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## Egg Donation Brokers:

### An Analysis of Agency Versus in Vitro Fertilization Clinic Websites

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### Abstract

**OBJECTIVE**—To compare Websites of agencies that broker the services women who provide human eggs for in vitro fertilization versus clinics that recruit egg providers.

**STUDY DESIGN**—We examined 207 websites, of which 128 were egg provider agency (40%) or clinic (60%) websites that recruited providers online. We compared them regarding several variables related to adherence to American Society for Reproductive Medicine (ASRM) guidelines.

**RESULTS**—According to their respective websites, agencies were more likely than clinics to mention ASRM guidelines, be located in the West/Pacific, indicate compensation, offer a fee range, set their minimum > \$5,000, specify preferable traits, cap provider age at 31, require an education minimum, allow both parties to meet, discuss short-term risks, and not acknowledge a possible cancer risk. Only 25.5% of agencies and 19.5% of clinics mention psychological/emotional risks, and 11.8% and 5.2%, respectively, mention risks, to future fertility.

**CONCLUSIONS**—This research, the first to systematically compare several key aspects of egg provider agencies versus clinics, suggests significant differences in adherence to guidelines, raising several concerns and suggesting needs for consideration of improved monitoring and regulation by ASRM or others.

### Keywords

egg donation broker; egg doner; egg provider; egg provider agency; egg provider compensation; egg provider recruitment; fertility clinics; in vitro fertilization; oocyte provider

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Over the past two decades, freestanding, for-profit agencies that broker the services of young women who are willing to provide their eggs to infertile women have proliferated in the United States,<sup>1–3</sup> but little is known about their practices. Agencies have been defined as

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“brokers hiring the egg donors and matching them to recipients.”<sup>3</sup> These entities often act as the “middle man” between the egg provider and the recipient or, in other cases, between the egg provider and IVF clinics in need of agencies’ anonymous services. Some IVF clinics work with agencies to identify and engage egg providers, while other clinics have their own recruitment and matchmaking programs.<sup>4</sup> But many questions about these agencies remain.

Beyond the U.S. Food and Drug Administration’s rules concerning reproductive tissue donation, federal regulations currently do not cover the recruitment of egg providers. Clinics, unlike agencies, are typically members of the American Society for Reproductive Medicine (ASRM) and are owned and operated by licensed physicians who are bound by professional ethical codes.<sup>5</sup> But egg agencies are typically commercial entities, owned and operated by individuals with a variety of backgrounds who do not necessarily have any formal licensing or professional training, and hence are not necessarily bound by any medical oversight.<sup>3</sup> Therefore, unique questions arise: whether agencies should fit into the U.S. model of self-regulation of assisted reproductive technologies (ARTs) and, if so, how.<sup>4</sup>

Agencies do not perform any of the medical procedures involved in oocyte donation (e.g., administering medication or conducting the actual retrieval), but may play pivotal roles in recruiting, educating and compensating egg providers. These activities are important and are the subject of ASRM’s ethical guidelines.<sup>6</sup> The recruitment process can strongly shape egg providers’ initial impressions about the process. Increasingly, websites are a major venue for healthcare information and services, including egg provider recruitment.<sup>7,8</sup> Such initial contact and framing of information undoubtedly influences how women perceive the act of providing gametes and can even be seen as the first step in the informed consent process, since first impressions often impact later decision-making.<sup>7</sup>

The amount of compensation offered is important, and controversial. Many Western countries ban compensating egg providers.<sup>4,9</sup> Currently, ASRM is facing a lawsuit brought by an egg provider for alleged price-fixing.<sup>10</sup> The practice of egg provision has been controversial since its inception nearly 30 years ago and continues to be debated, involving several ethical issues (i.e., appropriate informed consent, possible long-term risks to egg providers, exploitation of egg providers, commodification of human life, and the right of children born from provider eggs to know their genetic lineage).<sup>11–17</sup> In certain ways, young providers may constitute a vulnerable group since they face risks of ovarian hyperstimulation syndrome (OHSS)<sup>18</sup> and possible impediments in their ability to bear children in the future.<sup>19,20</sup> ASRM guidelines address several of these topics, stating that compensation should reflect the “time, inconvenience, and discomfort” associated with the egg donation process, which should be “...distinguished from payment for oocytes themselves, and compensation should not vary according to...the outcome of prior donation cycles, or the donor’s ethnic or other personal characteristics.”<sup>6</sup>

