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Merchandise or gift: Sperm banks and reproductive autonomy

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ABSTRACT

This paper is based on fieldwork conducted in a Scandinavian private sperm bank that operates independently of assisted reproduction clinics. The fact that it is openly run as a business has consequences for the perspective from which the genetic material is offered. It also mediates the relationship with individual recipients of the sperm. The existence of this sperm bank conflicts with the views of Spanish biomedical professionals, who argue that it is only possible to offer health and safety guarantees regarding samples and traceability of donations in authorized clinics in order to avoid the risks of incest and consanguinity.

KEY WORDS:

Sperm banks, sperm donation, reproductive self-management, anonymity / non-anonymity.

Selling means completely separating the thing from the person. Giving means maintaining something of the person in the thing given. (Godelier, 2000:189)

Introduction

Within a context of globalization and European integration, human assisted reproductive technology involving gamete donation (ART-D) cannot ignore two emerging factors: cross-border reproductive care and free movement of goods and people (Jociles, 2016:13). Set forth below are the reasons why this new reality is directly affecting sperm banks and donors. First, given the various national laws regarding ART-D, users are able to resort to countries in which it is feasible to implement reproductive practices that would not be possible in their home countries. Three particular services are of interest for Spanish users, who may wish to select their sperm donor, to choose between an anonymous or non-anonymous donor, or to directly self-inseminate at home. They can take any of these options by requesting the service they desire from a sperm bank located in another European country that has a different legal framework. As it is a more complex technique requiring medical intervention, egg donation cannot take place outside a clinical environment and will therefore not be considered in this article.

This article represents an in-depth continuation of the anthropological analysis commenced from 2002 to 2005 with respect to sperm banks and donors (Álvarez, 2008). The focus is broadened from a Spanish to a European and transnational scale. Though the fieldwork undertaken by Álvarez during the previous decade was carried out in sperm banks with links to private and public assisted reproduction clinics in Spain, this article is based on exploratory investigations in a private and independent Scandinavian sperm bank, which claims to be the largest sperm bank in the world. As we shall see, this bank is not linked to a particular clinic. As such, its background and management are fundamentally commercial rather than medical in nature. Even though Spanish law states that «donation shall never be for profit or commercial» (Law 14/2006, of 26 May, on assisted reproductive technologies, 126: 19949), the business approach of this sperm bank will inevitably have consequences for the form of presentation of the genetic material sold and for the relationships that the bank has with the individual recipients of that material.

Within this framework, management and decision-making with regard to semen sample collection, selection and use moves from experts working in clinics (biomedical professionals) to enterprises. Though these

businesses also employ biomedical professionals, they take decisions in an independent manner and those professionals no longer play such an important role in the management of the donation and insemination process. This new reality affects the relationship between sperm donor and bank. In particular, there is an impact on the choice available to recipients. They attain a degree of independence from medical authority; from the health-care professionals who previously held the power to make all significant decisions relating to donor identity and traits.

These changes would not have been possible without the emergence and spread of transnational and cross-border reproductive care (Storrow, 2011). Law 35/1988, on assisted reproductive technologies, was the first Spanish legislation in this respect and positioned Spain as a European leader in terms of assisted reproduction. This resulted in the development of clinics, experts and cutting-edge knowhow that have made Spain an international hub for assisted reproduction treatments (Bergmann, 2014; López and Moreno, 2015). In the context of globalization, people seeking access to reproduction treatments not available in their own countries due to legal or technological issues can travel to take advantage of opportunities in other parts of the world. Spain's favourable laws have made it a mecca for this kind of travel. There is abundant accumulated knowhow from decades of experience, which means high quality of care and competitive prices in terms of the international market. Spain is a benchmark for cross-border «reproductive tourism» (Deech, 2003:425), with a market share of 40% of European treatments according to the European Society of Human Reproduction and Embryology (León, 2016).

European legislation on freedom of movement and residence for people, and free movement of goods and capital has also encouraged the development of networks for the exchange of genetic material, which can be moved around the continent without facing customs barriers¹. This has meant that a sperm bank located in a Scandinavian country can provide male gametes both to clinics across the continent and to individuals who can directly access and select this genetic material online.

