and all associated and relevant executive order and circulars including: ○ LAW No. 129 of 30/01/2021[21] ○ ACT No. 1212 of 26/11/2024[22]	**Arrangements for obtaining donated gametes or embryos** **Known donor (eggs):** When deciding on the donation of eggs from a known donor, it is the responsibility of the treating healthcare professional to test the donor's motives to ensure that the donation is truly voluntary. This is best done during an initial conversation with her where the intended recipient is not present, for example in connection with the donor interview, which, according to the provisions of the Tissue Act, must be conducted as part of the assessment of whether the donor is suitable. It should be discussed here whether the woman or birthing person is clear about her choice of donation form. If it appears during the interview that the woman or birthing person has felt under a certain amount of pressure, for example, that she does not feel able to refuse a request for donation from a friend, family member or similar relationship, and that she herself experiences that the act is not voluntary, then the woman or birthing person cannot be accepted as a suitable donor. This must subsequently be communicated to the intended recipient, without providing further details as to why the woman or birthing person is not considered suitable. This is done to avoid the cancellation having negative consequences for the relationship between the prospective donor and the prospective recipient. **Known donor (sperm):** If an individual seeking treatment or a couple seeking treatment wishes to use a specific sperm donor that the individual or couple themselves bring with them in connection with treatment at a regional council hospital, the hospital may refer to the fact that sperm donation, including testing and evaluation, must be carried out via an approved tissue centre (sperm bank). Expenses in connection with the approved tissue centre's (sperm bank's) testing and evaluation, are borne by the individual or the couple seeking treatment.

○ ACT No. 1213 of 26/11/2024[23] ○ BEK No. 1452 of 01/12/2025[24] ▪ Calhaz-Jorge et al.[13]	**Sperm donor (sperm bank):** When ordering from a sperm bank, the individual or couple reserves one of the 12 pregnancies for this donor. Once all 12 pregnancies have been reserved, the sperm bank will not provide further sperm from this donor until any reservations are released, for example because pregnancy was not achieved with this donor and the individual or couple does not wish to continue with this donor. The donor sperm will normally be purchased from the sperm bank by the individual or couple themselves or purchased through the fertility clinic, which in turn has purchased it from the sperm bank. Many individuals or couples today purchase donor sperm via the sperm bank websites and have it distributed to a fertility clinic. If a sperm bank has depots at fertility clinics (called "loan tanks") from which fertility clinics can purchase sperm straws, the sperm bank must, upon achieving 12 pregnancies for a donor, notify these fertility clinics that they may no longer use sperm from this donor for anything other than sibling depots. ▪ In cases where the number of pregnancies with eggs or sperm from one donor is at least 12, the tissue centre may exceptionally distribute eggs from a donor, provided that this is done solely for the purpose of using eggs from this donor to help with assisted reproduction for the purpose of having more siblings from the same donor, if the individual or one of the couple already has a child with a donor. ▪ Frozen eggs fertilised from one donor, where the number of viable pregnancies established with eggs or sperm from the same donor has subsequently exceeded 12, may, however, continue to be used. **<u>Storage of donated gametes or embryos</u>** Storage of human eggs (in general) may only take place for the purpose of: 1. later return to the woman or birthing person who donated the egg 2. donation for research purposes, or 3. donation with the aim of inducing a pregnancy in another woman or birthing person. However, the recipient of an egg may be determined or undetermined at the time of donation. Storage of semen (in general) may only be done for the purpose of: 1) to achieve a pregnancy either in the man or person with male reproductive organ's own partner or in another woman or birthing person, or 2) research. ▪ Denmark has a legal limit for the duration of storage of gametes and embryos of up to 46 years for a woman or birthing person. Individuals and couples often have the option of purchasing multiple sperm and storing them frozen for a fee at a sperm bank or fertility clinic. This is typically called "storing" the donor sperm, and the individual or couple becomes the custodian. The idea of purchasing and owning donor sperm, even if it is not to be used in the short term, may be, for example, to ensure that the donor-conceived individual can have full siblings at a later date in the future. Donor sperm owners are not allowed to sell or transfer their sperm to other individuals, couples, or other tissue centres. Such actions would be considered unauthorized distribution, which requires permission from the Danish Health Authority. However, donor sperm owners may sell any remaining sperm back to the tissue centre, provided the centre agrees to purchase it. Some tissue centres also offer customers the option to reserve sperm from a specific donor. In this case, it is not specific sperm that is purchased, but only the right to receive donor sperm from a specific donor. **Partner egg donation without medical justification**

	It is possible for couples consisting of two people with uterine or ovarian tissue to make use of partner egg donation without medical reasons. This means that if the couple consists of two women or birthing people, a woman or birthing person and a transmasculine person, or two transmasculine people, it will be possible to donate eggs to their partner, who will then carry the pregnancy and give birth to the child. The person who donates their egg to their partner will be considered a known donor. The same requirements will continue to be imposed for screening, assessment and treatment of the donor, among other things, as currently apply to partner egg donation for medical reasons. The treatment is offered at private fertility clinics against payment. **Access to and or disposal of stored donated gametes or embryos** There are no rules regarding the destruction of donor sperm. The previous requirement for destruction of the spouse's or partner's stored sperm in the event of death has been repealed. Whether stored sperm must in future be destroyed upon the death of the spouse or partner can be regulated by agreement between the man and the tissue centre (fertility clinic or sperm bank) where the sperm and or embryos are deposited. For example, an agreement can be made between the man and the fertility clinic or sperm bank to provide sperm to the deceased donor's partner for the purpose of assisted reproduction treatment, or to provide it to others. **Quarantine or ban of sperm:** Where an individual and or couple has purchased donor sperm from the sperm bank and subsequently has the donor sperm delivered for processing and possible storage in a depot at the clinic, the clinic must inform the recipient(s) of the permanent ban on use. When a sperm donor's sperm is subject to a permanent ban on use because there is a risk that the donor's sperm may transmit a hereditary disease, sperm from that donor may no longer be provided for fertility treatment of individuals or couples. The same applies if the number of pregnancies exceeds the maximum number (12, with geographical spread). An exception to this is, however, delivery via "sibling depot". This means that the individual or one of the couple can still receive sperm from this donor if they already have a sibling with this sperm donor. This also means that if a couple who have a child with the help of donor sperm get divorced, they can each have a child in their respective new relationship with the help of donor sperm. The same applies in cases for individuals or where both women or birthing people in a couple want to carry a child. **Destruction of gametes and or embryos:** Stored unfertilised and fertilised eggs must be destroyed in the event of the woman or birthing person's death. Fertilised eggs must also be destroyed in the event of the couple's separation, divorce or termination of cohabitation. **This does not apply where the fertilised egg is fertilised with donor sperm.** The above applies to all couples regardless of gender. Fertilised eggs can be used to establish a pregnancy after the man's death. The Danish National Board of Health recommends that a written agreement be entered into between the couple and the tissue centre storing the fertilised eggs regarding whether and, if so, under what conditions the fertilised eggs can be used after the man's death. **Other management information** **Reporting of viable pregnancies:** Fertility clinics are obliged to report viable pregnancies to the sperm bank after assisted reproduction with donor sperm. It is irrelevant how the sperm was purchased, as long as it was supplied by a Danish sperm bank. If there are full siblings from the same donor, the clinic must also report this. The fertility clinic must provide the country of residence when reporting. **Suspicion of hereditary risk:** in a donor arises when illness, death, developmental defect or serious malformation is detected in a donor child either during pregnancy, at birth or later during the child's upbringing, and where this may be due to genetic conditions in

	either the mother, a donor, or both, or where the circumstances may indicate that donor sperm may have been contaminated with infectious germs. The healthcare professionals who treat a child born with the help of sperm or eggs from a donor, or who treat a person who has donated sperm or eggs, have a duty to report genetic diseases in the child or person to relevant tissue centres and the Danish Health Authority. The duty arises from the moment the healthcare professional becomes aware that the child was born with the help of sperm or eggs or that the person has been an egg or sperm donor. This change has been implemented to improve the ability of tissue centres to initiate relevant follow-up on both genetic disease in a child born with the help of sperm or eggs from a donor (other than a partner) and genetic disease in a donor of sperm or eggs. The healthcare professional has a duty to make the report to the extent that the healthcare professional can identify the relevant tissue centres (for example, the fertility clinic used by the child's mother, or the sperm and or egg bank or fertility clinic where the donor donated sperm or eggs) and the relevant donor number. The healthcare professional is expected to either look up this information in the patient's medical record or request it from the patient. A report to the sperm bank, to the treating healthcare professional or to the Danish National Board of Health may therefore, depending on the circumstances, also come from a maternity ward, from a paediatric or clinical genetic specialist and or department where the examination has taken place, or from a general practitioner. **Serious adverse events or side effects:** that may have an impact on or be related to the quality and safety of tissues and cells and that can be attributed to the procurement, testing, processing, storage or distribution of tissues and cells. The report must be made to the Danish Health Authority. Authorized healthcare professionals who use gametes as part of patient treatment are, obliged to report serious adverse reactions of possible significance for the safety of the use of tissue and or cells from a donor to the Danish Health Authority and to the sperm bank from which the sperm was requested. An essential prerequisite for healthcare professionals to comply with this obligation is that the treating authorized healthcare professional or the sperm bank receives feedback on the occurrence of serious adverse reactions from the individual and or couples treated in question. It is therefore important that the individual and or couple is thoroughly informed about the importance of reporting a serious adverse reaction to the treating healthcare professional or the sperm bank.
France ▪ Public Health Code: Title IV: Medically assisted procreation (Articles L2141-1 to L2143-9)[28] ▪ Public Health Code: Chapter IV: Donation and use of gametes (Articles L1244-1 to L1244-9)[29] ▪ L'Assurance Maladie: Assisted Reproductive Technology (ART)[26] ▪ Biomedicine Agency: Procreation-medical.fr[27] and associated webpages ▪ Agopiantz et al.[273] ▪ Calhaz-Jorge et al.[13]	**Arrangements for obtaining donated gametes or embryos** The Public Health Codes outlines that the use of gametes from the same donor may not deliberately lead to the birth of more than ten children. **L'Assurance Maladie outlined that the allocation of gametes and embryos is according to the chronological order of registration of applicants:** Gametes and embryos are allocated according to the chronological order of registration of the applicants, as in the date of validation of the file. The criteria of marital status, sexual orientation, whether or not they have children, the designation by the applicants of a person who volunteers to make a donation to an anonymous third party, or the geographical origin of the applicants, may not lead to prioritisation, exclusion or restriction of access to donation. However, the allocation period takes into account the existence of a disease that could lead to a loss of opportunity if the AHR attempt is postponed, and the matching on certain medical risk factors (negative blood rhesus, for example) or the request by the recipient couple or the individual for a match based on physical criteria (skin, eye colour, of the hair), which is carried out as far as possible. **Gamete donation matching on physical characteristics:** Matching is not mandatory but it must be offered to the couple or to the individual receiving a gamete or embryos. This matching is carried out by the medical team of the AHR centre as far as possible. When requested, matching shall take into account, as far as possible, the main physical characteristics such as the applicants' skin or eye colour. Recipients are advised that this match is not always possible, given the rarity of certain physical characteristics among donors, and may result in long waiting times.

The rules for assigning gametes: By law information on the possibility of matching on the basis of physical criteria and its modalities is provided during interviews prior to AHR treatment. The physician will notify the recipients:

- that the match does not guarantee resemblance to the child
- and the resulting waiting times.

The individual or the couple then has a month to think about it before indicating their choice of whether or not to match.

Storage of donated gametes or embryos

France has no legal limit for the duration of storage of gametes and embryos (in general, not specific to donated gametes and or embryos).

Access to and or disposal of stored donated gametes or embryos

The Public Health Code outlines the following:

- the donor's consent is obtained in writing and can be revoked at any time up to the use of the gametes
- both members of the couple or the individual whose embryos are stored are consulted each year on the question of whether they are maintaining their parental project. If they confirm in writing that their parental plan is maintained, the storage of their embryos is continued.
- If they no longer have a parental project, both members of the couple or the individual consent in writing:
  1. to their embryos being received by another couple or another individual under the conditions set out in the Public Health Code
  2. that their embryos are the subject of research under the conditions provided for in the Public Health Code
  3. that the storage of their embryos be terminated.

In all cases, this written consent shall be confirmed at the end of a reflection period of three months from the date of the first consent. Failure to revoke consent in writing within this period shall be deemed to be confirmation.

- On the occasion of the annual consultation, the two members of the couple shall specify whether, in the event of the death of one of them, they consent to one of the possibilities for the fate of the preserved embryos. In the event of the death of one of the members of the couple, the surviving member shall be consulted, where appropriate, on whether they maintain their consent to the possibilities provided, after the expiry of a period of one year from the date of death, unless they take an early initiative. If the surviving member revokes their consent, the embryo storage is terminated.
- In the event that one of the two members of the couple or the individual, consulted annually on at least two occasions, does not answer whether or not they maintain their parental project, the embryo storage shall be terminated if the duration of the embryo is at least equal to five years. The same applies in the event of disagreement between the members of the couple on the maintenance of the parental project or on the fate of the embryos. The same shall apply in the event of a written revocation of consent. When both members of the couple or the individual have consented, to the reception of their embryos and they have not been received within a period of five years from the day on which this consent was confirmed, the storage of these embryos shall be terminated at the end of this period. In the event of the death of both members of the couple, of one of its members or of the individual in the absence of the consents provided, the storage of their embryos shall be terminated.

