

### **12.3.3.1 OOCYTE DONATION**

#### ***WHAT IS OOCYTE DONATION?***

Oocyte Donation (OD) is the procedure whereby an oocyte from a donor is fertilized by sperm from a recipient man and the subsequent embryo is inserted into his partner's uterus with the intention of her becoming pregnant. The treatment has been used for many years and has a high success rate of up to 15% per month and 60% over a six month course of treatment.

#### ***WHO CONSIDERS OOCYTE DONATION?***

Approximately one in 35 women are unable to produce their own eggs. Indications for this include those women:

- i) entering menopause (prematurely);
- ii) having no ovaries;
- iii) having hereditary disorders;
- iv) having inaccessible ovaries (unable to collect her oocytes);

OD can also be used by women with advancing age and who have tried many IVF cycles without success.

Once it has been diagnosed that the female partner is unlikely to be able to produce her own oocytes, the couple have three choices. One is not to have children and to concentrate on developing their own lives and interests. Secondly, the couple can aim to adopt a child. Unfortunately this is difficult as there are few children for adoption and waiting lists are very long. If a couple does adopt, they have a ready made child, without the risk of complications of pregnancy and childbirth. However, they do not have the shared experience of pregnancy and labour, nor do they make any contribution to the genetic make-up of the child. The third choice is using donated oocytes.

OD has the advantage that a pregnancy can be shared by the couple and half the genetic make-up comes from the father. The shared experience starts with the excitement of the missed period, the diagnosis of pregnancy and continues throughout the pregnancy, climaxing with the delivery of the child.

OD cannot protect the expectant mother from the complications of pregnancy and childbirth. Women who have children by OD have exactly the same risk of an abnormality in their children as those who conceive naturally. There is no decrease or increase in the risk of congenital abnormality.

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#### ***WHO ARE THE DONORS?***

The selection of women who apply to become oocyte donors is complex. In order to be considered as a possible donor, a women must be aged between 18 and 35 years.

Prospective donors must provide a full personal and family medical history and answer questions specifically about activities associated with risk of AIDS infection.

The donor will be seen by her clinician who will discuss medical issues, and she & her partner (if any) will be required to attend a counselling session to ensure complete understanding about what is involved and the legal issues associated with becoming a donor.

Many people are interested to know what kind of women become donors. Studies indicate the most common characteristic donors possess is a desire to help others. Oocyte Donors are often blood donors and many report having friends or family who have had a fertility problem.

If a donor knowingly withholds any information on any genetic condition that she has, she will be held legally liable for any legal action that may be brought about as a result of any child being born with that genetic disease.

#### ***WHO ARE THE CHILDS LEGAL PARENTS?***

Legislation in Western Australia declares that the child conceived by a treatment involving the use of donated reproductive material is the legal child of the woman who gave birth and her consenting partner (if any). The donor has no legal rights or duties. It is presumed that the partner has consented to the treatment although this is rebuttable. If it is established that a partner has not consented they will not be a legal parent of the child.

Ammedments to the Human Reproductive Technology Act 1991 allow the child to have access to the donor's indentifying information when they turn 16 years of age, following approved counselling.

Sharing of identifying information about the donor and recipients is possible where both parties request this following approved counselling to address in particular, what may be in the best interests of the child.

#### ***OOCYTE COLLECTION***

If the donor meets the clinic requirements, the donor has blood taken. This blood is tested for HIV (AIDS virus), HTLV (Human T-cell Lymphotropic virus), Hepatitis B and C, Syphilis and Blood Group. If all these tests are clear the donor is examined by a clinic doctor who can

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review the family medical history and ensure that the donor is in good health.

The donor then undergoes a stimulation programme using natural hormones to produce a number of oocytes (refer to the IVF literature).

#### ***DONOR SELECTION FOR COUPLES***

Couples are given the non-identifying information about the donor. This information includes race, ethnic origin, height, build, hair and eye colour and blood group.

Couples are provided with oocytes from a donor whose physical characteristics most closely resemble those of the wife, although other factors such as ethnic origin and blood group may influence the decision. The availability of oocytes often makes close matching very difficult.

Consent Documentation must be read and clearly understood before accepting this type of treatment.