In the case of Spain, various reproduction practices are not incorporated into the legal framework but are in fact being implemented due to the wishes of many Spanish-resident individuals as regards reproduction:

1. Access to gestational surrogacy for heterosexual and homosexual couples and individuals of both sexes.

1. See the website of the Spanish Ministry for Health, Social Services and Equality: https://www.msssi.gob.es/profesionales/saludPublica/sanidadExterior/muestras_Biologicas.htm

2. Choice of donor for users, as selection and choice of donors and of their phenotypical traits (which must be similar to the mother- or father-to-be) is legally a matter for the reproduction clinics and their health-care experts.

3. Choice of a non-anonymous donor; in other words, a donor whose identity can be known and who can even be contacted by the child conceived using his semen upon reaching legal age (18 years in Spain).

As these practices are not possible in Spain, Spanish users access them by travelling to locations where gestational surrogacy is permitted (in the first case) and by going online to obtain genetic material from abroad (in the latter two cases). This article is focused on the second rather than the first option. It examines the aforementioned Scandinavian sperm bank and its implications in terms of social representations and practices. This will allow us to address aspects that cannot be analysed in Spanish banks, such as the opportunity to choose to be an anonymous or non-anonymous donor or whether or not to be included in certain profiles designed by banks that allow recipients to base their choices on a broader range of criteria.

The basis for this article is the experience of an ethnographic visit to the sperm bank in question, which took place in June 2015². The trip involved three interviews with sperm donors, supplemented by various interviews with senior staff at the sperm bank including its founder and director and its representative in Spain. We will also refer to the results of fieldwork carried out in clinics and with donors from the Community of Madrid between 2002 and 2005 by Álvarez (2008), in order to compare the current reality with the methods that have represented the hegemonic, majority approach in Spain to date.

The sperm bank

W. Pankhurst made the first recorded use of insemination with donor sperm in 1884 in Philadelphia (USA). The history of sperm cryopreservation dates back to 1953, when Bunge published news of having successfully frozen human sperm using dry ice. When subsequently thawed, this sperm maintained its fertilizing capacity and proper ensuing embryonic

2. Performed in the context of the project entitled «Crossed perspectives on families, assisted reproduction centres and donors: variations according to family structures and anonymous or non-anonymous donation» («Familias, centros de reproducción asistida y donantes: miradas cruzadas. Variaciones según modelos familiares y anonimato/no anonimato de la donación»). Ref.: CSO2015-64551-C3-2-R. (MINECO/FEDER)

development, the first baby being born using this technique in 1954. From the 1990s, concern over sexually transmitted infections (especially HIV) required cryopreservation prior to insemination with donor sperm (Swanson, 2012).

The first sperm bank in Spain was opened in 1978. There are various banks spread throughout the country, integrated within and authorized by the Spanish healthcare system and operating according to the standards established by Law 14/2006, of 26 May, on Assisted Reproduction Technologies. These standards entail the anonymity of gamete donors and oversight of the process for the selection of donors by agents of authorised healthcare centres or services (Official State Gazette, or BOE, no. 126, pg. 19949). Gamete recipients are hence not permitted to choose the donor in Spain (instead, the doctor will be the person to make the decision). Nor are children conceived via sperm donation allowed to know the identity or contact details of the donor who helped conceive them.

Sperm banks can be defined as a broad service that permits the preservation of frozen sperm samples over an indefinite period of time, held for use at the necessary time. The work of a sperm bank will range from scientific matters such as collecting and freezing samples (the freezing process uses liquid nitrogen at temperatures of -196 degrees centigrade) and subsequently preserving and thawing them, to administrative and managerial tasks such as identifying and locating samples, keeping registers, managing deposits and withdrawals, overseeing the periodic analyses required by law, and distinguishing between usable and unusable samples. Finally, the sperm bank manages sale and distribution of samples. Sperm samples are generally collected by masturbation after a period of three to four days' abstinence from sexual activity (Álvarez, 2008).