Both members of the couple or the individual may consent in writing to the retained embryos being received by another couple or another individual under the conditions provided for in the Public Health Code, including, in the case of both members of a couple, in

	the event of the death of one of them. Both members of the couple or the individual are informed of the legislative and regulatory provisions relating to the reception of embryos, in particular the provisions relating to access to non-identifying data and the identity of the third-party donor for persons conceived by AHR with a third-party donor. **<u>The Biomedicine Agency outlines a number of questions and answers in relation to AHR:</u>** ▪ **Surplus embryos if a person and or people no longer want a child:** When the person and or people concerned no longer wish to have children, several choices are available to them regarding the surplus embryos: ○ donate it to people waiting for gamete donation ○ donate it to scientific research ○ to stop their retention. Each year, a letter is sent by the AHR centre. This is a form that allows the person to express their choice regarding the continued conservation of their embryos. ▪ **Stopping storage of surplus embryos:** If a person and or people decides to stop the retention of embryos, the medical team at their AHR centre will destroy the embryos after thawing them. At any time, the person responsible for the embryos can decide to interrupt the parental project by sending a letter to the AHR centre. The embryos will then be destroyed. ▪ **Third-party donor in ART:** The third-party gamete donor (also called the donor) is the person who has donated the gametes (oocytes or spermatozoa) used by a couple or an individual for insemination or to conceive embryos as part of a parental project. At the end of the parental project, if the couple or the individual gives their consent, some of these embryos conceived from gametes from third-party donors can be offered at the reception (for example, given to another couple or another individual). For these embryos intended for reception, the following are considered to be third-party donors: ○ the donors of the spermatozoa and or oocytes that enabled their conception ○ the couple or the individual who has accepted that their embryos are hosted by another couple or another individual. ▪ **Gametes and embryos which can no longer be used from 31 March 2025:**The following are concerned: ○ gametes from third-party donors who have not accepted access to their identity and Digital National Identity (DNI) document ○ the embryos offered for reception but not yet allocated to another couple or another individual, from third-party donors of embryos who have not accepted access to their identity and DNI. ▪ **Gametes and embryos which can continue to be used from 31 March 2025. The following are concerned:** *Gametes:* ○ preserved for their own AHR journey, in the future, whether or not it is certain to date (for example, gametes preserved for autologous use) ○ from third-party donors who have consented to access to their identity and DNI. *Embryos:* ○ conceived with the gametes of both members of the couple (for medically assisted reproduction pathways without recourse to a third-party gamete or embryos) ○ conceived with the gametes of one or two third-party donors who have consented to access to their identity and DNI

	○ conceived with the gametes of one or two third party donors who have not consented to access to their identity and DNI but have already been stored on 31 March 2025 by the centres for an already identified couple or individual (embryos so-called supernumeraries) ○ offered for childcare already all located to a couple or an individual on 31 March 2025 ○ offered for reception not allocated to a couple or an individual but for which all the third-party donors have consented to access to their identity and DNI. For "supernumerary" embryos and embryos allocated to beneficiaries, a certificate must be signed by the couple or individual stating that they are aware that the children born from the use of these embryos will not be guaranteed to be able to access, when they reach the age of majority and if they so wish, the identity and non-identifying data of the third-party donor. ▪ **Certificate to be signed:** AHR centres are responsible for signing this certificate by the couple or the individual. Thus, depending on the organisation of each AHR centre, the certificate may be signed: ○ after delivery of an information letter to all couples or individuals who have embryos from third-party donors who have not consented to access to their identity and DNI, in the AHR centre ○ on the occasion of the annual reminder letter sent by the AHR centre for the continuation of embryo conservation ○ at the latest, before any embryo transfer from a third-party donor who has not consented to access to his or her identity and DNI. This signed certificate will be kept in the medical file of the couple or individual, which is itself kept within the AHR centre. A copy of this certificate is sent to the donation centre that issued the gametes. ▪ **Refusal to use embryos without guaranteed access to origins, after receiving the above information:** In this case, the couple or the individual does not sign the certificate. This choice implies that the couple or the individual completely renounces the use of these embryos. They may be donated to research or their conservation may be terminated (they may not be offered for reception to another beneficiary of an AHR). In compliance with the conditions applicable to AHR, in particular age conditions, other embryos may be conceived or given to this couple or individual thanks to third-party donors who have consented to access to their identity and non-identifying data.
Germany ▪ Act for the Protection of Embryos (Embryo Protection Act - ESchG)[53] ▪ Calhaz-Jorge et al.[13]	**<u>Arrangements for obtaining donated gametes or embryos</u>** Misuse of human embryos: 1. Anyone who sells or gives away, acquires or uses a human embryo produced extracorporeally or taken from a woman or birthing person before the completion of its implantation in the uterus for a purpose other than its preservation shall be punished with imprisonment for up to three years or with a fine. 2. Likewise, anyone who causes a human embryo to develop further outside the body for a purpose other than to produce a pregnancy shall be punished. 3. Attempting to commit this offense is a punishable offense. **<u>Storage of donated gametes or embryos</u>** Germany has no legal limit for the duration of storage of gametes and embryos [all, not specific to donated gametes and or embryos]. **<u>Access to and or disposal of stored donated gametes or embryos</u>** **Unauthorized fertilisation, unauthorized embryo transfer and artificial fertilisation after death** (1) Anyone who commits an offense against the law shall be punished with imprisonment for up to three years or with a fine.

	1. It undertakes to artificially fertilise an egg cell without the woman or birthing person whose egg cell is fertilised, and the man or person with male reproductive organs whose sperm cell is used for fertilisation has given his consent 2. it attempts to transfer an embryo to a woman or birthing person without her consent, or 3. knowingly artificially fertilises an egg cell with the sperm of a man or person with male reproductive organs after his death. (2) In the case of No. 3, the woman or birthing person undergoing artificial insemination shall not be punished.
Portugal ▪ Law No.32/2006: Medically assisted procreation (Consolidated Legislation currently in force)[56] ▪ Law No. 12/2009: Establishes the legal framework for quality and safety relating to the donation, collection, analysis, processing, preservation, storage, distribution and application of tissues and cells of human origin, transposing into national law (Consolidated Legislation currently in force)[57] ▪ Calhaz-Jorge et al.[13]	**<u>Arrangements for obtaining donated gametes or embryos</u>** **Buying or selling eggs, semen or embryos and other biological material:** The purchase or sale of eggs, semen or embryos or any biological material resulting from the application of AHR techniques is prohibited. **<u>Storage of donated gametes or embryos</u>** **Fate of sperm, oocytes, testicular tissue and ovarian tissue:** 1. Spermatozoa, oocytes, testicular tissue and ovarian tissue, which are collected and not used, shall be cryopreserved for a maximum period of five years. 2. At the request of the beneficiaries, in duly justified situations, the director of the AHR centre may assume responsibility for extending the period of cryopreservation of spermatozoa, oocytes, testicular tissue and ovarian tissue for a new period of five years, successively renewable for the same period. 3. Without prejudice to the extension of the period provided for in the preceding paragraph, after the expiry of the five-year period, spermatozoa, oocytes, testicular tissue and ovarian tissue may be destroyed or donated for scientific research if no other destination is given to them. 4. The destination of spermatozoa, oocytes, testicular tissue and ovarian tissue for the purposes of scientific research, may only be verified with the free, informed consent, expressly and in writing, of the original beneficiaries, through informed consent forms drawn up by the National Council for Medically Assisted Reproduction (CNPMA), presented to the responsible doctor. 5. Once the donation has been consented, without the spermatozoa, oocytes, testicular tissue and ovarian tissue having been used in a research project within 10 years of cryopreservation, they may be thawed and eliminated, as determined by the director of the AHR centre. 6. If donation is not consented to, as soon as any of the periods above have elapsed, spermatozoa, oocytes, testicular tissue and ovarian tissue may be thawed and eliminated, as determined by the director of the AHR centre. **Fate of embryos:** 1. Embryos which, do not have to be transferred, must be cryopreserved, and the beneficiaries undertake to use them in a new embryo transfer process within a maximum period of three years. 2. At the request of the beneficiaries, in duly justified situations, the director of the centre may assume responsibility for extending the period of cryopreservation of embryos for a further period of three years. 3. After the three-year period, without prejudice, embryos may be donated to other beneficiaries whose medical indication of infertility so advises, the decisive facts being subject to registration, or donated for scientific research. 4. The fate of the embryos provided for may only be verified with the consent of the original beneficiaries or of the surviving beneficiary, mutatis mutandis. 5. Embryos whose morphological characterisation does not indicate minimum conditions of viability shall not be subject to the above. 6. If donation is consented, without the embryos having been used by other beneficiaries or in a research project within six years of cryopreservation, they may be thawed and eliminated, as determined by the director of the centre.

	7. If donation is not permitted, as soon as any of the periods above have elapsed, the embryos may be thawed and eliminated, by determination of the director of the centre, previously communicated to the CNPMA. ▪ Portugal has a legal limit for duration of storage of gametes for 10 years, and embryos for 3 years (can be extended to 6 years). **<u>Access to and or disposal of stored donated gametes or embryos</u>** [See storage of donated gametes or embryos] **Post mortem insemination:** 1. In order to implement a clearly established and consented parental project, and after the period considered adjusted to the appropriate consideration of the decision, it is lawful, after the death of the husband or de facto partner: a) proceed with the post-mortem transfer of embryos b) perform an insemination with semen from the deceased person. 2. The provisions of the preceding paragraph shall apply to cases in which semen is collected, on the basis of a well-founded fear of future sterility, for the purpose of insemination of the woman or birthing person with whom the man is married or living in a de facto union and the donor dies during the period established for the preservation of semen. 3. Semen collected on the basis of a well-founded fear of future sterility, without consent having been given for post-mortem insemination, shall be destroyed if the person dies during the period established for its conservation. The period above shall not be less than six months, except for weighty clinical reasons duly attested by the doctor accompanying the procedure. Procedures must begin within a maximum period of three years from the death of the husband or de facto partner, and a maximum number of attempts may be made identical to that established for public centres. 6. Insemination with semen from the husband or de facto partner, as well as the post-mortem implantation of an embryo, may only occur for the realization of a single pregnancy resulting in complete and living birth. 7. Whoever so requests is provided with psychological support in the context of the decision to carry out post-mortem insemination, as well as during and after the respective procedure. **<u>Other management information</u>** **Reporting of serious incidents and adverse reactions:** In the case of AHR, any type of incorrect identification or exchange of gametes or embryos is considered to be a serious adverse event, and all persons and collection bodies responsible for its application in human beings that perform AHR must notify such incidents to the CNPMA.
Sweden ▪ Act (2006:351) on Genetic Integrity, etc.[30] ▪ SOSFS 2009:32 Use of tissues and cells in healthcare and clinical research etc.,[31] and amendment[61] ▪ National Board of Health and Welfare: Assisted fertilisation with donated gametes guidelines[33]	**<u>Arrangements for obtaining donated gametes or embryos</u>** **Known donor:** If the donation treatment is intended to be done with a known donor special focus should be placed on how well-thought out the decision is. If the donor is a close relative, it can be difficult to predict in advance how it may affect relationships and what it may mean emotionally for both the potential child and the parent as well as the donor. If a couple wishes to use gametes from a known donor, the doctor must therefore, among other things, examine the motives of the people involved for this and their ability to manage their mutual relationships in a good way in the future. The Act on Genetic Integrity regulates the process or donor selection and outlines that in the event of an insemination and or AHR treatment in a public clinic, the doctor selects the sperm, eggs and or fertilised egg. Eggs or sperm from a deceased donor may not be used for fertilisation. Nor may a fertilised egg (embryo) be used if the sperm or egg used for fertilisation originates from a deceased donor. Donor information must be recorded in a special journal. The journal must be kept for at least 70 years.

▪ Calhaz-Jorge et al.[13] ▪ Irwin[116]	Legally Swedish public clinics have the option of purchasing sperm from Denmark, as many private clinics do, but prefer to operate their own banks (in part to have control over the donor vetting process). Permission is also required from the National Board of Health and Welfare for frozen sperm to be brought into the country. **Storage of donated gametes or embryos** The Act of Genetic Integrity outlines that a fertilised egg may be stored in a frozen state for a maximum of ten years. An egg that has been the subject of a somatic cell nuclear transfer may be stored in a frozen state for a maximum of five years. The National Board of Health and Welfare may extend the periods. If consent is given, the National Board of Health and Welfare shall determine the additional period during which storage may take place. Consent may be subject to conditions. It may be revoked if the conditions are violated or if there are other grounds for revocation. The time during which the egg has been frozen is not included in the time during which testing may be carried out. ▪ Sweden has no legal limit for the duration of storage of gametes and a legal limit of 10 years for embryos. **Other management information** Assisted fertilisation: In the case of AHR, the woman or birthing person's medical record shall also contain information about: 1. which of the fertilisation attempts has led to pregnancy, and 2. the consent of the spouse, registered partner or cohabitant. The Genetic Integrity etc. Act there are provisions that in cases of assisted fertilisation where the donor and recipient are not married or cohabiting, a special record shall be kept to ensure the child's right to information about their genetic origin. **Serious adverse events and serious side effects:** The operations manager shall be responsible for ensuring that the tissue establishment that has distributed the tissues or cells that have been used on the recipient is notified without delay of: 1. serious adverse events that may affect the quality and safety of tissues and cells 2. serious adverse reactions suspected or observed during or after use that may be attributable to the quality and safety of the tissues and cells 3. detected transport damage that may have resulted in contamination of distributed tissues and cells, and 4. errors in packaging, packaging labelling or accompanying documentation (delivery note). **Infectious diseases:** If a contagious disease has been diagnosed or suspected in a recipient, the operations manager shall ensure that a report and an investigation are made.
UK ▪ National Institute for Health and Care Excellence (CG156) Fertility problems: assessment and treatment[69] ▪ Human Fertilisation and Embryology Authority[70] ▪ Fertility Network UK[71]	**Arrangements for obtaining donated gametes or embryos** Some clinics do not offer donor treatment or may only offer egg donation to those who are happy to use an anonymous donor from overseas. There are two main sources of egg donors: women or birthing people undergoing in vitro fertilisation (IVF) treatment who agree to share their eggs with a recipient or women or birthing people who offer to give their eggs for altruistic reasons. Egg donors should usually be no older than 35 years of age. Some women or birthing people may choose to use known donors, such as a sister or a friend, and this is permitted.