Additionally,

To discourage improper decisions to donate oocytes, [donors should] receive accurate and meaningful information on the potential physical [and] psychological effects of oocyte retrieval and donation. ... It would be prudent to limit donors to those who are 21 or older, and advertisements for donors [should be] accurate and

responsible...[such that] if financial...benefits are noted...the existence of risks and burdens also...[are] acknowledged.<sup>6</sup>

We have previously reported on adherence to these guidelines across all websites recruiting egg providers (i.e., clinics and agencies combined) and found several areas of noncompliance in regards to compensation structure, presentation of risks, and age minimums for recruitment.<sup>1</sup> We examined how a subset of agencies and clinic websites that discussed compensation (N=102) compare regarding a single characteristic—trait-based payment.<sup>1</sup> We found that agencies are more likely than clinics to mention explicitly paying more for certain donor traits, or to state that these were preferred or in demand. Yet, many other important questions and aspects of these entities' practices exist that we did not compare and that remain unexplored (e.g., whether agency and clinic websites differ in presenting risks, requirements to provide eggs, anonymity, long-term privacy, and compensation structure). These other potential differences are important in understanding whether agencies and clinics differ in additional ways and, if so, how.

These distinctions between agencies and Society for Assisted Reproductive Technology (SART)–registered IVF clinics are critical, as ASRM does not oversee these organizations. Similarly, ASRM can revoke physicians' membership in its professional society for noncompliance with published guidelines, a result which would likely damage the provider's and clinic's reputation and perhaps limit access to professional networks. Agencies, however, are stand-alone businesses that face no substantive legal or professional consequences for not complying with guidelines. To increase compliance among agencies, ASRM did arrange for voluntary agreements, whereby agencies could choose to state that they will abide by ASRM guidelines in exchange for appearing on the association's website as preapproved agencies.<sup>21</sup> Presence on this list currently serves as the only *de facto* regulatory mechanism of agency behavior, yet each agency's actual compliance has never been formally verified by ASRM. One study found that of 66 egg donation and surrogacy agency websites on the list in 2008, 10 were noncompliant with ASRM guidelines in the form of trait-based payment and 3 in the form of inappropriately high compensation,<sup>2</sup> but this study did not compare agencies and clinics in any specific way.<sup>2</sup> Two studies of agencies, IVF clinics, and personal recruitment ads in college newspapers and on craigslist demonstrated that agencies were more likely than IVF clinics to compensate women more for preferable traits—directly violating ASRM guidelines—and were more likely to recruit between the ages of 18 and 20, which is inconsistent with ASRM's suggested age minimum of 21.<sup>15,22</sup> Another study of anonymity policies of clinic, egg agency, and sperm bank websites and brochures found that agencies appeared to show provider photographs, proactively inform egg providers of cycle outcomes, and offer nonanonymous matching options more frequently than did IVF clinics, although this study did not report whether any of these differences were statistically significant.<sup>23</sup>

These issues are of concern outside the U.S., too. Egg providers and recipients enter the U.S. from other countries for these services, since few countries explicitly permit payment for egg providers, resulting in global markets that have raised ethical concerns.<sup>24,25</sup>

This paper thus aims to examine more fully differences between agencies and clinics. We also examine here critical additional issues and a larger sampling of websites (N = 128) than done previously (i.e., including sites that recruit, but do not mention trait-based provider compensation).

## Materials and Methods

We systematically reviewed fertility clinics within the U.S. and agencies involved in recruiting of egg providers by analyzing Internet websites. To simulate the steps that prospective egg providers would take to find provision opportunities, we conducted an online search through the search engine Google, entering the term *egg donation*, in June 2010. As shown in Figure 1, we collected a list of 414 websites from within the first 300 results returned from Google. Within the first 20 results a large health directory website ([www.ihr.com](http://www.ihr.com)) appeared, as did websites of SART and ASRM. We included all IVF practice/clinic and agency websites listed on these 3 sites and removed any duplicate site that appeared on more than 1 of these sites. We also eliminated sites that were not directly related to the recruitment of egg providers (e.g., news articles and informational websites).