Sperm banks may be part of a wider clinic or function as an entity that is independent from the management of an assisted reproduction centre. Sperm can be preserved for private future use or for public use as donor sperm. Preservation for private use may be desirable for various reasons, including medical treatment that will affect fertility or make future coital reproduction impossible, wishing to postpone maternity and paternity, or being a trans woman and wishing to be able to use one's gametes at a future time. The donation of sperm for public use is intended to help other recipients in need of Assisted Reproductive Technologies (ARTs) to achieve maternity or paternity. There are two routes via which these user-recipients can access and use samples: by on-site clinical intervention, or in domestic surroundings by self-insemination using sperm obtained online.

The roots of a conflict: sperm banks vs. assisted reproduction clinics

There is an on-going debate in Spain with regard to whether it is legally and ethically permissible to separate sperm banks from clinics in the context of assisted reproduction. If this separation occurs, clinics will no longer exclusively control the management of the entire sperm donor selection process and technical procedure. Tensions arise when sperm banks open their doors to individuals without the clinic's involvement, as this gives users the opportunity to choose their donor and allows them to perform the technique in privacy thanks to home delivery of samples.

When users directly contact a sperm bank, they can choose (though not in Spanish banks) the phenotype, «race», anonymity/non-anonymity and certain specific profiles of a psychological or cultural nature. These samples can be directly used via self-insemination or via clinical professionals for other techniques. It is also possible to choose certain sample parameters, such as the sperm count, based on the reproductive technology being used for the sample (insemination, IVF, intracytoplasmic sperm injection (ICSI)).

ART users making direct contact with sperm banks is no novelty in Spain. Between 2002 and 2005³, in public clinics that did not have their own bank but provided treatments using donor sperm, couples had to make direct applications to sperm banks and pay for the samples. The assisted reproduction centre never acted as an intermediary, limiting itself to providing couples with telephone numbers for various sperm banks. Once the sample was in its possession, it would process and use it for the relevant treatments.

The most suitable approach in public centres is for patients to manage sample requests. In order to do so, you must contact our centre at least one day (preferably at least three days) in advance. We will also advise you on any doubts you have with relation to our donors, as well as asking you for your phenotype and that of your partner. (Written letter from Spanish sperm bank in 2002 in response to a consultation made by Álvarez)

Samples were sent to the assisted reproduction centre via private courier in a special container that would ensure their preservation. Shipping would take two or three days. The cost ranged from €230 to €250 (2002 prices), including costs of delivery between two Spanish cities.

3. Fieldwork in clinics within the Community of Madrid (Álvarez, 2008).

If users go directly through a non-Spanish sperm bank, without the intervention of a clinic, they can receive a perfectly packaged and preserved sample delivered to their homes with precise instructions and materials for performing an artificial insemination. Some women and couples self-inseminate⁴ because it is simple, cheaper, and permits control over the whole process (Pichardo, 2009: 232-233). Since 2008, the Scandinavian sperm bank has sold sperm samples in Spain that allow women to choose their donor, who may or may not be anonymous, and then to inseminate themselves in their own homes. This approach has resulted in between 500 and 1,500 children being born in Spain (45,000 have been born worldwide via this method)⁵.

Spanish media made ample reference to an increase in use of the self-management option by the Spanish population in 2016, publishing large amounts of information referring to the opportunity and reporting on a dispute between the Scandinavian sperm bank and Spanish clinics. The response of the clinics to what they considered an invasion on their territory gave rise to strong tensions with the Scandinavian bank. Through their associations (the Spanish Fertility Association, the Association for the Study of Reproduction Biology and the Spanish Andrology Association), biomedical professionals issued a statement with relation to the supply of «at-home insemination» offered by some sperm banks (Sociedad Española de Fertilidad, 2016).

These professionals cited clinical and legal arguments against allowing the practice of direct sales of sperm to «patients» to continue. The legal grounds were based on the express statements in the Assisted Reproduction Act 2006 (*Ley de Reproducción Asistida de 2006*) that assisted reproduction technologies can only be performed in licensed healthcare centres or services, and that only the medical team implementing the technique can choose the donor. The clinical arguments referred to the absence of health guarantees, lack of compliance with quality and safety standards required under Spanish and European law, the lack of liability insurance for situations in which loss could arise, and the problem of traceability —that is, monitoring the children born from each donor's contribution.

The sperm bank argued that the privacy of the domestic environment in which the self-insemination was being carried out meant that there was no breach of law.