▪ Taylor et al.[310] ▪ Raperport et al.[303] ▪ Calhaz-Jorge et al.[13]	In a regulated setting, sperm is procured from donors recruited by the clinic's "in-house" bank (if they have one), or from a commercial sperm bank in the UK or abroad. Once the sperm has been selected and the recipient is ready for treatment, they may then undergo either intrauterine insemination or IVF. Donor sperm should be accessed through official channels and donors screened as recommended. Not only does this reduce the risk of blood-borne infection, it also helps conform to the 'rule of 10 families' and protects the donor from any legal or financial responsibility for the offspring. The UK 'rule of 10' precludes any donor from being the genetic parent to children in more than 10 separate family units. This limitation may not apply to sperm acquired from outside the UK. **The Human Fertilisation and Embryology Authority outline:** The couple or individual can choose to use a donor who they do not know by going to a fertility clinic. The couple or individual will not know the identity of the donor, but will be able to access anonymous information about them (such as height and eye colour) from the clinic. Alternatively, the couple or individual can use a donor who they already know or who have met via an introduction website. The couple or individual and the donor may either go to a fertility clinic or undergo a private arrangement (as in, the donor provides his sperm sample directly to them). **Storage of donated gametes or embryos** The UK has a legal limit of duration of storage of gametes and embryos of up to 55 years.
England ▪ North East London: Fertility Policy[74] ▪ Yorkshire and Humber Access to Infertility Treatment Commissioning Policy Document[76] ▪ NHS Lancashire and South Cumbria ICB Policy for Assisted Conception Services[77] ▪ Schedule of policy statements for ART for Kent and Medway ICB[78]	**Arrangements for obtaining donated gametes or embryos** **Kent and Medway Integrated Care Board (ICB):** will fund 1 transportation of genetic materials for patients who have undergone NHS-funded AHR treatments, but only where the receiving provider is undertaking National Health Service (NHS) funded AHR treatments using these materials. **Storage of donated gametes or embryos** **Kent and Medway ICB:** will fund 1 transportation of genetic materials and ongoing storage for patients who have undergone NHS-funded AHR treatments, but only where the receiving provider is undertaking NHS-funded AHR treatments using these materials. The total duration of storage of genetic materials funded by the ICB is two years for cryopreserved supernumerary embryos following each fresh cycle (following provision of IVF). Patients will have the opportunity to fund continued cryopreservation of any unused embryos for future self-funded frozen embryo transfer after the NHS-funded storage period concludes. **Lancashire and South Cumbria ICB:** ▪ The storage of gametes or embryos when AHR treatments produce more gametes or embryos than can be used immediately, the ICB will: ○ fund the freezing and storage of surplus eggs or embryos where AHR treatments have produced more eggs or embryos than can be used for immediate transfer to the uterus. However, eligibility for funding for ongoing storage will only be provided for the purposes of fertility preservation. ○ not provide funding for the storage of surplus sperm or semen except for the purposes of fertility preservation. **North East London ICB:** Cryopreservation of eggs, embryos and sperm will be funded for eligible patients who do not currently have fertility problems but are either: ▪ due to undergo a gonadotoxic treatment; this may include patients undergoing interventions for gender affirmation, or ▪ have a medical condition that, in their case, is likely to progress such that it will lead to infertility in the future.

	For patients aged under 32 years at the time of cryopreservation: storage of sperm, embryos and eggs will be funded until the patient reaches their 43rd birthday. For patients aged 32 and over at the time of cryopreservation: storage of sperm, embryos and eggs will be funded for 10 years duration. NHS funding of storage will end sooner where: ▪ fertility has been established through tests or conception, or ▪ the patient dies and no written consent has been left permitting posthumous use. To access assisted conception treatments using cryopreserved sperm, eggs or embryos, fertility preservation patients must meet the same eligibility criteria as other patients with fertility problems. An exception to this is that fertility preservation patients do not need to fulfil the ovarian reserve criteria to access IVF using their cryopreserved eggs or embryos. **Yorkshire and Humber ICBs:** [Note: in general, not specific to donated gametes] The cost of egg and sperm storage will be included in the funding of treatment for which it is required. Storage will be funded by the ICB for a maximum of 3 years or until 6 months post successful live birth, whichever is the shorter. This will be explained by the provider prior to the commencement of treatment. Following this period continued storage may be self-funded. Any embryos frozen prior to implementation of this policy will be funded by the ICB to remain frozen for a maximum period of 3 years from the date of policy adoption. Any embryo storage funded privately prior to the implementation of this policy will remain privately funded.
Northern Ireland	[See the UK]
Scotland ▪ NHS Scotland: Right Decision Service: Infertility[86] ▪ NHS Scotland Assisted Conception Units: ○ Edinburgh Fertility Centre – NHS Lothian[88] ○ Glasgow Royal Infirmary Assisted Conception Service - NHSGGC[38]	[See the UK] **<u>Storage of donated gametes or embryos</u>** **Storage period:** [Note: in general, not specific to donated embryos] If a person has any embryos or gametes in storage, please note that the storage period starts on the date of storage and the person has to have given consent to store for the duration specified on the treatment consent forms or gamete storage form. There is a legal obligation to review consent to storage forms at regular intervals and to thaw and or discard embryos if the clinic does not have valid consent to continue storage. The current statutory storage period is up to 55 years, with consent requiring renewal at 10-year intervals. The person seeking gamete storage will consent to store for up to 10 years initially. Extensions must be done before the current consent expires. If a person is storing embryos, both the sperm and egg providers must provide written consent to extend storage. There may be storage fees if it is a self-funding patient or the person or couple no longer meets the NHS Access Criteria. **<u>Access to and or disposal of stored donated gametes or embryos</u>** **Frozen embryos:** [Note: in general, not specific to donated embryos] When embryos are frozen as part of a treatment cycle, they can be stored for the time period consented to. Once ready to start an embryo transfer cycle there are a few steps to ensure you, the person and their partner are fully consented and meet the NHS access criteria. Should circumstances change and couples no longer meet the NHS eligibility criteria, self-funding for any future transfers will be required.
Wales	[See the UK]

Key: AHR = assisted human reproduction; ART = assisted reproductive technology; CNPMA = National Council for Medically Assisted Reproduction; DNI = Digital National Identity (France); ICB = Integrated Care Board (England); IVF = in vitro fertilisation; NHMRC = National Health and Medical Research Council (Australia); NHS = National Health Services; UK = United Kingdom.

Table D 5 Summary of governance information for publicly-funded DAHR services in selected countries.

Country Relevant documents	Governance
Australia ▪ Ethical guidelines on the use of assisted reproductive technology in clinical practice and research[65] ▪ ART Storage Funding Program[66] ▪ Parliament of Australia: Regulation of donor conception practices[208] ▪ Goedeke and Rodino[289]	Australia's broader Assisted Human Reproduction (AHR) governance (under which donor-assisted human reproduction (DAHR) falls) is shared through commonwealth, national, state and territory legislation, in which AHR clinics must comply. Furthermore, for AHR clinics to acquire accreditation from the Reproductive Technology Accreditation Committee (RTAC) clinics must also comply with the National Health and Medical Research Council's (NHMRC) Ethical Guidelines on the Use of Assisted Reproductive Technology in Clinical Practice and Research. Once accredited, AHR clinics must register their details with Services Australia, and will then enter into a Grant Agreement with the Department of Health and Aged Care. To received funding, all AHR clinics must: ▪ ensure their information in the Organisation Register remains up to date ▪ maintain a RTAC licence as evidence that they are compliant with industry requirements for providing safe and high quality cryostorage services ▪ notify Services Australia within 28 calendar days if they lose their RTAC Licence ▪ meet eligibility requirements ▪ engage fully in compliance activities undertaken by the Department or agents acting on the Department's behalf, and ▪ keep a copy of all documents relating to the ART Storage Funding program requirements for a minimum of 7 years. Clinics providing DAHR services are required to maintain accreditation as evidence that they meet professional standards relating to: ▪ donor screening ▪ infectious-disease testing ▪ counselling requirements ▪ recordkeeping, and ▪ open-identity donation obligations. In jurisdictions without donor-conception legislation, the NHMRC guidelines apply, informing clinics' responsibilities for information sharing, consent processes, and ethical donor management. State-based frameworks, including those in Victoria, South Australia, Western Australia, and New South Wales add additional governance requirements, including: ▪ mandatory donor registers ▪ identity release laws, and ▪ institutional oversight mechanisms for managing information and contact between donors, recipients, and donor-conceived people. **NHMRC Guidelines**: The NHMRC Guidelines set out ethical guidelines for clinical practice and research involving ART. With respect to donor conception, the guidelines describe appropriate practices in relation to: ▪ providing information and counselling to participants in ART ▪ record keeping ▪ the rights of donor-conceived people to information about their genetic parents and siblings, and ▪ limiting the number of people born using gametes from a single donor.

	While the NHMRC Guidelines provide guidance, they are not legally binding. However, in some cases, the NHMRC Guidelines are given legal effect through Commonwealth or state and territory legislation, or through agreements with Commonwealth bodies which require compliance with the guidelines.
Denmark ▪ Executive Order on the Act on Assisted Reproduction in Connection with Treatment, Diagnostics and Research, etc. (LBK no. 902 of 23/08/2019)[19] ▪ Executive Order on assessment of parental unfitness in connection with assisted reproduction treatment BEK no. 316 of 27/03/2019 (Current)[20] ▪ New agreement to help involuntarily childless people get pregnant[41] (and implementation agreement[42]) ▪ Catalini et al.[278]	In Denmark, AHR and DAHR are governed primarily by the Act on Assisted Reproduction which regulates sperm and egg donation, donor anonymity, donor limits, compensation, and data retention. Under this Act the Minister of Health may lay down detailed rules on egg and sperm donation, including anonymity and conditions for compensation, storage, and use, including the number of pregnancies per donor. ▪ The Danish Patient Safety Authority is authorised to lay down health professional rules for the donation, use, transfer and storage of human eggs and sperm. ▪ The Regional Councils make decisions regarding access to fertility treatment. These decisions may be appealed to the Danish Social Appeals Board, and the Council must inform the individual or couple of this right, with the Appeals Board issuing the final administrative decision. ▪ National monitoring is supported through mandatory reporting to the Danish IVF Register, which collects treatment-cycle and pregnancy-outcome data from all public and private clinics and links these with the Danish Medical Birth Register, ensuring population-level tracking of DAHR outcomes.
France ▪ Biomedicine Agency: Procreation-medical.fr[27] and associated webpages. ▪ Public Health Code: Title IV: Medically assisted procreation (Articles L2141-1 to L2143-9)[28]	The French Biomedicine Agency is a national agency under the Ministry of Health, created by the 2004 Bioethics Law. It oversees organ, tissue and cell harvesting and transplantation, as well as the fields of human reproduction, embryology and genetics. The Biomedicine Agency acts as the competent regulatory authority, ensuring that all activities within its scope comply with health and safety, ethical principles, and equity; it is the reference authority on the medical, scientific and ethical aspects of these issues. In terms of AHR, the Agency: ▪ manages national data on gamete and embryos ▪ manages authorisations of AHR techniques ▪ aims to improve access to AHR ▪ evaluates practices ▪ promotes egg donation and sperm donation. Finally, it is responsible for providing information to the general population, in close collaboration with health professionals. The Public Health Code also establishes a centralised, bioethics-based regulatory system in which AHR is strictly controlled by the State operating through: ▪ the Biomedicine Agency ▪ health establishments, medical biology laboratories and bodies authorised to carry out the relevant activities ▪ practitioners working in health establishments, medical biology laboratories and relevant organisations and ▪ any other relevant health professionals. The Public Health Code establishes the legal framework for all AHR activities, including the collection, storage, import, export, and utilisation of gametes and embryos, ensuring compliance with stringent bioethical, safety, and quality standards.

Germany ▪ Social Code Book 5: Statutory Health Insurance: Section 27a – Artificial insemination[52] ▪ Kentenich et al.[292]	The Federal Joint Committee (G-BA) is empowered to issue a guideline that regulates the details of the entitlement to benefits, as well as the requirements for doctors and reproductive medicine facilities, on behalf of the legislator. In the context of DAHR, the G-BA's governance influence lies in determining which fertility treatments are eligible for statutory insurance funding (as regulated by the Social Code Book), setting quality-assurance requirements, and defining clinical practice standards relevant to AHR procedures provided within the public system. The German Medical Association can establish the state of knowledge in medical science on the requirements for the medical assessment of medical suitability as a tissue donor, the examination of tissue donors and the removal, transfer and use of human tissue in guidelines and specify the various regulations at the statutory and sub-legal level. The "Guideline for the removal and transfer of human germ cells in the context of assisted reproduction", adopted by the Board of the German Medical Association on the recommendation of the Scientific Advisory Board, sets out the medical and scientific issues while clearly separating them from the socio-political aspects. The guideline is reviewed at least every 2 years by the Scientific Advisory Board of the German Medical Association, under the leadership of the Chairman of the Advisory Board, to determine whether they are up to date. The Sperm Donor Registry Act established a centralised, state-governed system for documenting donor-conceived people.
Portugal ▪ National Council for Medically Assisted Reproduction (CNPMA)[60] ▪ Law No.32/2006: Medically assisted procreation (Consolidated Legislation currently in force)[56] ▪ Law No. 12/2009: Establishes the legal framework for quality and safety relating to the donation, collection, analysis, processing, preservation, storage, distribution and application of tissues and cells of human origin (Consolidated Legislation currently in force)[57]	The National Council for Medically Assisted Reproduction (CNPMA) is the competent authority responsible for ensuring quality and safety in relation to the donation, collection, analysis, processing, storage and distribution of reproductive cells, and is responsible for monitoring the activity of the centres where AHR techniques are administered, and the centres where gametes or human embryos are preserved. The CNPMA supervise compliance with the legislation in Portugal. The CNPMA having overall governance in relation to the regulation of AHR centres including: ▪ updates to the scientific knowledge on AHR ▪ setting authorisation standards for AHR centres and gamete and or embryo banks ▪ monitoring and supervising ▪ evaluating new centre applications and suspensions ▪ overseeing stem-cell bank establishment and biological-material disposition ▪ approving research involving embryos ▪ authorising consent documentation for AHR beneficiaries ▪ providing donor-related information within legal limits ▪ centralising national donor, beneficiary, and offspring registries, and issuing case-by-case decisions on Human Leukocyte Antigen matched embryo selection. Inspections of AHR centres are carried out by the National Health and Safety Authority in conjunction with the General Inspection of Health Activities, but for reproductive cells and embryos these inspections are jointly carried out with the CNPMA.
Sweden ▪ Act (2006:351) on Genetic Integrity, etc.[30] ▪ National Board of Health and Welfare: Assisted fertilisation with donated gametes guidelines[33] ▪ Appelgren et al.[162]	AHR and DAHR in Sweden are governed through a national legislative framework, primarily through the Act on Genetic Integrity Act with implementation through the National Board of Health and Welfare (NBHW) together with the regional health authorities. Sweden also operates extensive mandatory national health registers, maintained by the NBHW and Statistics Sweden, which include the Medical Birth Register, National Patient Register and the National Quality Register for ART, enabling long-term monitoring of AHR outcomes and safety. Governance of AHR is further shaped by the Swedish Association of Local Authorities and Regions, which issues guidelines determining eligibility for publicly-funded care, complementing national legislation and NBHW standards.

