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Recruitment and motivation of semen providers in Sweden

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BACKGROUND: Legislation in Sweden requires that semen providers are prepared to be identified to offspring (at maturity) should this be requested. This study presents views of semen providers in Sweden regarding factors associated with their recruitment and motivation. METHODS: All semen providers (n = 30) in two clinics in different parts of Sweden participated in a questionnaire survey and both quantitative and qualitative data are reported. RESULTS: While there were some important demographic differences between the two clinic populations, there was total agreement that the desire to assist infertile couples was the sole or main motivating factor in becoming a semen provider. Monetary reward was not reported by respondents to be an important motivator, although at least 50% of the providers in both clinics thought that payment should be made and reimbursement of expenses was reported as being important. Men responded to both advertising and personal experiences or contacts they had with infertile couples. The involvement and support of the semen provider's partner was regarded as important. CONCLUSIONS: Semen providers can be recruited within a system that requires them to be prepared to be identified to offspring in the future. The characteristics of such providers vary, but are typified by a strong desire to assist infertile couples.

Key words: motivation/payment/recruitment/semen providers/Sweden

Introduction

Until 1985 donor insemination (DI) was performed worldwide without any legal restrictions. The semen provider was anonymous to the recipient couple as well as to the DI offspring. On March 18, 1985 the Swedish Parliament enacted legislation (Swedish Law of Artificial Insemination 1985, no. 1140/1984) which concerned the use of DI. This legislation gives the child born as a result of DI the right, 'when sufficiently mature', to receive identifying information about the semen provider. 'Sufficiently mature' is not defined in the law text. However, in the formal instructions from The National Board of Health and Welfare from 1987, where it was clarified how the law should be applied, the age is specified as 'the upper teens' with reference to the government bill (SOSFS, 1987).

The Swedish legislation, the first of its kind in the world, has attracted much interest, debate and criticism. Many physicians who had earlier practised DI claimed that it would become impossible, after the law came into force, to find semen providers (Sverne, 1990). This is reflected in the titles and comments in two papers from Sweden, 'Donor insemination—the end of an era' (Edvinsson *et al*., 1990) and 'Donor insemination; a treatment in crisis' (Hagenfeldt, 1990). However, in three other papers the authors have presented data which show that in one clinic specifically, as well as nationally, there has been an increase in the number of semen providers being recruited, suggesting that the possibility of future contact by genetic offspring has not had the negative impact on the availability of donors that was predicted (Lalos *et al*., 1993, 1998; Daniels and Lalos, 1995).

In a separate paper emerging from the present study (K.Daniels *et al*., unpublished data) it has been shown that semen providers from two different clinics in Sweden (Karolinska in Stockholm and Umeå in Northern Sweden) in fact have positive attitudes to future contact with their DI offspring. Results from this study will serve to encourage clinics in other countries that have been confronted with similar legislative requirements e.g. Switzerland, Austria, Holland and The State of Victoria in Australia. They may also impact on current policy and legislative discussions in several other countries e.g. UK, Canada, New Zealand and two further states in Australia.

Difficulties in recruiting sufficient numbers of semen providers have been widely discussed in the international literature (Barratt, 1993; Cook and Golombok, 1995; Daniels *et al*., 1996; Pennings, 2000), one of the major concerns being with anonymous versus open systems. Given the fears that existed in Sweden in moving from an anonymous to an open

system, it seemed appropriate to explore issues of recruitment from the perspective of those who became semen providers under an open system.

The study reported here sought to find out the initial awareness of semen providers for semen donation, the motivation for becoming a semen provider, the factors influencing the decision to become a semen provider, the semen provider's views on advertising and recruitment, the perceived advantages and disadvantages of being a semen provider and the partner's participation in the decision to become a provider.

Subjects and methods

All current semen providers (n = 30) at two Swedish Fertility Clinics in university hospitals participated in this study. The clinic at Karolinska is located in the capital, Stockholm, (population 1.4 million) and was performing ~80–100 treatment cycles per annum and had 14 active semen providers, most of them well-established. The clinic in Umeå, which is a university town (population 100 000) in the northern part of Sweden, was performing between 40–70 treatment cycles per annum and had 16 active semen providers, the majority being recently recruited.

