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EDITORIAL

DONOR SPERM

Epics and mythologies in different parts of the world are replete with apparently obvious references to conceptions resulting from donor sperm. Yet donor insemination is not legally accepted in many countries. In India there are no laws regarding donor insemination and hence the use of donor sperm in clinical practice is not legally forbidden. It is ethical to use it for proper clinical indications.

When the husband carries a Y-linked dominent major genetic disorder or the wife with a homozygous Rh positive husband is badly immunised against Rh antigen use of donor sperm is an obvious choice.

When the male partner is infertile or has a very poor fertility potential donor sperm can justifiably be used. Recent strides in Assisted Reproductive Technology (ART) have shaken up our concepts of male infertiljty and are even threatening to wipe out male infertility. Generally speaking, males with about 10 m sperm count have hopes with intrauterine insemination, 5 m sperm count with IVF-ET and still lower counts with micromanipulation. But ICSI (Intra Cytoplasmic Sperm Injection) conception can be achieved by a single sperm and even an apparently azoospermic male often presents a few motile sperm in lumens of the tubules at testicular biopsy. Whither male infertility?

For most of the infertile or grossly subfertile males in our country ART is either not available or not affordable. For those with marked oligoasthenospermia,

not amenable to standard treatment, donor insemination (AID) remains a practical option.

COUNSELLING

Adequate counselling is the essence of AID. A couple opting for AID must be happily married having a stable marriage. They should not be looking forward to the prospects of having a baby-by any possible means - as a solution to their marital problems. It is mandatory to counsel and thoroughly assess husband and wife individually and jointly. One must ensure that they have grasped the implications of AID and are looking forward to accept the resultant child without any reservation. Such a consentious counselling may have to spread over many sittings and it is better to give the couple ample time to make their final decision.

CONSENT

Valid, written and informed conset must be obtained from each of the partners in the presence of the other partner signing as witness. This consent authorises the gynaecologist to inseminate the female with donor sperm for the purpose of making her pregnant. It is desirable that there should be a fresh consent for each menstrual cycle of treatment. It is unethical and unpardonable to do AID without proper consent and knowledge of both the partners.

DONOR'S CONSENT

No body's sperm should ever be used for insemination without his knowledge and informed written consent. Donor's proper written consent must be obtained for using his sperm to inseminate a female, whose identity will remain unknown to him, for the purpose of achieving pregnancy in her.

CHOICE OF DONOR

Donor must be healthy, young, educated, from good family and of a proven fertility. His blood group and the gross features (e.g. skin colour, colour of the eyes, curly or straight hair etc.) should be the same as those of the husband. He should belong to the same ethnic stock as that of the couple. He should have no malformations (e.g. cleft palate, hare lip, spina bifida, hypospadias etc., - 5% chance for the offspring to have them), no Mendalian disorder (e.g. albinism, hemoglobinopathy etc.) and no familial disorder with genetic components (e.g. epilepsy, juvenile diabetes, asthma, hypertension etc. 5-15% risk for the offspring). Once a donor has sired 10 offsprings, he should no longer be used as sperm donor because of the possibility of future consanguinous intermarriages amongst these offsprings since they all could be living in the same geographical area. He should not be suffering from STD He should be HIV negative at the time of donating the sperm and for 4 months thereafter. He should abstain for 48 hrs. prior to giving semen.

ABSOLUTE NEED OF INTRA-UTERINE INSEMINATION FOR AID

The donor must be HIV negative at the time of collection of his semen. But he might have recently acquired infection and could still transmit it through his sperm though he be sero-negative. To avoid such

a possibility his sperm should be frozen, another test for HIV performed on him after at least 4 months (in practice this can coincide with the next donation of his semen) and the earlier frozen semen released for use only if he is still seronegative. This precaution should be considered absolutely mandatory since cases of HIV transmission through AID are coming to light with serious consequences to the gynaecologists involved. It is foolhardy to do AID with fresh semen sample. Since frozen sperm must be used, they have to be washed and intra-uterine insemination employed.

NEED FOR SECRECY

Under no circumstances the identities of the couple receiving semen and of the donor should ever be revealed to each other. It is ideal that no one individual should know the identity of the couple and that of the donor. The gynaecologist should not know who the donor is and the persons handling the donor and his sperm should not know who is going to receive the sperm.

RECORD KEEPING

In some states in U.S.A., children born as a result of AID, on reaching adulthood, are allowed to know the identity of their genetic father if they so desire. This apart, it is desirable that both the Gynaecologist and the semen bank maintain and preserve their records properly with confidentiality to be able to cope up with possible future legal problems.

PAYMENT TO THE DONOR

Should semen donation be clubbed with organ donation and/or blood donation? Most countries, including India prohibit payments for donating organs and aim to replace blood donors by voluntary professional blood donors. Trading in human tissues is frowned upon. In fact, sperm donation, though simple, is a much more serious matter than organ donation, or blood donation. This is because the person is donating his genetic material resulting in the birth of his biological offspring. Ideally, sperm donation should be voluntary. But donors are difficult to find and reasonable payment by way of compensation for the inconvenience for the time and money spent for visiting the semen bank is justifiable and ethical.

LEGAL STATUS OF THE CHILD

In countries where AID is specifically permitted by law, the child born as a result thereof has full legitimacy and enjoys the same legal rights as any other child. But what about countries like ours where there are no laws regarding AID? Despite all secrecy about AID treatment, the husband's aspermic status might come to the knowledge of his relatives who might try and deprive the child of property rights etc. in future on the ground that the husband could not have fathered the child. Quiet and secret but legal adoption of the child by the couple can be a desirable solution. But adoption is not permitted in certain religions. Incidentally, every aspermic or azoospermic male should be advised to keep his semen report a meticulously guarded secret from everybody except his spouse.

ADOPTION AS AN ALTERNATIVE

AID does not bless every couple with a baby. All couples coming for AID should

be asked to consider adoption as an option either in place of AID or after unsuccessful AID. Adoption is acceptable both socially and legally. Its only possible drawback is lack of breast feeding and bonding. But social benefits of adoption are tremendous. It is only the male ego and the implied open admission of infertility that makes adoption less acceptable. All attempts should be made to promote adoption.

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