▪ Elenis et al.[284] ▪ Elenis et al.[283] ▪ Irwin[116] ▪ Lind[122] ▪ McDermott et al.[151]	
UK ▪ Human Fertilisation and Embryology Act 2008[68] ▪ National Institute for Health and Care Excellence (CG156) Fertility problems: assessment and treatment[69] ▪ Human Fertilisation and Embryology Authority[70] ▪ Cavaliere et al.[126] ▪ Crawshaw et al.[281] ▪ Gilman and Nordqvist[288] ▪ Meads et al.[296] ▪ Raperport et al.[303] ▪ Taylor et al.[103] ▪ Taylor et al.[310]	AHR and DAHR in the UK is governed by Human Fertilisation and Embryology Act 2008 and regulated by the Human Fertilisation and Embryology Authority (HFEA), which: ▪ licenses clinics ▪ enforces identity-release donation and oversees donor screening ▪ maintains keeping, and ▪ maintains data reporting. All donor conception undertaken within the regulated system in the UK must take a place in HFEA-licensed clinics, which are required to meet the legal conditions set out in the Human Fertilisation and Embryology Act and the HFEA Code of Practice. NICE guidelines, including Fertility Problems: Assessment and Treatment (CG156), provide clinical guidance and psychosocial management of DAHR, however are not legally binding. Decisions about public funding of DAHR are made locally by Integrated Care Boards, contributing to significant regional variation in access.
England ▪ NHS Staffordshire and Stoke on Trent ICB Commissioning Policy Assisted Conception for Infertility[75] ▪ Guidance: NHS-funded in vitro fertilisation (IVF) in England[80]	[See UK for UK wide governance] Previously, Clinical Commissioning Group (CCG) areas made local decisions around their clinical commissioning policies. Since their establishment, Integrated Care Boards (ICBs) have been reviewing these policies to look at how they can be harmonised for all former CCG areas within their respective regions. However, where policies are yet to be harmonised, patients may continue to be treated under the existing policy of the CCG that covered the area they live in (for example, in Cheshire and Merseyside). This results in significant regional variation because: ▪ ICBs interpret NICE guidance differently ▪ budgets and priorities vary, and ▪ policies are written and approved locally (for example, the Staffordshire & Stoke-on-Trent ICB Assisted Conception Policy). NHS England sets the overarching policy and expectations that ICBs should use when organising AHR services. ICBs hold the legal responsibility for commissioning fertility and AHR services. Funding decisions, including: ▪ whether donor intrauterine insemination or donor in vitro fertilisation is publicly funded ▪ how many cycles are offered ▪ the eligibility criteria (age limits, BMI thresholds, prior children, and so on) ▪ whether same-sex couples or individuals must self-fund initial attempts ▪ whether private providers are commissioned for NHS treatment.
Northern Ireland	[See UK for UK wide governance]

▪ Eligibility for HSC (Health and Social Care Trust) funded IVF and related treatments effective from 1st June 2019[81] ▪ Belfast HSC Trust. Regional Fertility Centre[82]	▪ The Department of Health established formal links with NICE in 2006, whereby guidance published by NICE from that date would be locally reviewed for applicability to Northern Ireland and, where appropriate, endorsed for implementation in Health and Social Care (HSC). It is the responsibility of HSC organisations, to put in place the necessary systems, which should include adequate and comprehensive dissemination, as part of their clinical and social care governance arrangements, for implementing NICE guidance.[121] ▪ NICE guidance is proofed by the Department of Health to check for legal; policy and financial consequences related to its implementation in Northern Ireland. As a result, the guidance may be endorsed with caveats to advise local HSC organisations of any equivalent legislation and or policy or any specific instructions and or requirements. Following endorsement, the Department will issue a circular directly to the HSC Trusts and other relevant providers and stakeholders at the same time as the HSC Board and or Public Health Agency. ▪ The HSC Board ensures that relevant guidance is sent to the appropriate Family Practitioners. ▪ The Regulation and Quality Improvement Authority (RQIA) disseminates guidance to the independent sector as appropriate. The working assumption is that HSC Trusts will implement Clinical Guidelines within a further 9 months following the initial 3-month planning period after the Department of Health issued the guideline. The HSC Board will seek positive assurance that implementation has been achieved at bi-monthly director level meetings with HSC Trusts. ▪ RQIA will lead on assessing the implementation of Clinical Guidelines. The Department will require the HSC Board to formally report annually on the progress made generally in commissioning services in accordance with NICE guidance endorsed by the Department. Additionally, all AHR treatment in Northern Ireland is delivered through the Belfast HSC Trust's Regional Fertility Centre, the sole publicly commissioned AHR provider, which must comply with HFEA licensing, donor-identity rules, and HSC commissioning requirements.
Scotland ▪ National Infertility Group Report (March 2016)[87] ▪ Fertility Scotland (NHS Scotland National Strategic Network)[85]	[See UK for UK wide governance] Fertility Scotland is funded by the Scottish Government and ultimately responsible to the Scottish Government and the NHS Board Chief Executives to ensure delivery of improved care to patients and users of NHS Fertility Services in Scotland. The network consists of: ▪ the Oversight Board: provides overall strategic leadership, endorses recommendations from the Core Steering Group and ensures the network remains focussed on delivery ▪ the Core Steering Group: provides a forum for interchange between working groups, the Programme Management Team and relevant stakeholders. The group makes recommendations to the Oversight Board ▪ the Programme Management Team: oversees the day to day running of the Network, monitors progress and reports to the Core Steering Group and the Oversight Board ▪ the Working Groups: are established for each specific Project or Programme of work. Fertility Scotland aims to: ▪ promote consistent, equitable, high-quality fertility services across Scotland ▪ create national protocols and standards for fertility pathways ▪ support NHS Boards and clinics in service delivery ▪ facilitate sharing of best practice and clinical expertise.

	The Scottish Government is also funding Infertility Network Scotland an organisation which provides support to patients undergoing treatment, and work with NHS Boards, Clinics and Health Professionals to ensure a better patient experience. Infertility Network Scotland liaises regularly with all Health Boards and offer a service to provide patient representation at any Health Board meetings to discuss fertility services.
Wales ▪ Wales Fertility Institute[90] ▪ NHS Wales. Specialised Services Commissioning Policy: CP38 Specialist Fertility Services[89]	[See UK for UK wide governance] The Wales Fertility Institute (WFI) is an NHS facility managed by Swansea Bay University Health Board. All facilities providing AHR in the UK, including the WFI, are within the remit of the HFEA. Public access and funding, however, are nationally standardised in Wales through the Welsh Health Specialised Services Committee (WHSSC), which commissions fertility services for all seven Health Boards and sets country-wide eligibility criteria and determines which AHR and DAHR procedures are funded. Therefore, Welsh clinics deliver services in line with WHSSC policy and HFEA licensing conditions.

Key: AHR = assisted human reproduction; CCG = Clinical Commissioning Group; CNPMA = National Council for Medically Assisted Reproduction; DAHR = donor-assisted human reproduction; G-BA = Federal Joint Committee (Germany); HFEA = Human Fertility and Embryology Authority; HSC = Health and Social Care (Northern Ireland); ICB = Integrated Care Board; NBHW = National Board of Health and Welfare (Sweden); NHMRC = National Health and Medical Research Council (Australia); NHS = National Health Service; NICE = National Institute for Health and Care Excellence; RTAC = the Reproductive Technology Accreditation Committee; RQIA = Regulation and Quality Improvement Authority (Northern Ireland); UK = United Kingdom; WFI = Wales Fertility Institute; WHSSC = Wales Health Specialised Services Committee.

Table D 6 Summary of counselling, communication and information provision for publicly-funded DAHR services in selected countries.

Country Relevant documents	Counselling, communication and information provision
Australia ▪ National Health and Medical Research Council: Ethical guidelines on the use of assisted reproductive technology in clinical practice and research[65] ▪ Riggs et al.[304]	The Australian National Health and Medical Research Council (NHMRC) ethical guidelines provide extensive guidance on the information that should be provided to those undergoing AHR. They also recommend counselling for those involved in donation conception programmes. Despite this recommendation, there are no laws in any state which make joint counselling with donors and recipients mandatory, and there are no mandatory requirements for the content of counselling. Nonetheless, the Australian and New Zealand Infertility Counsellors Association has guidelines on counselling in relation to infertility. The revised guidelines specifically detail a minimum standards counselling protocol for embryo donation, which includes a minimum of two counselling sessions with all participants and their partners and, in the case of a known donation arrangement, a third session with all participants. Importantly, the guidelines go beyond the provision of procedural information, encompassing a diversity of topics that are recommended to be addressed in counselling for embryo donation (including reasons for donating, implications for children of donors, attitudes towards disclosure about donor conception, availability of support, and thoughts about contact between families). **The NHMRC ethical guidelines** **<u>Provide and discuss all relevant information - Individuals and couples involved in donor conception programs</u>** Clinics must consider the information needs of both donors and recipients. Clinics should ensure that the following information is discussed, the: ▪ possible implications and long-term psychosocial consequences of gamete or embryo donation for the donors and their families, the recipients and their families, and the person who would be born ▪ arrangements of the clinic for collection, storage and release of identifying information ▪ difficulties in finding gamete or embryo donors, including those related to specific preferences expressed by recipients ▪ scope of consent, decision-making responsibilities and the rights of each person involved to withdraw consent including the possibility that there may be unused gametes or embryos at the completion of the recipient's treatment and the possible options for these gametes or embryos ▪ ongoing responsibilities of each party to all other parties ▪ rights and responsibilities of the gamete or embryo donor and the intended parent(s) in the jurisdiction in which the clinic is located, or the gametes or embryos are used ▪ possibility that egg donation may affect the egg donor's own fertility. Potential gamete or embryo recipients need information about the potential gamete donor (or gamete providers in the case of embryos) that is relevant to the care of the person who would be born. Clinics must allow recipients of donated gametes or embryos access, through either a medical practitioner or an appropriately qualified health professional, to at least the following information about gamete donors: ▪ medical history, family history and any existing genetic test results that are relevant to the future health of the person who would be born (or any subsequent offspring of that person) or the recipient of the donation ▪ details of the physical characteristics of the gamete donor

	▪ the number, age and sex of persons already born from the gametes provided by the same gamete donor and the number of families involved. **Provide and discuss all relevant information - Individuals and couples seeking to store gametes or embryos:** ▪ the survival rate and suitability for transfer of gametes and embryos after freezing and thawing for the particular clinic ▪ the live-birth rate following the use of the thawed gametes, tissues and embryos for the particular clinic ▪ the currently available information about outcomes for persons born from stored gametes or embryos ▪ any limitations on use, specific to the clinic or the state or territory ▪ any limitations on storage times, specific to the clinic or the state or territory ▪ any circumstances under which the clinic may dispose of the gametes or embryos before the end of the consent period, including the clinic's policy for managing disputes that may arise between a couple for whom an embryo is stored ▪ the responsibilities of each party (including the clinic's) for stored gamete or embryos. **Provide counselling services - donor conception programs** Individuals and couples involved in a donor conception program must undergo counselling because of the complex nature of the issues involved. Counselling must include a detailed discussion of the following, the: ▪ potential long-term psychosocial implications for each individual and each family involved, including the person who would be born and any other child within the family unit(s) who may be affected by that birth ▪ potential significance of the biological connection, the right of persons born to know the details of their genetic origins, and the benefits of early disclosure ▪ potential long-term psychological implications for a person born from an embryo that has undergone multiple reallocations ▪ possibility that persons born may learn about their genetic origins from other sources (for example from family members or pathology testing) and may independently access information about their conception ▪ possibility that persons born may attempt to make contact with the donors in the future. The use of an embryo created using both donor sperm and a donor egg (double donation) may have an increased psychological impact on the person who would be born due to the range of biological connections and social relationships that would be created and the potential significance of these for any persons born. When double donation is being considered, counselling should acknowledge the complexity of this practice. **Information provision - Exchange of information between all relevant parties** There should be voluntary exchange of information between persons born from donated gametes, gamete donors and gamete recipients (the parents), with the valid consent of all parties. **Information provision - Support the right to know the details of one's genetic origins** Persons born from donated gametes are entitled to know the details of their genetic origins. Counselling received by potential gamete recipients must explore the potential significance of the biological connection, the right of persons born to know the details of their genetic origins, and the benefits of early disclosure. Whilst recipients cannot be forced to disclose this information to their children, clinics have a role in encouraging and supporting early disclosure. Clinics must: ▪ encourage gamete recipients to disclose to their children their genetic origins

	▪ provide ongoing support to parents, to help them to understand the potential significance of the biological connection and the benefits of early disclosure ▪ assist parents to find effective ways of disclosing to their children their genetic origins ▪ provide persons born from donated gametes with a supportive environment within which to explore the possibility of meeting with the donors and or siblings. **<u>Information provision - Provide persons born from donated gametes with information about the gamete donor</u>** A clinic that is approached by a person born from gametes donated at that clinic, who has reached the age of 18, must arrange for counselling by a professional with the appropriate training, skills, experience and competency to support their decision-making, prior to providing the following information, as a minimum: ▪ identifying information about the gamete donor ▪ any identifying information that any person born from the gametes of the same donor has consented to being released. A clinic that is approached by a person born from gametes donated at that clinic, who has not yet reached the age of 18, must arrange for counselling by a professional with the appropriate training, skills, experience and competency to support their decision-making and make a determination of the person's maturity and ability to appreciate the significance of the request (including any implications for any younger siblings).
Denmark ▪ ROAD no 9351 of 26/05/2015: Guidance on the activities and obligations of healthcare professionals and tissue establishments in the field of assisted reproduction[45] ▪ LBK no. 902 of 23/08/2019: Executive Order on the Act on Assisted Reproduction in Connection with Treatment, Diagnostics and Research, etc.[19] and all associated and relevant executive order and circulars including: ○ LAW No. 129 of 30/01/2021[21] ○ ACT No. 1212 of 26/11/2024[22] ○ ACT No. 1213 of 26/11/2024[23] ○ BEK No. 1452 of 01/12/2025[24]	**The following information requirements are contained within the legislation.** **<u>Consent</u>** Before AHR treatment written consent must be obtained from the woman or birthing person and from her possible spouse, registered partner or partner. **For the woman or birthing person:** ▪ written consent for the use of frozen, thawed fertilised human eggs must be obtained before each treatment cycle ▪ if storage of retrieved, unfertilised human eggs is carried out with a view to donation for research purposes or donation with a view to inducing pregnancy in another woman, the donating woman or birthing person must, before the storage takes place, give written consent to the storage. **For the man or person with male reproductive organs (where appropriate):** ▪ before treatment is initiated, the treating healthcare professional must inform the man or person with male reproductive organs that they can give their written consent to the woman or birthing person using their sperm or eggs fertilised with their sperm for AHR after the their death, and about the consequences of not giving consent to this. ▪ if the treatment is to take place after the man's death using his sperm or eggs fertilised with his sperm, the treating healthcare professional must first ensure that there is written consent from the man and that any conditions for the consent have been met. The treating healthcare professional must ensure that, before consent is given, information is provided about the civil law effects of the man's sperm or eggs fertilised with his sperm being used in assisted reproduction treatment after his death. **In general:** ▪ before storage of retrieved, fertilised human eggs takes place, the individual or the couple must give written consent to storage. The individual or the couple in question must be informed beforehand, verbally and in writing, about the consequences of the storage.