4. The concept of DIY conception, as coined by Bettina Bock von Wülfingen (Bergamann, 2014: 308)

5. Estimate from Cryos International <http://www.elmundo.es/cronica/2016/01/03/5687c-9d2ca474110268b45cb.html>

The accusations that at-home insemination is prohibited in Spain, that our website is illegal and that the method is dangerous are incorrect. This is a method that the woman chooses to use in her home, and this law does not cover what someone does in their own home [...]. Of course, women with fertility problems should attend a clinic (Eckstein, *El Mundo* newspaper, 1 March 2016).

Moreover, some women using self-insemination demand more pragmatic regulation, so that legal recognition may be afforded to this reality: many users wish to choose the traits of their sperm donor and prefer if possible to avoid the rigid and unwelcoming environment of the clinics (Pichardo, 2009: 232-233, 244).

Various issues are subject to debate in this dispute between Spanish clinics and the Scandinavian sperm bank. In this article, we will focus on four of them: whether at-home insemination is a technically (and medically) assisted reproduction technology; whether it should be the biomedical professionals who are the (only) actors with social authorization to choose donors; whether it is only possible to eliminate health risks in clinics (excluding sperm banks outside of the perimeters of the health system); and whether traceability (monitoring the number of births from a donor) is only guaranteed in clinics.

The International Committee for Monitoring Assisted Reproductive Technology (ICMART) and the World Health Organization (WHO) revised glossary of ART terminology (2009) defines artificial insemination, whether using sperm from a partner or from a donor, as follows:

Assisted reproductive technology (ART): all treatments or procedures that include the *in vitro* handling of both human oocytes and sperm or of embryos for the purpose of establishing a pregnancy. This includes, but is not limited to, *in vitro* fertilization and embryo transfer, gamete intrafallopian transfer, zygote intrafallopian transfer, tubal embryo transfer, gamete and embryo cryopreservation, oocyte and embryo donation, and gestational surrogacy. ART does not include assisted insemination (artificial insemination) using sperm from either a woman's partner or a sperm donor (Zegers-Hochschild, 2009: 1521).

The lead author, Dr Zegers-Hochschild, was consulted on 3 January 2016 regarding the statement in the glossary that artificial insemination is not considered an ART. He responded that it is not technically an ART as most countries do not include it in their statistics:

The reason for not including insemination as an Assisted Reproductive Technology (ART) is essentially a matter of record-keeping. In the majority of the world where detailed records are kept of IVF (*in vitro* fertilization), ICSI

(intracytoplasmic sperm injection) and OD (oocyte donation) procedures, the ovulation stimulation and intrauterine insemination cycles are not recorded [...] The same does not happen with andrology laboratories responsible for preparing the sperm, or with the recording of those procedures. The term of medically assisted reproduction (MRA), which includes insemination as well as ARTs, was created for these reasons.⁶

The second area of debate relates to whether biomedical staff should have sole discretion in terms of choice of donor. Both Spanish law and Spanish clinics state that the medical team is responsible for selecting the donor, maintaining that the guarantee that the donor would be the most appropriate fit for the recipient couple would be affected if the recipients were to take on this responsibility. They also argue that there would be a risk of promoting commercialization of gametes due to the demand for specific phenotypes. In this respect it should be noted that, while Spanish law does clearly allocate this responsibility to the medical team, the reality is that there is a phenotype market in Spain. Under the umbrella of «integrating» the future child into the woman's family environment, certain aspiring donors will be discarded due to their phenotypical traits (Álvarez, 2008). The insistence on «similarity» masks the opportunity to decide to conceal genetic origin, both within the family and from the child themselves. Pichardo, Stéfano and Martín-Chiappe (2015) have described this as «phenomania» based on the premise advanced by Fonseca (2008): «a value is placed on the importance of —and informal strategies are employed in the interest of— making the child phenotypically similar to the parenting couple, with the aim of naturalizing the relationship both within the family and vis-à-vis the family of origin and society as a whole».⁷ There is a strong racist bias, with certain phenotypes or «races» not easily accepted in Spanish clinics and others, in contrast, subject to high levels of demand. In any case, nobody can guarantee that the desired traits will materialise and no claim can be made in this respect, since genetics offers no certainty as to descendants (Álvarez, 2008). For the heads of the Scandinavian bank, this is straightforward: if the couple or individual chooses the donor, they bear sole responsibility for the resulting child, freeing the doctor or medical team of any problems.