Three coders independently read a randomly selected sample of websites to familiarize themselves with website content and develop a systematic coding manual. Afterwards, every second website was selected from the master list, totaling 207. Two coders analyzed each of these 207 sites. Coders examined the websites independently for quality and quantitative data and compared results, discussing ambiguities in the coding to arrive at a consensus. In reviewing these 207 sites, we removed 13 that were not egg provider agencies or clinics (e.g., egg banks, research facilities, and affiliate networks. For the remaining 194 websites we coded the following broad categories: (1) Background Information: IVF clinic versus agency, and geographic region of the country,<sup>26</sup> (2) Provider Eligibility Restrictions: minimum and maximum age for participation; minimum education requirements, (3) ASRM Endorsement: agency's endorsement by ASRM (agencies) or membership in SART (clinical practices); whether site referred to ASRM guidelines when discussing compensation, (4) Compensation Structure: whether a site mentioned a compensation amount, offered a flat fee versus a range, noted its base minimum compensation as above or below \$5,000, mentioned desirable traits, or offered an upfront bonus to register or a referral bonus for introducing another provider, (5) Egg Provider Privacy: whether a site required visitors to register before viewing the database of available providers, whether photos of providers were publically accessible, whether the site allowed providers and recipients to meet, and (6) Disclosure of Health Risks: any mention of short-term health risks (e.g., OHSS),<sup>27</sup> any mention of psychological/emotional risks (beyond hormone related imbalances), any acknowledgement of an unknown or possible risk of cancer or any long-term risk to future fertility (e.g., via severe infection or ovarian torsion and tissue necrosis).<sup>28-30</sup>

We categorized websites as either "clinic" or "agency," based on whether the recruitment web-page was housed within an IVF clinic or agency website. In some instances the recruitment page referred to the entity as an "agency" but either shared a domain name with an established IVF clinic or clearly directed the visitor to the IVF clinic's website, in which case we categorized such websites as IVF clinics. We assessed the frequencies of website

characteristics across these two types of organizations and used a logistic regression to compare websites of agencies with those of clinics, and examined the strength of associations. We were not required to obtain Institutional Review Board approval as we did not collect data concerning any human subjects and assessed only publicly available websites. We have no conflicts of interest.

## Results

As seen in Figure 1, of the 194 IVF clinic and agency examined, nearly two-thirds (N=128 [66%]) actively recruited providers online (i.e., provided a registration form or a number to call). As shown in Table I, of these 128 sites 39.8% were agencies, 78.9% were SART members or ASRM approved, and 30.5% were in the Western U.S. Of the websites, 73.5% made no mention of ASRM ethical guidelines on financial compensation to egg providers, 39.5% accepted providers under age 21, 48.3% limited a recruited provider's age to  $\leq 31$ , and 18.0% had a minimum educational requirement to provide eggs (high school or above). Of the websites, 78.9% indicated a compensation amount, of which 46.1% offered a range as opposed to a flat fee, 25.8% set a minimum amount  $> \$5,000$ , 49.0% mentioned preferable provider traits, and 6.7% offered an up-front cash incentive to register or a referral bonus for introducing a new egg provider. Of the websites, 14.1% did not require online registration to view provider profiles, 7.8% provided unregistered public access to view photos of potential providers, and 23.9% facilitated providers' and recipients' meeting each other. Regarding donor risks, 62.5% did not discuss any short-term risks (e.g., OHSS, infection or hospitalization), 4.7% (all of which were clinics) acknowledged a possible risk of cancer, 92.2% did not mention risks to future fertility (e.g., damage to the ovaries), and 78.1% did not mention possible emotional or psychological risks of egg provision.