	The individual or the couple in question must also declare that they have been made aware of the terms and conditions for storage stipulated in the legislation. ▪ consent must also be obtained before allogeneic gamete donation. **<u>Written and oral information provided by the fertility clinic prior to AHR treatment (must also be available on the clinic's website).</u>** ▪ **Treatment effectiveness:** Information on the prospect of successful treatment outcome with AHR must, among other things, highlight the probability of achieving a viable pregnancy of a child with the treatment in question, calculated per treatment cycle started. The information must include conditions that are important for the individual prognosis, for example the woman or birthing person's age or a combination of several fertility-reducing factors in the couple. It is not sufficient to provide information on average success rates for a larger patient population. The information must, to the greatest extent possible, be based on the individual clinic's own achieved, documentable treatment results. In the case of AHR, the fertility clinic must provide information about the civil law consequences of the donation and the treatment, including in relation to paternity. ▪ **Treatment complications:** The fertility clinic must provide information about possible complications and risks of the treatment, such as the risk of overstimulation, infection, ectopic pregnancy, or multiple pregnancy. If there is no consensus in the relevant professional circles about the magnitude of the possible risks, this must also be mentioned. Individuals treated with donated eggs should be informed that they should inform the prenatal diagnostic service that they are egg donors if pregnancy is achieved. This allows the risk assessment to be adapted to the donor's age. ▪ **Infection and hereditary risk:** When treating in connection with heterologous egg or sperm donation and when selling sperm to private individuals in connection with home insemination, information must also be provided about the risk of infection and inheritance for the recipient and their future child. This obligation lies with both fertility clinics and sperm banks. Information must be provided about how donors are selected and tested for diseases and that it cannot be ruled out that the future child will inherit a disease when donating gametes, as not all hereditary diseases are tested or can be tested for. The individual and or couple must be informed about the importance of reporting back to the clinic if the unborn child is unexpectedly born with a disease that may be hereditary. **<u>It is assumed that in cases where PGD is offered counselling has been provided.</u>** A prerequisite for receiving sperm from a donor, where in this situation there is a known risk that a genetic disease may be transmitted to the child, is that the individual or couple is thoroughly informed about the risk of a possible known genetic disease and any consequences thereof, and on that basis consents to receive the sperm despite the risk. Sperm donors may be anonymous or non-anonymous. In connection with the use of an anonymous sperm donor, the tissue centre may only disclose information about the donor's skin colour, hair colour, eye colour, blood type, height and weight.
France ▪ Public Health Code: Chapter IV: Donation and use of gametes (Articles L1244-1 to L1244-9)[29] ▪ Biomedicine Agency: Procreation-medical.fr[27] and associated webpages.	Since 2022, the Commission for Access to Third-Party Donor Data for Persons Born from Medically Assisted Procreation has been responding to requests from people born from donation. This Commission is attached to the Ministry of Health and Prevention. A person who, when they reach the age of majority, wishes to access non-identifying data relating to the third-party donor or the identity of the third-party donor shall contact the commission. **Donor information the donor recipient can have access to:** The person resulting from a donation can have access to:

	Non-identifying data: ▪ age ▪ general condition at the time of donation ▪ physical characteristics ▪ family and professional situation ▪ country of birth ▪ motivations for their donation, written by them. Identifying data: The identity of the donor. This access is only possible if the donor who donated before September 2022 has agreed to have their identity and non-identifying data revealed to the person resulting from the donation who requests it. For people who made a donation after September 2022, this consent to access their identifying data and or identity for the people resulting from their donation is mandatory.
Germany ▪ Federal Ministry for Education, Family Affairs, Senior Citizens, Women and Youth: Fertility Information Portal[51]	The Fertility Information Portal: for rainbow families, there are also associations and counselling centres that specialise in the special legal concerns of these family constellations.
Portugal ▪ Law No.32/2006: Medically assisted procreation (Consolidated Legislation currently in force)[56] ▪ National Council for Medically Assisted Reproduction (CNPMA)[60]	**The following aspects of consent and confidentiality are regulated within Law No.32/2006:** **Consent** 1. Beneficiaries must give their free, informed consent, expressly and in writing, to the responsible doctor. 2. Beneficiaries shall be informed in advance, in writing, of all known benefits and risks resulting from the use of AHR techniques, as well as their ethical, social and legal implications. 3. The information shall be contained in a document, to be approved by the National Council for Medically Assisted Procreation (CNPMA), through which the beneficiaries give their consent. 4. The consent of the beneficiaries may be freely revoked by any of them until the start of the therapeutic processes of AHR. 5. The provisions shall apply to the surrogate mother, in which case her consent may be freely revoked until the moment of registration of the child born. 6. In the situations provided for, the beneficiaries and the surrogate mother shall also be informed, in writing, of the significance of the surrogate's influence on embryonic and fetal development. **Confidentiality** 1. Whoever, in any way, becomes aware of the identity of participants in AHR techniques, including surrogacy situations, is obliged to maintain confidentiality about their identity and about the act of AHR itself. 2. Persons born as a result of AHR processes using gamete or embryo donation may, from the competent health services, obtain information of a genetic nature concerning them, as well as, provided that they are 18 years of age or older, obtain information on the civil identification of the donor from the CNPMA. 3. Persons born as a result of AHR processes, using the donation of gametes or embryos, provided that they are 16 years of age or older, may obtain information on the possible existence of a legal impediment to a projected marriage. 4. 'civil identification' shall mean the full name of the donor. 5. Without prejudice, information on the identity of the donor may also be obtained for weighty reasons recognised by a court decision.

	6. The birth certificate may not, under any circumstances, including in situations of surrogacy, contain an indication that the child was born from the application of AHR techniques. As outlined in Consent, the CNPMA have produced Informed Consent forms for AHR procedures undertaken in Portugal.[318] The CNPMA outline that: Before starting the therapeutic processes of AHR, the beneficiary persons must give their consent expressly and in writing. For free and informed consent, the beneficiary persons must be properly informed about the known benefits and risks resulting from the use of these techniques, as well as their ethical, social and legal implications.
Sweden ▪ Act (2006:351) on Genetic Integrity, etc.[30] ▪ SOSFS 2009:32 Use of tissues and cells in healthcare and clinical research etc.,[31] and amendment[61] ▪ National Board of Health and Welfare: Assisted fertilisation with donated gametes guidelines[33]	The following is contained within Swedish legislation: **Consent:** The written consent of the spouse, registered partner or cohabitant to insemination being performed must be submitted. The spouse's, registered partner's or cohabitant's written consent to the transfer of a fertilised egg (embryo) into the body of the other spouse, partner or cohabitant must be submitted. If the fertilised egg has been stored in a frozen state, the consent of the spouse, registered partner or cohabitant must be obtained again. Once the physician responsible for the treatment has received the consent, they must confirm it by signing the consent document. The donor must also give written consent to the sperm being used for insemination. The donor may withdraw his consent until the insemination has taken place. **Information about consent:** The responsible physician shall inform the couple about the meaning of consent. Information shall be provided that: 1. the consent is valid until further notice from the date the consent document is signed 2. a revocation can be made orally or in writing 3. the responsible physician shall be immediately notified that consent has been withdrawn, and a revocation is valid from the time the doctor was notified about the recall. **Revoking consent:** If consent is revoked, the physician must confirm this by signing the consent document in connection with the notification of the revocation. The couple shall also be informed that consent from a donor of gametes, in cases where the donor is a person other than the spouse, registered partner or cohabitant, may be revoked until an egg has been fertilised. **Right to information** A person who has been conceived through insemination has, and who has reached sufficient maturity has the right to: ▪ access the information about the donor recorded in the hospital's special medical record ▪ access the information recorded in the special medical record and which relates to other persons who have conceived with sperm from the same donor. If someone has reason to believe that he or she has been conceived through insemination, the social welfare committee is obliged, upon request, to help him or her find out whether there is any information recorded in a special record. The National Board of Health and Welfare (NBHW) further outline information that should be provided related to AHR and or DAHR treatments. **The special examination to assess for eligibility for AHR**

	The examination: It may be useful to explain to the applicant that the examination is motivated by the fact that society assumes responsibility in donation treatment, primarily for the child, but also in relation to the donor. It can be reassuring for applicants to initially receive information about how the investigation is carried out and that it is carried out to meet children's needs for a safe upbringing. The investigation itself can be seen as an opportunity for applicants to reflect on and strengthen their readiness for parenthood. It can also be good to ask about applicants' expectations, concerns and beliefs before the investigation in order to be able to provide clarifications that can create trust in the contact. **The result of the examination:** The couple or individual should be given individually tailored information about the results of the special examination. If assisted fertilisation is not permitted due to what emerged from the examination, the doctor must provide information about the reasons why the treatment is not considered appropriate and that the couple or the individual can request that the NBHW review the matter. The decision not to allow assisted fertilisation and the reasons for this must be documented. The applicant can also receive information about how the decision is reviewed and contact details for the unit at the National Board of Health and Welfare to which the applicant can turn. **Information about telling children about their genetic origin:** The couple or individual needs to gain insight into and understand the importance and the benefits of telling the child about its genetic origin early on. In donation treatment, applicants often feel confident in their decision and are then also prepared to tell their child about its genetic origin. Nevertheless, it can be difficult for them to know when and how this should happen. Resistance can also arise, especially from the parent who has no genetic connection to the child, which is difficult to understand in advance. The basis for the parents to both want and be able to tell the child is that they are given good information about this in connection with the special assessment. An essential part of the information provided to parents consists of the reasons why the legislation gives the child this right and what we know from research about children's need to know. Conversations with applicants can involve a meeting between different value systems regarding views on children and what is discussed with children, children's rights and children's relationship with adults. This can be a good opportunity to explain that children's right to know their genetic origin follows from the Genetic Integrity.
UK ▪ Fertility Network UK[71] ▪ National Institute for Health and Care Excellence (CG156) Fertility problems: assessment and treatment[69] ▪ Human Fertilisation and Embryology Authority[70] ▪ Human Fertilisation and Embryology Act 2008[68]	**The National Institute for Health and Care Excellence Guidelines provide a number of recommendations for information provision.** **<u>Information provision</u>** ▪ people should be informed that the consumption of more than 1 unit of alcohol per day reduces the effectiveness of assisted reproduction procedures, including in vitro fertilisation (IVF) ▪ people should be informed that maternal and paternal smoking can adversely affect the success rates of assisted reproduction procedures, including IVF treatment ▪ people should be informed that maternal caffeine consumption has adverse effects on the success rates of assisted reproduction procedures, including IVF treatment. **<u>Information and counselling:</u>** ▪ couples should be offered information about the relative merits of intracytoplasmic sperm injection (ICSI) and donor insemination in a context that allows equal access to both treatment options ▪ couples considering donor insemination should be offered counselling from someone who is independent of the treatment unit regarding all the physical and psychological implications of treatment for themselves and potential children

	▪ all potential semen donors should be offered counselling from someone who is independent of the treatment unit regarding the implications for themselves and their genetic children, including any potential children resulting from donated semen ▪ oocyte recipients and donors should be offered counselling from someone who is independent of the treatment unit regarding the physical and psychological implications of treatment for themselves and their genetic children, including any potential children resulting from donated oocytes ▪ all people considering participation in an 'egg-sharing' scheme should be counselled about its particular implications. **<u>Providing information:</u>** ▪ couples who experience problems in conceiving should be seen together because both partners are affected by decisions surrounding investigation and treatment ▪ people should have the opportunity to make informed decisions regarding their care and treatment via access to evidence-based information. These choices should be recognised as an integral part of the decision-making process. Verbal information should be supplemented with written information or audio-visual media ▪ information regarding care and treatment options should be provided in a form that is accessible to people who have additional needs, such as people with physical, cognitive or sensory disabilities, and people who do not speak or read English. Within the Human Fertilisation and Embryology Act the following is also regulated: **A request for information as to genetic parentage etc.** Briefly this outlines that: ▪ once a person reaches the age of 16 they may apply to the Authority to confirm if they were donor-conceived, and if so may attain non-identifying information about their donor (a physical description, height, weight, eye and hair colour, the year and country of birth, their ethnicity, whether they had any children at the time of donation, how many and their gender, their marital status, their medical history, a personal description and goodwill message to any potential children (if they chose to write one at the time of their donation) ▪ the person may find out if other donor-conceived people exist from this donor ▪ the Authority will only provide information to a donor-conceived person if they have received proper counselling about the implications of compliance with their request ▪ once a person reaches the age of 18, they may apply to the Authority for their donor's name, date of birth and last known address. Additionally, specific to the donor, the Human Fertilisation and Embryology Act outlines that: ▪ donors will be notified when the Authority has received a request for donor information ▪ donors can access information on any resulting children from their donated gametes.
England ▪ Yorkshire and Humber Access to Infertility Treatment Commissioning Policy Document[76] ▪ NHS Staffordshire and Stoke on Trent ICB Commissioning Policy Assisted Conception for Infertility[75]	[See UK for UK wide requirements] **<u>Yorkshire and Humber Integrated Care Boards (ICBs)</u>** People should have the opportunity to make **informed decisions** regarding their care and treatment via access to evidence-based information. These choices should be recognised as an integral part of the decision-making process. Information should be provided in the following formats: ▪ face to face and remote discussions with couples ▪ appointments should be face to face if clinically indicated or patients' preference.