In the present study, self-completed, anonymous questionnaires collecting both quantitative and qualitative information were distributed to the semen providers in the period 1995–1996. All received the same written information, and the questionnaire was semi-structured and contained 52 questions, mainly with given response options. However, most questions were followed up with a request for the respondent's comments, explanations or reasoning. The multiple-response questions gave the men an opportunity to choose more than one option and answers other than the given response alternatives could also be supplied. In the Umeå clinic respondents—after completing the questionnaire—had the opportunity to meet a social worker (the first author) to discuss any issues that had arisen for them. Some statements from these interviews are included in the Results section.

The response rate was 100%, however, one semen provider from Karolinska passed over a section of the questionnaire in error. Accordingly, for ~50% of the questions in the survey, the total number of respondents is 29 rather than 30.

Initial questions sought detailed demographic information plus any future plans for having (additional) children of their own. The degree to which the semen provider had consulted with or advised their partners, family, existing offspring and acquaintances about their semen donations were ascertained plus the reactions they observed. Other topic areas explored in detail were: motives for becoming a semen provider; previous contact with infertile persons; recruitment/screening procedures and experiences; views on payments to semen providers and advertising; perceptions of community acceptance of DI and semen providers; and overall satisfaction with being a semen provider and the service received.

Completed questionnaires were translated into English and responses analysed both at the University of Canterbury, New Zealand and at the University Hospital of Umeå, Sweden.

Ethics committees' approval from the two universities was obtained for this study and all semen providers gave informed consent.

Results

Demographics

The socio-demographic background of the semen providers has been described in detail elsewhere (Daniels *et al*., 2002). In summary, the mean and median age for providers in Stockholm were 37 and 40 years (range 28–46) and the corresponding values for Umeå were 34 and 33 years (range 26–47). Approximately two-thirds of all respondents were in on-going relationships, however, the younger semen providers at Umeå were more likely to be in their first marriage or co-habitation arrangements, whilst the majority of the older Karolinska semen providers were in second or later marriages. Approximately one-third in both groups reported having no offspring other than from their involvement in DI. Karolinska had a higher proportion of men in the professional/technical workers category, whilst the Umeå clinic had more semen providers who were students.

Initial awareness of semen donation

Concerning initial awareness of semen donation, the overall number of semen providers who first heard about DI through media and general publicity was approximately equal to those who were made aware by personal contacts. Direct contact with infertile couples was frequently mentioned as the means by which semen providers learned about DI. Print media is by far the most commonly quoted, general-publicity source of information. Newspaper articles and advertisements at the blood donor centre were also commonly referred to. Inter-clinic differences were, however, found. All semen providers from Stockholm, (except one missing answer), reported first learning about DI from the media, whilst two-thirds (66%) of the respondents from Umeå first heard about semen donation through personal contacts such as staff, friends and family. Some providers described how they intended to, or already had, motivated a friend or relative to become a semen donor, for example: ''I went straight home from the doctor and immediately got into touch with two of my pals who I believed would be suitable as donors.''

Motivation for becoming a semen provider

All semen providers, both in Stockholm and Umeå, declared that they wanted to become a provider in order to help infertile couples. This was the only response given (in contrast to others who gave multiple responses) in 70% of the respondents. The younger donors from Umeå were, in general, more influenced by real-life, directly experienced fertility/infertility issues pertaining to themselves and their networks. The older Karolinska providers were more influenced by general infertility issues after exposure to media publicity. The following statements illustrate some semen providers' considerations: ''I can see how my fellow-worker really suffers when there's a chat about children—it must be sheer hell! And look at me and my partner, we just shed our seed…''. ''It feels important and right to contribute, to do one's share, there's nothing strange about that, I simply want to help childless couples.''