Agencies were more likely than clinics to be based in the Western U.S. (41.2% vs. 23.4%, OR = 1.51,  $p < 0.034$ ) and not be ASRM/SART approved (41.2% vs. 7.8%, OR = 8.28,  $p < 0.001$ ). Agencies were also more likely to refer to ASRM's ethical compensation guidelines (51.0% vs. 2.0%, OR = 0.19,  $p < 0.001$ ), set maximum provider age at  $\leq 31$  (70.8% vs. 32.9%, OR = 4.96,  $p < 0.001$ ), have a minimum education requirement to provide eggs (35.3% vs. 6.5%, OR = 7.86,  $p < 0.001$ ), mention an egg provider compensation amount (98.0% vs. 66.2%, OR = 0.04,  $p < 0.002$ ), offer a range of compensation as opposed to a flat fee (78.4% vs. 13.7%, OR = 22.86,  $p < 0.001$ ), list a minimum compensation amount  $> \$5,000$  (37.3% vs. 18.2%, OR = 2.67,  $p < 0.018$ ), and mention preferable provider traits (76.5% vs. 21.6%, OR = 11.82,  $p < 0.001$ ). Agencies were more likely to discuss short-term risks like OHSS or infection (52.9% vs. 27.3%, OR = 0.33,  $p < 0.004$ ) and to allow providers and recipients to meet (39.6% vs. 12.3%, OR = 4.67,  $p < 0.001$ ). Clinics were more likely than agencies to acknowledge an unknown, possible risk of cancer (7.8% vs. 0%, respectively,  $p < 0.041$ ). While not statistically significant, only 25.5% of agencies vs. 19.5% of clinics mentioned psychological/emotional risks, and 11.8% vs. 5.2%, respectively, mentioned risk to future fertility.

## Discussion

This study, the first to examine systematically risk disclosures, eligibility requirements, mention of professional guidelines, and key aspects of the compensation structure in comparing egg provider agency and clinic recruitment websites in the U.S., suggests key differences in how these two entities operate. Specifically, clinics and agencies appear to differ in compliance with published ASRM guidelines and, more broadly, in ethical issues related to online recruitment. Agencies are more likely than clinics to violate ASRM guidelines about not only compensation for time and inconvenience, as opposed to the eggs themselves (as previously reported), but also to display compensation amounts online, to let the amount fluctuate, and to set the minimum > \$5,000—the threshold above which ASRM claims that payment “requires justification.”<sup>1,2,15</sup>

While previous research found that agencies are more likely than clinics to pay premiums for preferable traits (e.g., beauty, academic pedigree, ethnicity) and for proven fertility or tolerance of the egg donation process,<sup>1,15</sup> the present data examines a broader array of practices (e.g., whether compensation is displayed, fixed, above the \$5,000 threshold, and contingent upon the egg provider’s education). Agencies appear more likely not only to compensate women for their time, but to vary prices based on market demand and to offer ethically questionable higher sums without a case-specific justification.

Clinics are often associated with academic medical centers and inevitably involve physicians. Agencies may thus be more likely than IVF clinics to discuss short-term and long-term risks in order to gain trust from physicians and clinics that might refer patients. Agencies are also more likely than clinics to refer to ASRM guidelines on compensation—perhaps to be seen as ethically responsible by website viewers. In contrast, ART physicians are expected to follow higher professional standards and may thus feel less need to state regulations explicitly on their websites. Agencies also may discuss risks more frequently because they also specify compensation amounts more often. ASRM guidelines state that advertisements presenting financial or other benefits should also present risks and burdens.<sup>6</sup> In contrast, clinics may feel less compelled to discuss risks online because they are also less likely to discuss compensation there. Clinics also may see discussion of risks as premature, since they are the ones prescribing the medications and conducting the procedures and thus anticipate discussing the risks in person.

Agencies’ greater likelihood of setting an age ceiling of 31 years suggests that agencies may seek to build an egg provider population with more ideal, marketable characteristics, since women’s fertility begins to decline at age 32.<sup>31</sup> Many infertile women looking for egg providers will know that increasing age is associated with declining fertility; indeed, these women may themselves be seeking eggs as a result of age-related infertility. However, agencies’ tendency to set the age maximum for providers at 31 years could also be seen as biased against women aged >31 who may still be reasonably fertile and viable egg providers.

Agencies are more likely to require a minimum level of education in order to provide eggs. This requirement may reflect traits that recipients often seek in egg providers, and beliefs



that intelligence is substantially genetic. This finding may underscore the notion that egg provision agencies look for “sellable” qualities in providers.<sup>32</sup>

Agencies are more likely to be in the Western U.S., consistent with previous findings on regional variations in egg provision practices in the U.S. Two studies have reported that egg providers are more likely to receive higher compensation in the West.<sup>2,30</sup> Our previous study found that websites located in the West are more likely to base compensation upon traits.<sup>1</sup> These findings do not establish a causal link between the greater number of agencies and higher compensation amounts in the West, but suggest that the West may have a more market-driven egg provider environment.