▪ Taylor et al.[103]	▪ written information and advice ▪ culturally sensitive and gender inclusive ▪ sensitive to those with additional needs for example, physical or cognitive, or those for whom English is not their first language ▪ sensitive to couples' needs and preferences. As infertility and infertility treatments have a number of psychosocial effects on couples, access to psychological support prior to and during treatment should be considered as integral to the care pathway. **Treatment for infertility problems** may include counselling, lifestyle advice, drug treatments, surgery and assisted conception techniques such as IVF. **Providers of specialist fertility services are expected to:** ▪ support appropriate interventions to promote lifestyle behaviour changes which are likely to have a positive impact on the outcome of assisted conception techniques and resulting pregnancies ▪ use any appointment or meeting as an opportunity to ask couples about their general lifestyle including smoking, alcohol consumption, recreational drug use, physical activity and eating habits. If they practice unhealthy behaviours, explain how health services can support people to change behaviour and sustain a healthy lifestyle to offer those who would benefit a referral to local wellbeing services and or locally commissioned lifestyle services. For those that are unable or do not want to attend support services direct them to appropriate self-help information to record this in the patient record or accepted local equivalent. **Counselling and Psychological Support**: As infertility and its treatment has a number of negative psychosocial effects, access to counselling and psychological support should be offered to the couple prior to and during treatment. **<u>Staffordshire and Stoke-on-Trent ICB</u>** The referring clinician must ensure that patients are aware of the implications of IVF and or ICSI treatment, and the commitment required, before making a referral to tertiary care for assisted conception. If there is any doubt over the couple's ability to make the necessary commitment to comply with the treatment regime, they must be referred for counselling, in the first instance, to establish whether assisted conception is appropriate for them. The referring clinician must ensure that couples are aware of the implications of IVF treatment and the commitments required before making a referral for assisted conception. Taylor et al.[103] noted that information on public funding for regulated donor insemination treatment is not readily available on UK fertility websites. The lack and inaccessibility of information provided on public funding for donor insemination treatment also made it difficult to decipher who is eligible for this funding, with only six websites mentioning funding for same-sex couples, and only two mentioning funding for individuals.
Northern Ireland	[See UK for UK wide requirements]
Scotland ▪ National Infertility Group Report (March 2016)[87] ▪ NHS Scotland Assisted Conception Units:	[See UK for UK wide requirements] All Centres in Scotland have their own independent counsellor linked to the tertiary Centre, which is more than the Human Fertilisation Embryology Authority (HFEA) legally require of each Centre. The Group is satisfied with counselling services that are provided in licensed clinics providing National Health Service (NHS) treatment in Scotland on a regular 9-5 basis. Infertility Network Scotland raised

○ Edinburgh Fertility Centre – NHS Lothian[88] ○ Glasgow Royal Infirmary Assisted Conception Service - NHSGGC[38]	concerns about the availability of crisis counselling. The Group agreed that patients should be signposted to out of hours crisis counselling already available, including NHS 2422 which provides advice for patients who feel anxious or depressed. Additionally, consideration should be given to developing specific information to give to NHS 2422 to help staff provide assistance to patients undergoing assisted conception treatment, who require help out of hours. **Glasgow Royal Infirmary** Counselling is available before, during and after treatment. Meeting with counsellors can offer a safe, discreet and quiet place where people can explore difficult feelings and find ways of making the situation more manageable. People can talk through their options, prepare for treatment or have support during or after treatment. **DAHR service specific:** For those who are considering treatment using donor eggs, sperm or embryos or who may be considering surrogacy, it is an HFEA requirement to meet with the counsellors to look at the implications of such treatment both in the short and longer term for both the adults and for the potential children who may be born through donor conception. For those considering becoming a donor either to help known recipients or as an altruistic donor, it is also an HFEA requirement to meet with one of the counsellors to explore the implication of donation. For both donors and recipients, this is a confidential and supportive service and can greatly help in making a positive decision for their future and reduce some of the fears and more difficult feelings which may arise. **How counselling is undertaken:** After being referred to the Assisted Conception Unit and being accepted as a patient of the service (including being on the waiting list for treatment), the patient can either ask to be referred to the counsellors by a member of clinical or nursing staff or can directly refer themselves. The counselling service is independent and confidential. There is no payment for counselling. Patients may need only one session of counselling or may decide, with the counsellors, that further sessions would be helpful. If patients are considering treatment with donor eggs, sperm or embryos, or thinking of becoming a donor, they will be referred by a member of staff to the counselling service prior to moving forward to treatment. **Edinburgh Fertility Centre** The service offers emotional support before, during or after, what can be a stressful time. Fear of treatment outcome, pain of loss and crisis of meaning are some of the issues people bring. Often it is helpful to simply talk through the treatment and look at options for the future with support and understanding. The aim of counselling is to encourage people to find their own solutions in a safe and supportive space. If a person is considering storing sperm, eggs or embryos for later use, or treatment using donated sperm, eggs or embryos, they will be asked to attend counselling to discuss the implications of their treatment. This special kind of counselling is called "implications counselling".
Wales Wales Fertility Institute[90]	[See UK for UK wide requirements] **Counselling** The impact of fertility issues and treatment can sometimes be overwhelming. Support from counsellors at any time throughout care can be comforting and provide additional support. Counselling is a requirement when having treatment that involves donated sperm or eggs, surrogacy or fertility preservation.

Key: AHR = assisted human reproduction; CNPMA = National Council for Medically Assisted Reproduction; HFEA = Human Fertilisation and Embryology Authority; ICB = Integrated Care Board (England); ICSI = intracytoplasmic sperm injection; IVF = in vitro fertilisation; NBHW = National Board of Health and Welfare (Sweden); NHMRC = National Health and Medical Research Council (Australia); NHS = National Health Services; UK = United Kingdom.

Table D 7 Summary of ethical and social considerations for publicly-funded DAHR services in selected countries.

Country Relevant documents	Ethical and social considerations
Australia ▪ Ethical guidelines on the use of assisted reproductive technology in clinical practice and research[128] ▪ Dempsey et al.[110] ▪ Fernandez et al.[123] ▪ Goedeke et al.[290]	**The National Health and Medical Research Council (NHMRC) ethical guidelines** [88] **Valid consent - Obtain consent from all relevant parties for each specific procedure – donor conception programs** Consent for participation in a donor conception program must include: ▪ provision of full details of the agreed arrangements including any limitations the donors have placed on the use, storage or discard of the embryos (including reallocation) ▪ provision of advice to all parties about the donor's biological connection to any person who would be born using donated gametes or embryos, the potential significance of this connection to the person born and the benefits of early disclosure ▪ obtaining an acknowledgment from each party that they have received and understood the information provided about gamete or embryo donation, including an acknowledgement of the decision–making responsibilities of each party ▪ obtaining specific consent from the donor to make relevant information available to the recipients and any donor-conceived person ▪ obtaining specific consent from the potential recipients to make the information available, on request, to the donor and an acknowledgement of their responsibility to the donor. Potential gamete or embryo donors and gamete or embryo recipients should be allowed adequate time for consideration of information and the complex issues involved before consent is obtained. **Recognise the right of individuals or couples to withdraw or vary their consent:** Clinics must recognise that, except for some specific issues relating to the donation of gametes and embryos, individuals and couples have the right to withdraw or vary their consent for AHR activities. **<u>Accepting and allocating gamete donations</u>** **Respect the donor's wishes** ▪ if the donor specifies recipients they know personally (known donation), clinics must respect the wishes of the donor unless the donation is prohibited by law or is contrary to the NHMRC Ethical Guidelines ▪ clinics must not accept donations from any donor who wishes to place conditions on the donation that the gametes are for the use only by individuals or couples from ethnic or social groups, or not to be used by ethnic or social groups. This type of donation ('unknown directed donation') is considered unethical on the basis that it is discriminatory and inequitable ▪ donors wishing to direct their donations to individuals or couples from ethnic or social groups can only do so through known donation. This also applies to gametes and embryos in storage that were not allocated to a specific individual or couple prior to the introduction of the NHMRC Ethical Guidelines [2017]. **Consider the physical, psychological and social wellbeing of each party when accepting or allocating gamete donations:** Clinics must not accept donations from children and young people (who are defined as 'minors' in each jurisdiction) for use by others in a reproductive procedure. **Donation from a relative:** ▪ the donation of gametes between relatives (for example, between sisters, from daughter to mother) may offer benefits to all parties involved, including the donor-conceived person. However, due to the possible influence the relationship, or the family, could have

	on the potential donor's decision to donate and the impact of potentially confusing family relationships, this practice requires special consideration ▪ clinics must not create embryos from gametes derived from close genetic relatives, as defined by relevant legislation. **Older donors:** Clinics must not create embryos from gametes derived from close genetic relatives, as defined by relevant legislation. The risk of an abnormality occurring in the person who would be born increases with the advancing age of the gamete donor. Therefore, clinics should not use gametes provided by older donors unless the potential recipient understands and accepts the implications and risks of proceeding with such an arrangement for the donor-conceived person. **Donors with an increased risk of infectious disease**: Clinics must meet regulatory requirements and have policies and procedures in place to minimise transmission of infectious diseases from the donor to the recipient or the donor-conceived person. These policies and procedures must be reviewed considering new evidence. **Limit the number of families created from a single donor:** Clinics must take all reasonable steps to minimise the number of families created through donated gamete treatment programs. Gametes from a single donor must be used to create only a limited number of families. in the absence of specific state or territory legislation, clinics must take account of the following factors when deciding on an appropriate number of families to be created: ▪ the number of persons already born from the donor's gametes ▪ the risk of a person born from donor gametes inadvertently having a sexual relationship with a close genetic relative (with reference to the population and ethnic group in which the donation will be used) ▪ any limitations on the number of families expressed as part of the consent of the donor ▪ whether the donor has already donated gametes at another clinic. In the absence of a national registry for gamete donation, to encourage disclosure of multiple donations at multiple clinics, potential gamete donors should be reminded of the importance of limiting the number of families created from a single donor. Prior to donation, clinics must: ▪ ask potential donors whether they have donated at other clinics ▪ obtain consent from potential donors to contact other clinics about any previous donations. **Respect the privacy of all parties involved in AHR procedures** When approached by a donor-conceived person who now seeks identifying information about their gamete donor, the clinic must examine the consent from the gamete donor and proceed as follows: ▪ if the consent form does not include permission for release of identifying information (because the donation was made before the introduction of the 2004 Ethical Guidelines and the gamete donor has not come forward in response to the public information campaign), the clinic should make all reasonable efforts, consistent with the original consent document and the privacy rights of the donor, to contact the gamete donor and request their consent to the release of their information. ▪ if the consent form includes permission for release of identifying information, the clinic should make all reasonable efforts to notify the gamete donor of the request prior to the release of the information. This process should not, however, unreasonably delay the release of such information to the person born. When approached by a donor-conceived person who now seeks identifying information about others born from gametes donated from the same donor, the clinic must examine the consent from the individuals involved and proceed as follows: ▪ if consent has been registered by the individuals concerned, the information may be released

	▪ if consent has not been registered, clinics must not release identifying information or contact the individuals. Clinics must provide the donor with access to counselling by a professional with the appropriate training, skills, experience and competency, as part of the preparation for the release of identifying information. **Withdrawal of consent for donation:** A gamete donor can withdraw or vary consent for donation at any time before the treatment cycle of the recipient commences, or at any time before the creation of an embryo, whichever is sooner. **Allocation of donated embryos - Support the right to know the details of one's genetic origins:** ▪ donated embryos (including those obtained from overseas) must only be used in reproductive treatment if all of the requirements for donated gametes are satisfied ▪ clinics must ensure that the genetic origin of the person who would be born is certain. This includes not transferring multiple embryos, at any one time, where the embryos have different genetic origins. **Donor practice is altruistic:** The HART Act (2004) stipulates that the commercial supply of human embryos or gametes is prohibited, and that 'no person may give or receive, or agree to give or receive, valuable consideration for the supply of a human embryo or human gamete', This position is similarly replicated across Australian states and territories, whereby commercial inducements are strictly prohibited by state legislation and federal guidelines. **AHR for all:** Provision of primary healthcare services should meet overall needs, of which fertility treatment is just one component. Fertility treatments should be equally accessible and equitable: ▪ a fertile woman or birthing person in an opposite sex couple who needs donor sperm to conceive but no other intervention is considered 'clinically' infertile within the guidelines and eligible for rebates, whereas a fertile intended birth mother in a same-sex couple is not. The implications of this distinction can be very costly ▪ lower rates of infertility encounters among those holding a Commonwealth concession card, current smokers and those living in regional and remote areas may reflect lower health literacy, lower rates of access to healthcare, and difficulty navigating services more generally.
Denmark	[see Appendix D, Table D. 6 for information regarding counselling, communication and information provision]
France ▪ Biomedicine Agency: Procreation-medical.fr[27] ▪ Agopiantz et al.[273] ▪ Rozee and Malmanche[307]	**The 2021 Bioethics Law:** The law of 2 August 2021 amends the legal provisions of AHR: ▪ it expands access to AHR to all couples and individuals ▪ it authorises the self-preservation of gametes without medical indication, and without prior donation conditions ▪ it gives new rights to people born from ART with a third-party donor. **The three main principles of gamete donation and embryo reception** Anonymity, free of charge and voluntary are the main principles on which gamete donation and embryo reception are based. These 3 main principles remain unchanged following the revision of the bioethics law in 2021. **The right of access to origins:** Donor-conceived people will be able, when they reach the age of majority, to have access to the identity of their donor but also to non-identifying information about them. Indeed, since September 1, 2022, the Commission for Access to Third-Party Donor Data for Persons Born from Medically Assisted Procreation (CAPADD) has been responding to requests