The providers were also asked whether they considered semen donation to be analogous to blood donation. Almost two-thirds at each clinic (62%) replied in the negative. However, five in Umeå and two in Stockholm answered in the affirmative, whilst the rest were unsure. Those who disagreed cite the significant difference that in semen donation

they are firstly assisting in creation of life and secondly are passing on their genetic inheritance.

Most influential person/factor in the decision to become a semen provider

In the Umeå group 69% knew at least one infertile couple versus 38% of the group from Karolinska. However, both semen provider groups were influenced by a desire to assist infertile couples, as mentioned above. In addition, an open-ended question sought information concerning who/what had been most influential in their decision to become a semen provider. In total 'the female partner' was the most frequent answer (10/30). Other common stimuli to action were influence from advertising (7/30) and the all-embracing desire to help others (7/30). Others mentioned, for example, the desire to procreate and financial reasons. In this aspect there were some regional differences (Table I). Half the semen providers in Stockholm referred to the influence of the partner whilst the desire to help others was the most common reason given among semen providers from Umeå (37%), illustrated by the following statements: ''It's not a question of giving, it's a question of receiving. If I get sick I want blood donation, kidney transplantation… If my wife and me had this problem we would have liked to have donor insemination! That is to say, I must be ready also to give. Somehow it's simple, you see.'' ''I see it as a humanitarian contribution, I want to help childless couples. On the whole, I have a humanitarian approach, I'm a member of the Red Cross.''

Table I. Most influential person/factor in the decision to become a semen provider

Clinic	Most influential person/factor			
	Desire to help (%)	Partner (%)	Advertising (%)	Other factors (%)
Karolinska	8	50	21	21
Umeå	37	19	25	19

Table II. Views on payment and reimbursement of expenses for semen providers

Monetary compensation	Karolinska (%)	Umeå (%)
Payment		
Paid	57	50
Not paid	7	37
Unsure about payment	21	13
No answer	15	0
Reimbursement		
Reimbursed	43	81
Not reimbursed	29	0
Unsure about reimbursement	7	19
No answer	21	0

Table III. Semen providers' views on advertising

Clinic	View (%)			
	Positive	Negative	Unsure	No answer
Karolinska	35	29	29	7
Umeå	94	0	6	0

Monetary compensation

As previously mentioned, most providers reported only one reason for becoming a donor. Every fifth man, however, gave a combination of reasons, for example, five donors in Umeå also mentioned secondary financial reasons. At the time of the study, all semen providers at both clinics got a small amount of money in order to cover travel expenses. On the direct question whether semen providers should be paid in addition to their expenses, there were no regional differences, more than half at both clinics answering in the affirmative (Table II). Moreover, 31% in Umeå commented that payment probably would increase the number of providers compared with half as many in Stockholm. One provider in Stockholm and four in Umeå were opposed to payment and three versus two, respectively, found the issue too complex to give an opinion.

There was, however, no general agreement among respondents that semen providers should be reimbursed for expenses for travel costs or loss of income (Table II). Almost twice as many from Umeå (81%) compared with Stockholm (43%) thought that providers should be reimbursed and not suffer financially. Some expressed the view that lack of expenses would lead to the loss of semen providers. Four respondents, all from Stockholm, answered that semen providers should not be compensated for expenses. Additionally, one-fifth of the donors from Stockholm did not answer the question.

Semen providers' views on advertising

Table III shows that semen provider's views on advertising differ considerably between the two clinics. All respondents in Umeå, except one, were in favour of advertising. The following statements illustrate this positive attitude: ''Why not, there's nothing to be ashamed of, how else will we get more donors.'' ''They should be more creative and call in an advertising agency and put a groovy placard at the maternity ward showing a father and a baby… addressing men who just recently have become fathers with the message: We've got help from a semen provider—you can also offer yourself as a candidate!''

In Stockholm the semen providers' reactions to the idea of advertising were divided into three almost equal parts; positive, negative or unsure (Table III). This difference is interesting since Karolinska providers were predominately motivated by media publicity and those from Umeå were recruited through personal contacts.