The third issue that arises relates to the alleged health risks run by users engaging in at-home insemination. In this regard, the Spanish Fertility Association (SEF, due to its initials in Spanish) insists that though the controls may be correct at a sperm bank as regards sample processing

6. Author's own translation.

7. Author's own translation.

and storage, it is possible that the cold chain could be broken in transit, meaning the samples would not arrive in a perfect state⁸. Samples are undoubtedly not subject to the same controls in homes as are implemented in clinics, and techniques are not applied with the same conditions of asepsis/sterility. Nor is the technique exactly the same: the sample is introduced into the interior of the uterus in clinics, while it is placed in the vagina at home as would be the case for coital reproduction.

Finally, sample traceability—that is, their route and effectiveness (live births)—is another matter of concern for clinics. This is an interesting issue, as Spanish clinics also purchase samples from the same Scandinavian sperm bank that offers them directly to private individuals. The doubt hence relates not to control of the bank-(sperm)-clinic / clinic-(birth information)-bank route, but to the bank-(sperm)-home / home-(birth information)-bank pathway. It is taken for granted that clinics report births to banks but, in contrast, users are not trusted to do their part. This information is highly important given that there is a legal limit on live births per donor in many countries. These limits are domestic, meaning that a single donor can reach the maximum limit of babies in each one of the countries to which his semen is sent. This enormously increases the number of babies that can be born from a single donor in Europe and throughout the world. The website of the Scandinavian bank in fact specifically lists the countries to which samples from a particular donor can no longer be sent due to the legal limit having been reached in that case. In addition to these legal limits, knowing the effectiveness of samples with regard to live births originating from each donor is also necessary in case complications arise with regard to the child's health, which would make it necessary to retrace the donor.

Though the clinics argue that there are higher levels of effectiveness for the assisted reproductive technologies used in their context than for at-home self-insemination, this claim has not been proven with empirical data. They also state that doctors are the parties legally authorized to select the donor and that the law will be broken if the recipient woman or couple can choose the physical features of donors. The argument that only a certain kind of phenotype would be selected contradicts the phenomena to which we have referred: the desire that parents have for their children to physically resemble them. If these are the *emic* arguments, from an *etic* perspective we may argue that this rejection of a self-managed process (from donor selection to the technology itself) has material

8. <http://www.sefertilidad.net/newsletter/newsletter19.html> (accessed on 21 April 2017)

foundations: financial loss for clinical enterprises and loss of control over the reproductive process for health professionals.

This conflict places us in a difficult conceptual position with regard to the use of gametes —and, in general, concerning assisted reproductive technologies. We are faced with a biomedical process taking place via «donations», or with an industry in which sperm is simply another item of merchandise to be bought, sold and distributed.

Sperm as merchandise vs. sperm as genetic material. Should gametes be commercialized?

The *Statement of the Spanish Fertility Association on gamete donation*⁹ states that there is an increasing need for gametes in Europe. It is calculated that 33% of assisted reproduction treatments in Spain are carried out with donor gametes. In the case of sperm donation, the increase in demand is due to new groups such as single women and lesbian couples having access to ARTs, but also because of the increase in problems with male fertility due, among other factors, to environmental issues. A burgeoning market has developed, which is of particular importance in the Spanish case given that Spain is identified as one of the main «reproduction destinations» in Europe with a flourishing «fertility industry» (Benavente & Farnós, 2015).

Should gamete donation be financially compensated? Do private clinics take a profit from the sum they charge recipients for gametes or are these clinics limited to charging for the costs of their management? The Assisted Reproduction Act 2006 establishes that donation is a contract without consideration, formal and confidential between the donor and the authorized centre and not for profit. Conceiving of gametes as merchandise causes concern, bringing into question as it does the altruistic motivations attributed to those providing their samples. However, the legal and social discourse focusing on the absence of consideration does not correspond to the practical reality. The majority of donors are acting for financial reasons. According to a study conducted by Lucía and Nuñez (2015), in the case of Spain in 2012 and 2013 only 23.91% of men and 31.6% of women donors cited exclusively altruistic reasons («to help») for donating gametes. We find similar data in Denmark, where only 19% of sperm donors in 2012 reported a solely altruistic motivation (Bay et al., 2014).