Previous research has found that agencies were more likely than clinics to give egg providers the option of being nonanonymous.<sup>23</sup> Our data supports this finding, while also indicating that this difference may arise from agencies’ sole, primary identity and function as businesses, rather than also providing treatment and care as clinics do. The fact that agencies more than clinics now allow nonanonymous egg provision may demonstrate a more flexible approach, presumably geared toward intended parents’ desires. This openness in the matchmaking process may appeal to intended parents who want to evaluate egg providers as much as possible, not just through minimal online profiles.

These data have several implications for future practice and possible policy. Our findings suggest possible needs for more professional guidelines, oversight, or monitoring regarding agencies, including better incentives for them to follow guidelines, given their higher likelihood to deviate in certain ways. Since agencies are free-standing entities, without necessarily having any licensed healthcare providers involved, their oversight poses a unique challenge to the fertility industry. Efforts could be made to expand the number of agencies that agree with SART to follow ASRM guidelines regarding oocyte donation. Currently, SART offers agencies, as an incentive for agreeing, listing on ASRM and SART websites. But other, stronger incentives, motivations or penalties could be offered. The agreement might include willingness to be randomly audited by ASRM and/or rewarded for compliance.

Agencies could also be consulted concerning ways of increasing compliance with ASRM guidelines and factors motivating noncompliance. Agencies have acknowledged the pressure to offer egg providers high compensation in order to remain competitive in the recruitment landscape.<sup>30</sup> If true, ASRM may benefit from understanding these challenges from agency perspectives. Extending a collaborative dialogue to other stakeholders (e.g., egg providers, intended parents, and even adults born from third-party egg providers) might also be beneficial.

Our findings indicate several areas for further research: to improve monitoring and aid in consideration of further possible guidelines and/or regulation. Research can examine the proportion of egg providers recruited through agencies versus clinics, assessing different recruitment pathways. Studies could investigate the paths that intended parents follow in approaching agencies and/or clinics. For example, if a fertility clinic does not recruit oocyte providers, how often does it refer potential egg recipients to agencies? Our data suggest this

scenario is likely, since 47% of clinics did not recruit egg providers online. Such clinics might refer prospective parents to ASRM-approved or other, compliant agencies or simply use the business value of the referral relationship to encourage agencies to improve practices.

Studies of egg providers, such as whether they simultaneously provide eggs through multiple clinics and agencies, and perhaps their own personal advertising, are also important. Research can probe, too, other aspects of the business and financial relationships between clinics and agencies. Some clinics or physicians may have financial stakes in agencies, generating conflicts of interest between market-oriented agencies and duty-bound clinics. Research can also assess the effectiveness of ASRM's existing regulatory practices, comparing the recruitment and compensation behaviors of SART-affiliated versus independent IVF clinics. Research might also investigate the behavior of agencies listed on SART's website that have signed the agreement versus those that have not.

Our study has several potential limitations. We collected data from agency and clinic websites, and information on the websites may differ from actual practices. A list of websites could have been compiled alternatively, potentially using searches for keywords other than *egg donation* (e.g., *selling eggs*) or using classified ads.

Nonetheless, this study provides the first systematic data on how agencies differ from IVF clinics in key aspects of their websites' compensation, communication practices, and compliance with guidelines. This research thus has important implications for future practice, research, and possible guidelines.

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Relevant web hits for the term <i>egg donation</i>	414
No. of sites systematically assessed (50%)	207
No. of fertility clinics or agencies	194
No. that actively recruit online or via phone	128

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**Figure 1.**  
Summary of recruitment websites surveyed.