Perceived advantages and disadvantages of being a semen provider

In an open-ended question about what were the most satisfactory aspects of being a semen provider, most responses from both groups had to do with empathy with infertile couples and the happiness of helping others. A few in Umeå also added monetary reward and some in Stockholm responded that helping clinic staff was the most satisfactory aspect.

In relation to the least satisfactory aspects of being a semen provider most answers focused on dissatisfaction with the facilities provided for the collection of the semen. Often this

had to do with difficulties producing a semen sample or where they have to masturbate and feelings of embarrassment.

When asked about donor screening and matching issues, nearly all semen providers in Umeå, in contrast to those from Stockholm, remembered being questioned about physical characteristics, education, occupation, interests, medical history and hobbies. Providers in Stockholm were, however, more often asked about temperament and skills.

Partner participation in decision-making

Among those having a stable partner-relationship (19/30), a slight majority had a partner that was 'involved' or 'very involved' in the decision-making to become a semen provider (10/30). However, differences were found between clinics, 8/10 partners in Umeå but only 2/9 in Stockholm were involved in the decision-making to become a semen provider. In this latter group there were six partners that stayed 'neutral' and in Umeå only two. Thus, the newly recruited providers from Umeå had advised their partners of their decision to become semen providers and involved them in the decision making to a higher degree than providers from Stockholm.

Concerning the women's reaction to their partner being a semen provider, the majority were reported as either enthusiastic or neutral. The respondents from Umeå had more enthusiastic partners (six) compared with Stockholm (two). In total, only two were not enthusiastic and in Stockholm two additional women did not know about the partner's sperm donations. Thus, the majority of the respondents had a partner who did not object but rather supported them in being a semen provider. The following statements illustrate some positive attitudes: ''Oh yes, it was just she that suggested it!'' ''Since we had had difficulties to get children—but succeeded at last—we were in agreement on doing something good for involuntary childless folks.'' ''We both have close friends who can't have children and know what great meaning it has. So we believed it was splendid if we could help someone.''

Discussion

A marked difference exists between the two groups of semen providers in relation to how they first became aware of DI—almost all the Karolinska semen providers having DI brought to their attention via the media, while 66% of the Umeå semen providers first became aware of DI as a result of personal contact with staff, friends or family. This difference may reflect the demographic differences, particularly age, between the two groups. The younger (Umeå) respondents were in their family-creating years where family planning is a common topic of conversation amongst friends and family. The older (Karolinska) semen providers may not have been exposed to as many couples that were wishing to conceive and form families. Another possible explanation is that the recruitment policies of the two clinics meant that men with different characteristics were recruited. In a study of semen providers at two London clinics (Daniels *et al*., 1996) it was found that the recruitment policies of the two clinics were very different and it was suggested that this lead to different 'types' of men being recruited. None of the respondents indicated that they were introduced to semen donation by another semen provider, but several suggested that this was something they had done or intended to do. The encouragement of current semen providers to recruit others seems to be very appropriate. An enthusiastic semen provider is likely to have an impact significantly different from that of staff or advertisements. However, it needs to be noted that the least satisfactory aspect of being a semen provider cited by respondents was the facilities provided by clinics for the collection of semen. Semen providers who leave a clinic feeling uncomfortable or embarrassed are not likely to be good promoters of the service.

The respondent's attitudes towards advertising for semen providers do not correspond to how they were themselves engaged. Although Karolinska providers predominately responded to media publicity and those from Umeå were recruited through personal contacts, all semen providers from the latter group, except for one, were clearly positive about advertising compared with only one-third from the Stockholm group. However, being recruited through interpersonal contacts does not imply that there are negative attitudes towards print-media. On the contrary, semen providers in Umeå did experience media publicity as an additional confirmation of their decision to become a semen provider.