#### ***WHAT IS INVOLVED IN OOCYTE DONATION***

The donor oocytes must be fertilized at the time of collection, which occurs in the middle of the donor's menstrual cycle. Once fertilized the embryos may then be implanted into the female recipient or frozen for storage. The procedure used depends upon whether the recipient's hormone and monthly cycle coincides with the donor or not. Ovulation is monitored by blood tests which must be undertaken daily to predict the exact timing of OD.

The embryo transfer is a simple procedure rather like having a Pap Smear Test. It is done in the clinic and does not take long. Afterwards the recipient is required to lie quietly for 30 minutes before being free to resume her normal activities.

If a pregnancy does not occur the treatment may be repeated during subsequent menstrual cycles if further oocytes are available. If any embryos were stored, they could be thawed and a frozen embryo transfer cycle undertaken.

#### ***DECISION MAKING***

In our society today there are many different ways to form a family. OD is one way many couples have chosen to produce their families. However, the decision may not always be straightforward, nor will each partner be certain that this method of family formation is for them.

### **12.3.3.4 OOCYTE DONATION**

All couples approaching the OD service should discuss their plans with the centre counsellor. This session does not consist of any assessment as to a couple's suitability to become parents. The decision to start on an OD programme is one made by the couple in consultation with their doctor. It is, however, a decision which we consider to be a serious one and it may not be the right choice for all couples.

Even for those couples who proceed to OD, there can be social and emotional hurdles to be overcome.

The clinic counselling service offers the opportunity to discuss the issues that might arise if a couple proceed with OD. The counsellor may also be in a position to discuss the issues which have arisen for other couples who have children from the programme. The legal aspects and issues such as telling the family, friends and the children about oocyte donation will be discussed with you in the counselling session which is required for all donors, recipients and their partners.

#### ***COMMON PROBLEMS***

- i) To tell or not to tell friends and family?
- ii) Practical difficulties - travelling to and from the doctor or Concept Fertility Centre, explaining to employers the need to arrive late, leave early, or even take days off ... all without giving a reason why!!
- iii) Anxiety can often delay the ovulation cycle and further complicate treatment.
- iv) Couples under stress may develop some problems with their sexual relationship.
- v) Couples may also experience problems when one partner wants to undergo OD and the other partner is not comfortable with this form of treatment.

#### ***KNOWN DONORS***

Some couples decide that the use of a donor known to them is preferable to the notion of an unknown donor. This is perfectly acceptable under Western Australian law and the same legal position applies to both known and unknown donors.

A known donor, her partner and the recipient couple, should discuss their plans with their doctor and then the centre counsellor before donating or receiving oocytes. The counsellor will see the Known donor & their partner if any, separately from the recipient & their partner, then all parties will be seen together.

### **12.3.3.5 OOCYTE DONATION**

After the completion of counselling a three (3) month "cooling off" period is required before oocyte collection or donation can occur.

At the end of the 3 month cooling off period you will be offered further contact with the counsellor to ensure all parties are still willing to proceed.

An exit interview will be provided for participants who are not proceeding with the programme.

Donated eggs cannot be used or fertilized to create an embryo where the recipient is known to the donor until the "3 month cooling off" period has lapsed. Therefore in the case of a known donor where a fresh transfer is requested, the fertilization process will not take place before 3 months from the time of completion of counselling.

In the case of donated oocytes (eggs) (including known donation) RTAC recommends that the oocytes be fertilized and the embryos frozen and stored for 6 months. At the end of the quarantine period ( 6 months), the donor is required to be re-tested for HIV, Hepatitis B & C & if clear, FET (Frozen Embryos Transfer) cycles can be organized for the recipient of the donated oocytes.

When a fresh transfer is requested by the recipient of the oocytes or embryos the fallibility of the HIV test & the risks of using fresh transfer will be again discussed with the recipient.

#### ***OD - SOME IMPLICATIONS FOR THE CHILD, PARENTS AND DONOR.***

1. Does a child have the right to know about his or her origins?
2. Are there dangers inherent in telling a child about its OD status?
3. Are there dangers inherent in attempting to keep OD a secret from the child?
4. Should there be legislative changes nationwide, in order to safeguard a child's legal status and rights?
5. What is the effect of denying OD on the marital relationship of the childless couple?
6. Does secrecy have harmful effects on relationships within the wider OD network?
7. The immediate transfer of an embryo (rather than storage for 6 months) will allow an increased success rate but does not allow for further health testing of the donor.
8. What impact will access to the identification of the donor have on the child?

If you require more information about OD please contact a Nurse Coordination on 9382 2388.