**Table 1**

Characteristics of Websites by Business Type

Characteristic of website	Business type (N = 128) <sup>f</sup>			Clinic vs. agency	
	Total	IVF clinic	Egg donor agency		OR (95% CI)
Organization information					
Type				n/a	n/a
Clinic	60.2%	77 (100.0%)	0 (0.0%)		
Agency	39.8%	0 (0.0%)	51 (100.0%)		
West coast vs. rest of the country				1.51 (1.03–2.22)	0.034
Northeast, South, Midwest, nationwide	69.5%	59 (76.6%)	30 (58.8%)		
West coast/Pacific only	30.5%	18 (23.4%)	21 (41.2%)		
Regulatory endorsement					
SART or ASRM approval				8.28 (3.04–22.58)	<0.001
Approved	78.9%	71 (92.2%)	30 (58.8%)		
Not approved	21.1%	6 (7.8%)	21 (41.2%)		
Does site reference ASRM guidelines when discussing compensation?					
Refers to ASRM	26.5%	1 (2.0%)	26 (51.0%)		
No mention of ASRM	73.5%	50 (98.0%)	25 (49.0%)	0.19 (0.002–0.15)	<0.001
Recruitment requirements for donation					
Age minimum				1.58 (0.74–3.36)	NS
21–22	60.5%	43 (65.2%)	26 (54.2%)		
18–20	39.5%	23 (34.8%)	22 (45.8%)		
Age maximum				4.96 (2.24–11.02)	<0.01
32–35	51.7%	47 (67.1%)	14 (29.2%)		
31	48.3%	23 (32.9%)	34 (70.8%)		
Education minimum					
No mention	82.0%	72 (93.5%)	33 (64.7%)		
Has minimum requirement	18.0%	5 (6.5%)	18 (35.3%)		
Compensation structure					
Compensation amount mentioned				0.04 (0.005–0.30)	0.002
Yes	78.9%	51 (66.2%)	50 (98.0%)		

Characteristic of website	Business type (N = 128) <sup>J</sup>			Clinic vs. agency	
	Total	IVF clinic	Egg donor agency	OR (95% CI)	p Value
No	21.1%	26 (33.8%)	1 (2.0%)		
Flat vs. range				22.86 (8.01–64.66)	<0.001
Flat	53.9%	44 (86.3%)	11 (21.6%)		
Range	46.1%	7 (13.7%)	40 (78.4%)		
Minimum compensation <\$5,000				2.67 (1.19–6.01)	0.018
Yes	74.2%	63 (81.8%)	32 (62.7%)		
No	25.8%	14 (18.2%)	19 (37.3%)		
Mentions preferable donor traits				11.82 (4.67–29.94)	<0.001
No	51.0%	40 (78.4%)	12 (23.5%)		
Yes	49.0%	11 (21.6%)	39 (76.5%)		
Offers referral bonus or upfront cash				0.39 (0.07–2.12)	NS
No	93.3%	48 (90.6%)	49 (96.1%)		
Yes	6.7%	5 (9.4%)	2 (3.9%)		
Donor privacy				1.62 (0.60–4.41)	NS
Access to donor database					
Requires registration	85.9%	68 (88.3%)	42 (82.4%)		
Does not require registration	14.1%	9 (11.7%)	9 (17.6%)		
Public access to donor phones				2.43 (0.65–9.10)	0.186
No	92.2%	73 (94.8%)	45 (88.2%)		
Yes	7.8%	4 (5.2%)	6 (11.8%)		
Allows donor/recipient meeting				4.67 (1.83–11.94)	0.001
No	76.1%	57 (87.7%)	29 (60.4%)		
Yes	23.9%	8 (12.3%)	19 (39.6%)		
Risks					
Short-term risks discussed				0.33 (0.16–0.70)	0.004
Yes	37.5%	21 (27.3%)	27 (52.9%)		
No	62.5%	56 (72.7%)	24 (47.1%)		
Are psychological/emotional risks discussed?				0.71 (0.30–1.65)	NS
Acknowledges risk	21.9%	15 (19.5%)	13 (25.5%)		
No mention of risk	78.1%	62 (80.5%)	38 (74.5%)		

Characteristic of website	Business type (N = 128) <sup>1</sup>		Clinic vs. agency		
	Total	IVF clinic	Egg donor agency	OR (95% CI)	p Value
Acknowledge possible cancer risk? <sup>2</sup>				n/a	0.041
Yes	4.7%	6 (7.8%)	0 (0.0%)		
No	95.3%	71 (92.2%)	51 (100.0%)		
Risks to future fertility acknowledged? <sup>2</sup>				0.411 (0.11–1.54)	NS
Yes	7.8%	4 (5.2%)	6 (11.8%)		
No	92.2%	73 (94.8%)	45 (88.2%)		

<sup>1</sup>For some website Characteristics, the data was not discussed on all websites, reducing the sample.

<sup>2</sup>No risks acknowledged<sup>1</sup> refers to both sites that do not mention the risk as well as sites that discuss it but assert no risk exists.