9. <http://www.sefertilidad.net/docs/noticias/donacionGametos.pdf>. (accessed in August 2016)

As stated by Pichardo et al. (2015), we can refer to a «reproduction market» containing people who give money for access to sperm, eggs, embryos and uteruses, and others who will receive (symbolic) financial compensation for supplying those materials. Acting as intermediaries in these processes are private clinics, the State (via public clinics and hospitals) and other kinds of businesses such as sperm banks; it is these entities that will broker the relevant exchanges. If the entities in question are private clinics or private sperm banks—that is, businesses—then one of their main aims will be to obtain a financial return from the exchanges¹⁰. And if they are public entities, while they will not have this aim of making a profit, they will nonetheless also have to pay for access to gametes or embryos from their donors or act as intermediary so that recipients can pay for the reproductive material collected by private clinics or businesses.

The World Medical Association (WMA) recommends not engaging in commercial transactions involving human reproductive material, eggs, sperm and embryos (WMA Resolution, 2014). But this material has a very high market value, generating millions of dollars worldwide. In Scandinavia and the USA, direct reference is made to donor remuneration. In contrast, in the south of Europe and particularly in Spain, this term is avoided and replaced by compensation for inconvenience (*compensación por las molestias*), thereby denying the possibility of the transaction being reproductive work. All of this occurs in a country that is, in reality, a commercial powerhouse for assisted reproduction (Bergmann, 2014; López et al. 2015).

As regards financial compensation, both the Spanish Fertility Association and the National Committee on Assisted Human Reproduction (*Comisión Nacional de Reproducción Humana Asistida*) support the continuation of compensation for gamete donation in Spain, with equal sums available from each centre to avoid commercialism. It is prohibited to state the sum that donors will receive for their genetic material in publicity. In contrast, the professionals at the Scandinavian sperm bank refer to the «semen industry» without attaching any pejorative meaning to the term. The director of the bank speaks clearly on the commercialization of sperm:

«Sperm is a good or service for European law. [...]. There are laws in Europe on the free movement of people, goods and services. Sperm can travel freely in Europe since it is not subject to duties or customs control within the countries of the European Union» (June 2015).

10. For example, the IVI-RMANJ group invoices 300 million euros annually and has 2,400 employees. <http://valenciaplaza.com/ivi-fusion-rmanj> (accessed on 21 April 2017)

With relation to this idea of the reproduction market, we encounter fears that removing anonymity in Spain could increase the risk of a reduction in the number of donors and, consequently, endanger the industry generated by these technologies (Igareda, 2014).

Recipients: client vs patient

The clinic/business and donation/merchandise dichotomies are reflected in conceptions regarding the people receiving the gametes as part of their ART treatments. Are they clients or patients? The term «client» implies the person being involved in a commercial relationship as the consumer, who is paying and therefore in a position to choose and demand the best service, holding rights and enjoying a capacity to make decisions in the reproductive process. The moment when the client/user signs an informed consent document within the context of this relationship represents a point at which they can exercise this capacity to make decisions and choices. This approach is characteristic of privately financed healthcare services. Meanwhile, the term «patient» suggests submission to the medical professional (Priego, 1995). If we move these terms into the context of assisted reproduction, the expectations and needs of those attending Spanish clinics are satisfied, but the same cannot be said of some of their preferences. Users can choose from different techniques (insemination, intracytoplasmic injection, receiving a partner's eggs, etc.). They can decide whether to become parents alone or as part of a couple. They can decide to postpone the genetic process (by freezing eggs, sperm, or embryos), and they can donate their genetic material to other people. But they cannot select the donor phenotype or opt for a non-anonymous donor. In the Spanish system, the doctor is the sole actor empowered to select the phenotype of the donor.

Various issues arise as a result of this restriction, including why recipients should be prevented from choosing a donor, whether they want to be able to choose donors, and if they can be prevented from using a foreign sperm bank that offers them such a choice.