	from people born from donation. This Commission is placed under the Ministry of Health and Prevention, accompanied by a register, it collects data relating to people who have donated their gametes before September 1, 2022 who come forward to CAPADD in order to consent to access their non-identifying data and their identity. Please note that for people who donate after September 1, 2022, this consent is mandatory in order to help donor-conceived people in the quest for their origins. No parent-child relationship can be established between the person born from gamete donation or Embryos and the donor. **Anonymity hinders developments in equality of provision:** Anonymity has a corollary and the main motive on which was based on the prohibition of the oocyte reception method on or of the partner (reception of oocytes from the partner - ROPA). The main argument developed by the government during parliamentary debates on the revision of the Bioethics Law in 2021 against the legality of ROPA and taken up since then by the council of state ruled that it was a non-anonymous donation. Maintaining strict anonymity at the time of donation is therefore hindering, many developments of DAHR. Despite the revision of the Bioethics Law of 2021, which highlights the need to address the all parenting projects equally medical aspects of a parental projects by a single man is impossible, and so is that of transgender people remains complex, due to the ROPA bans. The revision of the law in 2021 provoked intense debates public and parliamentary, fed by the opponents of "ART for all" around the theme of "families without father" that the law would henceforth allow. These debates highlighted the "solo motherhoods" that merge outside the couple, thanks to sperm donation.[307]
Germany ▪ Bals-Pratsch et al.[276] ▪ Bauer and Meier-Credner[124] ▪ Beier et al.[125]	**Disclosure of Donor-Conception:** While studies have acknowledged that sharing knowledge on donor conception is generally not associated with negative outcomes for family relationships, it has been suggested that disclosing this information to a donor-conceived child at an older age might impair the parent–child relationship and evoke negative emotions from the child toward the parents due to perceived parental deception. Conversely, early disclosure has been reported to be advantageous for family relationships—or at least not detrimental. **Unequal treatment of the sexes:** In principle, the desire for egg donation on the part of affected couples in which the woman or birthing person does not have viable eggs is understandable. Sperm donation is legally possible, which raises the question of unequal treatment of infertile women or birthing people compared to infertile men or people with male reproductive organs. Men can establish fertility treatment, this option is denied to women or birthing people who, for example, can no longer produce their own eggs as a result of cancer. This unequal treatment of the sexes is difficult to justify.
Portugal ▪ Diario Da Republica Law No. 32/2006 of 26 July Medically assisted procreation[56] [2006] ▪ Baia et al.[120] ▪ Silva et al.[309]	**Dignity and non-discrimination:** ▪ AHR techniques, including those carried out in the context of surrogacy, must respect the human dignity of all persons involved ▪ discrimination on the basis of genetic heritage or the fact that one was born as a result of the use of AHR techniques is prohibited. However, health professionals, including those working in reproductive medicine in Portugal, tend to favour the prioritization of access for opposite-sex couples and married women or birthing people, revealing negative views on same-sex couples' and individuals parenting abilities. Heteronormativity is more often expressed by male health professionals, who, in so doing, contribute to the reinforcement of indirect and subtle barriers in the provision of healthcare (for example, lack of sensitivity, withholding of fertility services, absence of psychological screening).[120] **Beneficiaries' rights** The rights of the beneficiaries are: ▪ not to be subject to techniques which do not offer a reasonable probability of success or the use of which would entail significant risks to the health of the mother or child

	▪ to be assisted in a suitable medical environment that has all the material and human conditions required for the correct execution of the advisable technique ▪ be properly informed of the likely medical, social and legal implications of the proposed treatments ▪ to know the reasons that motivate the refusal of AHR techniques ▪ to be informed of the conditions under which it would be possible for them to have recourse to adoption and of the social relevance of this institute. In Portugal ethical discussion regarding the implication of gametes donation has revolved around three topics: ▪ accessibility to gamete donation ▪ anonymity and compensation regimes for donors ▪ and the responsibilities of professionals ▪ prioritization of alternatives such as adoption and primary-care prevention, and ▪ balancing autonomy with equity and child welfare.[309]
Sweden ▪ Appelgren et al.[162] ▪ Armuand et al.[274] ▪ Asplund[275] ▪ Elenis et al.[284] ▪ Lind[112]	**Educating Healthcare professionals on DAHR and its implications:** There is a need to develop educational resources for healthcare professionals in order to increase awareness of the practice and implications of embryo donation: ▪ healthcare professionals need to be aware of the diversity in family structures and provide culturally sensitive care. Culturally sensitive care includes the concepts of knowledge, consideration, understanding, respect and tailored care ▪ children born to older single mothers or conceived via AHR have higher morbidity rates and a greater need for specialist healthcare services compared to children born to partnered mothers. **Reproductive autonomy:** Ethical considerations that have evolved in the discussions on social oocyte cryopreservation have concerned reproductive autonomy, risks involved in egg retrieval, undue hope, risk of failure, and the need for truly informed consent. **Emphasis on appropriate conditions to raise a child:** The primary argument for assessing the psychological and social conditions of applicants for assisted reproduction treatment is based on the best interests of the child. People who are to undergo medical treatment aimed at making them parents must, according to the legislation, have the conditions to give the child a good upbringing.
UK ▪ Human Fertilisation and Embryology Authority[70] ▪ Human Fertilisation and Embryology Act 2008[68] ▪ Bracewell-Milnes et al.[127] ▪ Cavaliere and Fletcher[126] ▪ Gilman and Nordqvist[288] ▪ Meads et al.[296] ▪ Pennings[301] ▪ Taylor et al.[103] ▪ Taylor et al.[310]	**Anonymous donation:** Assuming they are aware of their donor conception, known donation enables children to contact, or ask questions of, their donor when they wish and not to have to wait until they are adults to do this. Legal change in April 2005 requiring sperm donors to provide their personal details in order for the child to know its origins, has meant that same-sex couples purchasing sperm can now only do this via a regulated clinic. **Discrimination of funding:** In the UK, only around 8% of donor insemination (DI) treatments among these patients are funded by the National Health Service. The systematic discrimination of these groups from public funding for fertility treatment is frequently hidden behind other criteria such as age and body mass index. While disparate funding for assisted conception (including DI) is most certainly a cause for concern, issues of funding accessibility are further exacerbated for marginalised groups, such as same-sex couples and individuals, who do not ascribe to the 'traditional' (as in opposite-sex) family structures which continue to dominate regulated fertility settings. However, recent Human Fertilisation and Embryology Authority (HFEA) figures show that same-sex couples and individuals are increasingly using regulated fertility services, and DI in Particular.

	Inequality of access **Unequal treatment for minorities**: A HFEA report, entitled "Ethnic diversity in fertility treatment 2018," published in 2021, highlights disparity in access to, and outcomes of, fertility treatment for ethnic minorities. From the HFEA data, and a comparison with statistics from the general population (also contained within the report), it is evident that white patients are overrepresented in regulated DI treatments (87% of UK population but 92% of DI treatments); Black patients are slightly underrepresented (3% of UK population but 2% of DI treatments), Asian patients are also underrepresented (7% of UK population but 3% of DI treatments) and those of mixed ethnicity are equally represented (2% of UK population and 2% of DI treatments). When sexuality and ethnicity are considered together, even more disparity is evident, with 96% of same-sex couples receiving DI being white. **Ageism:** Restricting access to women or birthing people aged thirty-five or forty is not due to the impossibility of successfully establishing a pregnancy in women or birthing people who are aged thirty-six or forty-one. Rather, it is based on the estimated chance of success. As such, considerations concerning clinical efficacy are paired with considerations concerning resource allocation. Without resource limitations, in vitro fertilisation (IVF) could be offered to a larger pool of older women or birthing people, many of whom would successfully become pregnant. The criteria used to dictate IVF access in the UK manifests ageism, but the age limit imposed on women or birthing people simultaneously represents a form of evidence-based practice, maximizing effectiveness. Thus, simplistic ageism and or age-discrimination conflations, and justified and or unjustified binaries, are incompatible with real-world complexities of fertility research and governance on men's age to discriminate access to state-funded fertility treatments. Men's age limits range between forty-nine and sixty, which are significantly more permissive limits than those typically imposed on women or birthing people. **Concerns over egg sharing**: First, there are concerns the donor is only agreeing to donate to gain access to much desired treatment, which brings into question the egg share donor's quality of consent. Second, there is concern for the psychological wellbeing of egg share donors whose own treatment is not successful. Egg sharers may regret their decision to share their eggs and may feel their treatment would have been successful if they had not done so, with these feelings potentially worsened by the knowledge that their matched recipient may have conceived their genetic children. Third, there is concern for the impact on the child psychologically if they were to discover that their parents indirectly paid a donor to contribute. **The donors rights to children conceived from their donation:** When having treatment at a licensed fertility clinic in the UK, the donor will have no legal rights or responsibilities to any children born with their sperm, eggs or embryos. This means: ▪ they will have no legal obligation to any children conceived from their donation ▪ they won't be named on the birth certificate ▪ they won't have any rights over how the child will be brought up ▪ they won't be required to support the child financially. If treatment is not conducted within a licensed clinic the situation is more complicated. There's a risk that the donor will be considered a parent by law – with all the rights and responsibilities that brings. **Same donor family limits:** In the UK, a donor's eggs, sperm, or embryos may only be used to create children in up to ten families. This limit doesn't include the donor's own family. This means donor-conceived people could have genetic half-siblings in up to nine other donor families, as well as any children the donor may have themselves. The 10-family limit is something that people using sperm donation are more likely to need to consider than those using egg donation. This is because it is rare for an egg donor to be

	used to create ten families. The 10-family limit does not apply to donors who donate outside of a licensed clinic through a private arrangement. Some donors may donate both privately and through a licensed clinic. UK donors who reach the 10-family limit here can still have their donations exported and used abroad, potentially creating more families outside the UK where different limits (or no limits) may apply. Individual sperm banks can discuss if and where donor sperm stored with them are used globally. **Note:** Donated eggs, sperm, or embryos imported into the UK may also be used in the country where they were originally donated and or exported to other countries, not just the UK. The 10-family limit does not apply to private donations made outside licensed clinics – also known as unregulated donation. Some donors may donate both privately and through a licensed clinic **Use of sperm, or transfer of embryo, after death of man providing sperm** If: ▪ the child results from embryo placement, sperm-and-egg placement, or artificial insemination ▪ the embryo was created using the man's sperm after his death or created before death but placed after his death ▪ the man gave written consent (not withdrawn) to posthumous use of his sperm or embryo placement and to being treated as the legal father ▪ the mother elects in writing within 42 days of birth (21 days in Scotland) for him to be treated as the father ▪ and no other person is treated as the child's father or parent under adoption law. The rules apply regardless of whether mother was inside or outside the UK at the time of treatment. When all criteria are met, the man's details can be entered in the official birth register.
England ▪ Yorkshire and Humber Access to Infertility Treatment Commissioning Policy Document[76] ▪ Tippett[99]	[See UK for UK wide requirements] **Yorkshire and Humber Access ICBs:** Equality the ICB is committed to creating an environment where everyone is treated equitably and the potential for discrimination is identified and mitigated. As a result of preforming the screening analysis, the policy may possibly have an adverse effect on people who share protected characteristics and further actions are recommended in the equality impact assessment. **The use of donor sperm outside of regulated clinics:** Invites a plethora of legal issues (alongside ethical and medical issues), where donors could, if they so choose, legally assume fatherhood of any children born and mothers could, if they so choose, seek financial assistance from donors (who, outside of licensed clinics, could be legally classified as fathers) until any child conceived reaches eighteen. **Equality of access:** Reproductive rights, which are considered human rights, come down to luck of location, age, sexual orientation, relationship status and existing family structure. The Integrated Care Board is committed to creating an environment where everyone is treated equitably and the potential for discrimination is identified and mitigated. As a result of preforming the screening analysis, the policy may possibly have an adverse effect on people who share protected characteristics and further actions are recommended in the equality impact assessment. Although not all the themes discussed relate to the protected characteristics of the Equality Act 2010, it is clear that where one lives; a person's sexual orientation; whether someone wishes to pursue parenthood as a single mother or father; whether someone has had a child or children from a previous relationship where infertility did not present as an issue; and those experiencing secondary infertility (where they have had a live birth in the past but have gone onto experience infertility when trying for another child), should not constitute unreasonable grounds for equal access to funding.[99]
Northern Ireland	[See UK for UK wide requirements]

Scotland ▪ NHS Scotland Assisted Conception Unit: ○ Edinburgh Fertility Centre – NHS Lothian[88] ▪ National Infertility Group Report (March 2016)[87]	**The risks of using donated sperm, eggs or embryos:** If donated gametes or embryos are used, the risks are minimised as much as possible. Donors must answer a series of questions designed to ensure that they are suitable. The donors' family histories for inherited diseases are checked. All donors go through stringent screening checks to ensure they are not carrying infections, such as HIV, Hepatitis B and C, cytomegalovirus, syphilis and gonorrhoea. Donated sperm and eggs (if not used fresh) is quarantined for three to six months whilst the donor is being screened. There are limits on the numbers of families created by each donor where donor gametes are used. Please be aware that although we carry out comprehensive screening, it is not possible to screen for every disease. If a person is considering using donated sperm, eggs or embryos they will be given further information about these issues. In addition, if treatment involves the use of donated gametes, the following will be discussed: ▪ a child's potential need to know about their origins and whether the parent is prepared for the questions which may arise while the child is growing up ▪ the possible attitudes of other members of the family towards the child, and towards their status in the family ▪ the implications for the welfare of the child if the donor is personally known within the child's family and social circle ▪ an explanation of who will be the legal parents of any child produced as a result of treatment with donated gametes these issues will be discussed in detail at the 'implications counselling' appointment which is a pre-requisite before donor gametes or embryos can be used. **Emphasis on appropriate conditions to raise a child:** No treatment services regulated by the HFEA may be provided unless account has been taken of the welfare of any child who may be born as a result (including the need of that child for supportive parenting) and of any other child who may be affected by the birth. **Equality of access:** National Health Service Boards should be reminded that there should be no discrimination in the provision of infertility services on the grounds of race, faith, gender identity, sexual orientation or disability.
Wales	[See UK for UK wide requirements]

Key: AHR = assisted human reproduction; CAPADD = Commission for Access to Third-Party Donor Data for Persons Born from Medically Assisted Procreation (France); DAHR = Donor Assisted Human Reproduction; DI = donor insemination (UK); ICB = Integrated Care Board (England); HFEA = Human Fertilisation and Embryology Authority (UK); IVF = in vitro fertilisation; NHMRC = National Health and Medical Research Council (Australia); ROPA = reception of oocytes from the partner (France); UK = United Kingdom.