The role, or potential role, of a female partner in recruitment has been highlighted in the results. The respondent who said that it was his partner who suggested that he became a semen provider is an example of this. The level of enthusiasm of partners in relation to semen provision was also important to respondents with just over 50% saying their partner was 'involved' or 'very involved' in the decision-making. Overall, the females' reactions to their partner being a semen provider were enthusiastic or neutral. Thus, the majority of the respondents had a partner who did not object but rather supported them in being a semen provider. It could be worth considering the targeting of couples in recruitment strategies, semen provision being seen as a contribution by one couple to another couple. Some of the comments made by semen providers in this study indicated—by using the word 'we'—that the decision to contribute was seen as a joint one.

In an overview of studies of semen provider motivations Daniels suggests that younger men, who are predominantly students, tend to have quite different reasons for becoming semen providers than older men who are married or in permanent relationships and have children within that family grouping (Daniels, 1998). This age factor was not reflected in the current study, which shows that all semen providers stated that the reason for becoming a semen provider was to help infertile couples, and for the vast majority this was the sole reason. Monetary gain was seldom mentioned as an additional reason.

The primarily altruistic motives of semen providers in this current study can be regarded as an indicator of the successful implementation of the primary charitable requirements of the Swedish legislation. The study reflects the fact that semen providers have a drive to be of use and an urge to help infertile couples, in spite of the fact—or thanks to the fact—that there is a possibility of future contact by genetic offspring.

The results may also be reflective of the notion of citizenship, including voluntary non-paid contributions to the communal good which are a part of the long established

welfare ideology of Sweden (Wuthnow, 1991; Jeppsson Grassman and Svedberg, 1996, 2001; Putnam, 2000). There has been considerable debate in the literature concerning the importance of monetary payment for semen providers (Sauer *et al*., 1989; Schover *et al*., 1992; HFEA, 1995; Cook and Golombok, 1995). Lui (1998) has said ''If financial reimbursements are discontinued on ethical grounds, clinics may expect a decline in the number of donors''. He then links payment and other attitudes/motivations by saying: ''recruiting from other more altruistically motivated groups may satisfy ethical demands, but results in donors who are less suitable with respect to other attitudinal issues, such as personal involvement''. 'Personal involvement' is not defined but seems to refer to those who are prepared to be identified to offspring in the future. The contrast between Lui's position and the results that we report may reflect cultural variations. They may also reflect the fact that established patterns of recruitment are just that—established patterns.

The Swedish legislation forced a review of the established pattern in that country. The changes, particularly those relating to information-sharing by semen providers, did not lead to the collapse of the system. As our study shows, men with characteristics different to those found, for example, by Lui (1998), and Cook and Golombok (1995) respond to recruitment drives. It may be the semen providers who have a strong desire to 'help others', who are open to future contact with offspring, and will not see their contribution as one that requires financial recompense. It is clear from our results that financial factors will be a consideration for some semen providers. It is also interesting to note that a third of respondents thought that offering payment would lead to an increase in the number of men coming forward as potential semen providers. No general agreement was found over whether providers should be reimbursed for travel costs or loss of income. Almost twice as many men from Umeå compared with Stockholm thought that semen providers should be reimbursed for their financial costs. This clinical variation is probably due to the greater distance that providers have to travel compared with Stockholm.

Conclusions

The results of this study highlight the fact that semen providers can be recruited within a system that requires them to be prepared to be identified to offspring in the future. The characteristics of such men vary, but are typified by a strong desire to assist infertile couples. For this group of men, monetary reward is not reported to be an important motivator, but expenses for travel and loss of income are seen to be important. This is particularly the case where semen providers are required to travel long distances to the clinic. Men responded to both advertising and personal contacts/experiences, and their partner's involvement and support seemed to be significant, suggesting that recruitment that targets the female partner and/or the couple should be considered. Another aspect of recruitment strategies could be the encouragement of current semen providers to recruit their friends and relatives.

The results illustrate that semen providers vary in a number of ways, perhaps reflecting the different ways in which clinics approach recruitment. This is despite operating within the same legislative framework. It is also important to note that despite concerns and anxieties about 'open systems' and 'information sharing' the advent of such change in Sweden has not lead to the disaster that was predicted.

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