We have a licence to distribute worldwide. But if you want to prevent a woman from carrying out a private self-insemination, are you also going to stop her going to a disco and finding a man there? [...] we have no idea of how something like this would be prosecuted (professional, Scandinavian sperm bank, February 2015).¹¹

11. Author's own translation.

People are not limited to clinics. At-home insemination represents a viable alternative. In such a context, users may have different concerns about donor selection. They may demand additional information regarding health and safety controls and sperm quality.

People want to get pregnant and at-home insemination is a cheap option. There is also an increase in single women and lesbians. [...] What clients are interested in and lots of people ask about is the subject of screening and the tests we do. [...]. You also have to add an extraordinary quality of sperm. (professional, Scandinavian sperm bank, February 2015)

Everything leads to the conclusion that there is no end to the potential complexity of demands, and that new groups will also request ARTs. These demands are far from purely biomedical in nature. As the authorized intervening social actor, doctors must judge situations that go beyond the healthcare field and are required to satisfy the genetic desires that groups have. But should professionals take decisions or restrict themselves to providing advice? The Scandinavian sperm bank refers to «counselling» and self-service vis-à-vis the broad range of options available to its clients. This self-service occasionally requires counselling, which —our respondents insist— simply entails responding to doubts and pointing out key issues to take into account when making the choice as to a donor.

When someone is involved in the process and goes online, there is so much information! [...] Is there anything else I have to think of? That's why we have done a video, too. [...] It explains pretty well what you have to bear in mind and what ... We also say: 'You have to consider: do you think you would like your child to know or not?' We give some sort of guidelines: this is what you have to bear in mind» (professional, Scandinavian sperm bank, February 2015)

The client relations department offers a highly important service for clinics and also for sperm banks, agencies and all businesses connected with assisted reproduction. The level of complexity encountered in the ART process is so high that some recipients are even seeking personalized assistance independently of the advice they obtain from clinics. In the course of our fieldwork, we encountered new professionals who are emerging in Spain and known as «international patient care advisors». These professionals have an awareness of the social reality of certain other European countries where regulatory restrictions mean there is demand in the area of cross-border reproductive care. They offer benefits to both clients and clinics, performing market studies in order to identify the potential demand for reproductive services that cannot be satisfied in a

particular country (France and Italy, for example) and then advising potential clients on the clinics they can attend before guiding those clients through the process.

Oversight of sperm donations and donor selection

We noted above that authorized clinics and banks are the only entities to which Spanish law grants the capacity not only to guarantee basic health-care standards, but also to choose donor. The intent is to avoid eugenic reasoning in donor selection and to manage the number of donations, enabling control over the number of babies born per donor with the aim of preventing the risk of consanguinity. These issues raise two matters that are ethically charged in European society and go beyond medical grounds: avoiding eugenics and incest.

The ethical debate regarding donor selection by users is underscored by the possibility that such selection may be made on the basis of eugenic criteria. It is first necessary to discard the idea that this is not in fact already happening with clinic-controlled ARTs. The director of the Scandinavian sperm bank informed us that in his opinion, donor selection criteria will go beyond phenotypes, becoming focused on gene sequence and entering the area of reprogenetics (Lee, 1997). Linking genetics and assisted reproduction may have a high impact on family structures and demographics (Sánchez, 2011), with the human genome no longer considered as «an inviolable inheritance (of humanity) that must be preserved» (Hidalgo, 2011:119).

Does the control function as performed by the clinics prevent consanguinity? How do clinics monitor births from children born using donor sperm? During the ethnographic fieldwork phase between 2002 and 2005, it became clear that there was great difficulty in obtaining details with regard to the incidence of live births from gamete recipients (Álvarez, 2008). Birth was not reported to the clinics in all cases of pregnancy, making it impossible to identify the precise number of births per donor. In this respect, we were informed of the difficulty of requiring and monitoring such information at interview:

We always ask for it. It's in the contract that they have to do it. But of course, what can we do if they don't? I mean, we want to trust that they are doing it. It is true that in Spain the registration issue... it would be a lot of work if we had to chase it up. (professional, Scandinavian sperm bank, February 2015).