Table D 8 Summary of legislation for publicly-funded DAHR services in selected countries.

Country Relevant documents	Legislation
Australia ▪ Understanding Medicare – Provider Handbook[111] ▪ Ethical guidelines on the use of assisted reproductive technology[65] ▪ Adams et al.[129]	Medicare is Australia's universal health insurance scheme. Through Medicare, the Australian Government subsidises all or part of the costs of many health services, including general practice, specialist services, surgical procedures, pathology tests, diagnostic imaging scans and allied health services. Medicare elements are contained in the Health Insurance Act 1973. The National Health and Medical Research Council (NHMRC) Act 1992 establishes the NHMRC as a national body to promote health standards and foster medical research in Australia.[128] It is noted that jurisdictional differences in legislation occur across states, for example: ▪ donor limits: Western Australia: 5 families; Victoria: 10 women or birthing people; New South Wales: 5 women or birthing people. Other states follow NHMRC guidelines stipulating that number of offspring per donor must be balanced with risk of consanguinity. ▪ embryo storage: Allowed for (10+ years), however only two Australian states currently have statutory time limits on embryo storage (Victoria and Western Australia) More broadly, assisted human reproduction (AHR) legislation in Australia, both nationally and via state also includes: ▪ Assisted Reproductive Technology Act 2007 (New South Wales) ▪ Assisted Reproductive Treatment Act 2008 (Victoria) ▪ Human Cloning and Embryo Research Act 2004 ▪ Human Reproductive Technology Act 1991 (Western Australia).
Denmark ▪ LBK no. 902 of 23/08/2019: Executive Order on the Act on Assisted Reproduction in Connection with Treatment, Diagnostics and Research, etc.[19] and all associated and relevant executive order and circulars including: ○ BEK No. 316 of 27/03/2019[20] ○ LAW No. 129 of 30/01/2021[21] ○ ACT No. 1212 of 26/11/2024[22] ○ ACT No. 1213 of 26/11/2024[23] ○ BEK No. 1452 of 01/12/2025[24]	Assisted human reproduction (AHR) is legislated by the following laws and amendments (information specific to donor-assisted human reproduction (DAHR) services has been noted): ▪ LBK No. 902 of 23/08/2019: Proclamation of the Act on Assisted Reproduction in Connection with Treatment, Diagnostics and Research, etc. This law governs the overall treatments included within AHR. ▪ Law No. 129: amending the Act on Assisted Reproduction in connection with treatment, diagnostics and research, etc. (Amendment of the permitted storage period for human eggs retrieved on medical indications) ▪ Act No. 1212: amending the Act on Assisted Reproduction in connection with treatment, diagnostics and research, etc. (Fertility treatment for second child) ▪ Act No. 1213: amending the Act on Assisted Reproduction in connection with treatment, diagnostics and research, etc. (Legalization of partner egg donation without medical justification). This amendment noted that DAHR may only be established where the use of both donated sperm and donated egg cell is justified on health grounds and either the sperm or the egg cell is donated in a non-anonymous form. ▪ BEK No. 1452: this amendment states that donation of fertilised human eggs is only permitted for research purposes. Donation of unfertilised human eggs may only take place if it is done for the purpose of to achieve a pregnancy in another woman or birthing person or research. Additionally, it outlines conditions around the use of known donors, the storage of human eggs, the number of viable pregnancies allowed when using donor gametes (12, with gametes recruited after 2013), and the number of times an egg donor can donate.

▪ ROAD no 9351 of 26/05/2015: Guidance on the activities and obligations of healthcare professionals and tissue establishments in the field of assisted reproduction[45] ▪ New agreement to help involuntarily childless people get pregnant[41] ▪ New agreement provides twice as many fertility attempts for child number two[43]	▪ BEK No. 316 of 27/03/2019 is an executive order on the assessment of parental unfitness that must be undertaken in order to access publicly-funded AHR treatment. It outlines the conditions upon which a person must be assessed for parental fitness in order to be eligible for AHR treatment. ▪ ROAD No. 9351 of 26/05/2015 (Current) Guidance on the activities and obligations of healthcare professionals and tissue establishments in connection with assisted reproduction. This guidance outlines a number of factors related to DAHR services including the information that must be provided by the clinic related to treatment effectiveness, treatment complications, infection and hereditary risk; the information that fertility clinics need to report in terms of viable pregnancies (after AHR treatment with donor sperm), and or serious adverse events, and information in relation to when pre-implantation genetic diagnosis can be performed. The handling of human tissues and cells is also protected by the Danish Tissue Act. Within the Finance Act for 2024, the Danish government has taken the initiative to strengthen fertility treatment with DKK 45 million, which will be used to provide better services to the many people who need help to have children. The possibility of having up to six fertility attempts for child number two without co-payment is part of the Finance Act agreement for 2026.
France ▪ Public Health Code: Title IV: Medically assisted procreation (Articles L2141-1 to L2143-9)[28] ▪ Public Health Code: Chapter IV: Donation and use of gametes (Articles L1244-1 to L1244-9)[29] ▪ Agopiantz et al.[273] ▪ Rozee and La Rochebrochard[306] ▪ Rozee and La Rochebrochard[305]	AHR is legally regulated by the Bioethics law (which is enshrined in the Public Health Code), which was revised in 2021 to be more inclusive; infertility is recognised as a public health issue and the use of AHR is covered by the universal health insurance system. The 2021 revision primarily includes three major changes: 1. access to AHR for individuals regardless of their marital status 2. access to origins for donor-conceived people, that is to say the possibility for them to have information about the donor, whereas prior to this gamete donation was strictly anonymous 3. the authorization of egg freezing for all women or birthing people, including for non-medical reasons, whereas this technique was previously only authorized for medical reasons (when a treatment, such as chemotherapy, impairs fertility) or as part of egg donation. Revision of the Law on the Elimination of Genetic Testimony in 2021, removed the criterion of pathological infertility, extended eligibility to couples and individuals, authorised double gamete donation, eliminated the requirement for spousal consent for gamete donation, and enshrined access to origins. Public Health Code: Title IV: Medically assisted procreation is the main legislation regulating AHR in France. Areas of the Public Code applicable to DAHR services include: ▪ the interviews which must be conducted by healthcare professionals to assess eligibility for AHR ▪ those who can receive embryo donation ▪ the import or export of gametes ▪ that those conceived via donated gametes and or embryos can contact the commission when they reach the appropriate age. Public Health Code: Chapter IV: Donation and use of gametes outlines that: ▪ artificial insemination with fresh donor sperm and the mixing of sperm are prohibited ▪ the use of gametes from the same donor may not deliberately lead to the birth of more than ten children

	▪ a doctor may access non-identifying medical information, in case of medical necessity, for the benefit of a person conceived from gametes from a donation or for the benefit of a gamete donor.
Germany ▪ Social Code Book 5: Statutory Health Insurance: Section 27a – Artificial insemination[52] ▪ Act for the Protection of Embryos (Embryo Protection Act - ESchG)[53] ▪ Bauer and Meier-Credner[124] ▪ Beier et al.[125]	Artificial insemination is legislated within the Social Code Fifth Book and outlines the eligibility criteria which must be met to receive artificial inseminations. It also outlines that the health insurance fund covers 50 per cent of the costs approved by the treatment plan for the measures carried out on its insured person. The Act for the Protection of Embryos focuses on the prohibition of donor egg treatment in Germany. This act outlines the that the transfer of a foreign unfertilised egg cell to a woman or birthing person is not allowed, and any attempt to fertilise an egg cell for the purpose other than to bring about a pregnancy in the woman or birthing person from whom the egg cell originates, is not allowed. This is further expanded to prohibit sex choice, pre-implantation genetic diagnosis (PGD) (unless there is a high risk of a serious hereditary disease) and the fertilisation of an egg cell with a man's sperm cell after his death. Sperm Donor Registry Act in 2018 mandates that the identity of sperm donors be registered and made available to donor-conceived individuals upon request.
Portugal ▪ Law No. 32/2006 of 26 July Medically assisted procreation[56] ▪ Regulatory Decree No. 6/2016[59] ▪ Ordinance No. 300/2024/1, of 25 November[58] ▪ Law No. 12/2009: Establishes the legal framework for quality and safety relating to the donation, collection, analysis, processing, preservation, storage, distribution and application of tissues and cells of human origin[57] ▪ Galhardo[285] ▪ Baia et al.[120]	Law No. 32/2006 of 26 July Medically assisted procreation is the main legislation in regard to AHR in Portugal. In relation to DAHR services, it outlines: ▪ those who are the beneficiaries of AHR (in general) ▪ those who are beneficiaries of sperm, oocyte and or embryo donation ▪ those who can undergo PGD ▪ the authorised centres in which AHR can be carried out ▪ what is prohibited in relation to: ○ buying and or selling of gametes and embryos ○ AHR techniques. ▪ the determination of parenthood. Regulatory Decree No. 6/2016 guaranteed the access of all women or birthing people to AHR in Portugal since 2016 and provides further information on: ▪ access to AHR within the National Health Services ▪ authorised centres in which AHR can be undertaken ▪ the medical teams responsible for AHR treatment in authorised centres (with the specific requirement of having one gynaecologist and or obstetrician and a licensed technician with experience and skills compatible with AHR in centres exclusively dedicated to artificial insemination). Ordinance No. 300/2024/1 outlines that medicines intended for the treatment of infertility, especially for AHR, are reimbursed at 90%. A list of medicines covered is included with pituitary antagonists, ovulation stimulants and gonadotropins, and progesterone, examples of medicines included. Law No. 12/2009: Establishes the legal framework for quality and safety relating to the donation, collection, analysis, processing, preservation, storage, distribution and application of tissues and cells of human origin. In 2018, there was also a change in the law, and gamete donations became non-anonymous.

Sweden ▪ Act (2006:351) on genetic integrity etc.[30] [2006] ○ Amended by Government bill 2017/18:155 [More modern rules on assisted reproduction and parenthood][32] ▪ SOSFS 2009:32 Use of tissues and cells in healthcare and clinical research, etc.[31] and the associated appendix[61] ▪ **A**pplegren et al.[162] ▪ Elenis et al.[284]	Act (2006:351) on genetic integrity etc.[30] outlines a number of regulations in relation to DAHR services including: ▪ special conditions for treatment with a donated fertilised egg ▪ conditions for prenatal diagnosis ▪ conditions for pre-implantation genetic diagnosis ▪ donor selection ▪ the storage period of fertilised eggs ▪ the right to information for those who have been conceived through artificial insemination. In 2016, Sweden legalized fertility treatments for individuals using donated sperm, and in 2019, double donation (both egg and sperm). SOSFS 2009:32 Use of tissues and cells in healthcare and clinical research provides for restrictions on the use of certain biotechnology developed for medical purposes and certain legal effects of such use. Specific to DAHR services this act applies to: ▪ prenatal diagnosis and pre-implantation genetic diagnosis, ▪ insemination, and ▪ fertilisation outside the body. **Other relevant legislation include**: The Patients' Act (2014:821) and the Health and Medical Services Act (2017:30) contain fundamental provisions on patient self-determination and respect for the equal value of people in health and medical services, and the Patient Safety Act (2010:659) provides for obligations for health and medical personnel. The Biobank Act (2023:38) regulates how human biological material, with respect for the integrity of the individual, may be collected for and preserved in a biobank and used for certain purposes.
UK ▪ Human Fertilisation and Embryology Act 2008[68]	In the UK, the Human Fertilisation and Embryology Act 2008 is the main legislation governing AHR. Specifically in relation to DAHR services, a number of provisions are included, such as: ▪ conditions for licences for treatment, including: ○ ensuring those in receipt of services are given a suitable opportunity to receive proper counselling about the implications of being provided with treatment services of that kind ○ ensuring those in receipt of services are given a suitable opportunity to receive information on the importance of informing any resulting child at an early age that the child results from the gametes of a person who is not a parent of the child, and suitable methods of informing such a child of that fact. ▪ registry of information, including: ○ the procurement or distribution of any sperm, other than sperm which is partner-donated sperm and has not been stored, in the course of providing non-medical fertility services for any identifiable individual ○ the keeping of the gametes of any identifiable individual or of an embryo taken from any identifiable woman or birthing person. ▪ request for information as to genetic parentage, including: ○ a person who has attained the age of 16 may by notice to the Authority require the Authority to comply with a request to gain donor information that is non-identifying. Donor information which identifies the donor can be accessed when the person conceived by donor gametes reaches the age of 18 years.

	▪ the use of sperm, or transfer of embryo, after death of man providing sperm. The Health and Care Act 2022 amended the Human Fertilisation and Embryology Act 2008 to extend the storage period of gametes and embryos to 55-years.[319] When donated gametes are used to create embryo's, consent for storage is required by both the donor and the recipient. If the recipient withdraws their consent for storage but the egg or sperm provider does not wish to withdraw their consent, the embryo is stored for up to 12 months and cannot be used within this period.[320] UK legislation be adapted based on each territory in the UK.
England	[See the UK]
Northern Ireland	[See the UK]
Scotland	[See the UK]
Wales	[See the UK]

Key: AHR = assisted human reproduction; DAHR = donor-assisted human reproduction; NHMRC = National Health and Medical Research Council (Australia); PGD = pre-implantation genetic diagnosis; UK = United Kingdom.

Published by the Health Information and Quality Authority (HIQA).

For further information please contact:

Health Information and Quality Authority

George's Court

George's Lane

Smithfield

Dublin 7

D07 E98Y

+353 (0)1 8147400

info@hiqa.ie

www.hiqa.ie

© Health Information and Quality Authority 2026