The non-functioning of the donor registration system in Spain to which the professional refers¹², in addition to the difficulty of knowing with precision the number of children born from donor sperm (whether in clinics, through known donors, from direct purchases of sperm from banks, or via websites offering men to donate sperm with or without remuneration outside the context of clinics and sperm banks), allegedly gives rise to a risk in terms of consanguinity issues. But is this actually the case? The rationale for the choice of a particular number of births from one donor and not another appears to be arbitrary in terms of quantity. In fact, up to 25 descendants per donor in a population of 800,000 people would not lead to a higher probability of consanguinity from accidental contact between descendants of donors (Janssens et al., 2015).

Concern over consanguinity does not provide reasons for arriving at an acceptable quota of live births per donor. Quotas on descendants are not uniform worldwide: in some countries, such as Spain, there is a limit of six, while in others such as the USA there is no maximum number. Defining an opinion as to donation quotas is a complex matter, since it involves highly diverse interests: those of clinics and sperm banks that have to «monetize» their donors, and those of recipients who may wish to control and reduce the quotas of live births per donor. This is what seems to be suggested by the availability of direct-purchase sperm banks offering the opportunity to make a donor «exclusive» via the purchase of all the sperm samples that a bank has obtained from that donor.

And what do the sperm donors think of quotas? Van der Akler et al. (2006) conducted a survey in which the majority of donors imposed no limit on the maximum number of descendants conceived with their sperm, while others did impose a limit ranging from four to twenty. The Scandinavian sperm bank offers its donors the option of setting a limit. Of the three donors we interviewed in Denmark, two opted for a limit of 50 and one for 25 live births, from which point the sperm bank would cease to use their sperm.

12. In November 2016 (twenty years after Royal Decree 413/1996, which insisted on control over the traceability of donors), at «*the 8th Workshop for the National Activity Register of the Spanish Fertility Society (SEF), which took place at the headquarters of the Ministry of Health, the general subdirector of the Basic Services Portfolio of the National Health System and Cohesion Fund (Cartera Básica de Servicios del Sistema Nacional de Salud y Fondo de Cohesión) has announced that the draft Royal Decree that will regulate the gamete and pre-embryo donor register has been finalized, for which reason it is soon to be approved. Ten (in reality, twenty) years after its existence was presumed, it appears that the register will finally be a reality*». (our emphasis) http://www.elespanol.com/ciencia/salud/20161108/169233574_0.html (accessed on 3 December 2016).

It is difficult to reach a consensus on the maximum number of babies that may be born from a donor's sperm (in their country and abroad), particularly in situations involving cross-border reproductive assistance. Janssens et al. (2015) state that at international level, there are no rules for the responsible use of donor sperm and research can only offer support and guidance. Faced with private individual initiatives involving reproductive self-management, little can be restricted. Janssens et al. suggest that the best approach is to offer guidance and transparency, and not to criminalize or sanction such activities. The acceptable number of descendants per donor is not solely in the hands of the clinics and not even within the control of the authorities of a single particular country.

Would I choose this donor for myself? Phenotype *versus* intuition

Issues with regard to sperm donors that require in-depth examination include —among many others— the systems for recruiting sperm donors, granting exclusion from or access to the donation system, donors' motivations, the impact of donation on their lives, and the repercussions of removing anonymity. We will restrict ourselves here to briefly noting some aspects of the relationship between sperm bank and sperm donor; for example, the requirements to be a donor beyond biomedical and phenotypical aspects and the perception that professionals at the sperm bank have of donors.

Donor selection adheres to a particular procedure at the Scandinavian sperm bank. The first filter is based on the quality of the sperm, and entails the rejection of 90% of candidate samples. There is then a psychological questionnaire and medical and analytical exploration, which results in more samples being discarded. Once these filters have been completed, the donor chooses whether they wish to make an anonymous or a non-anonymous donation. There is a choice in both cases between providing a basic profile (with a small number of very general details such as hair and eye colour, height, blood group, race, and ethnic origin) or offering an extended profile for which the donor provides more personal details without revealing their identity (tastes, interests, family details, childhood photo, voice recording, written note) in addition to the basic details. Finally, sperm bank employees record their personal and subjective impressions of each donor, answering the question: «would I choose this donor for myself?». Their answers for each donor are published online.

What features must a sperm donor have in order to be selected? In Spanish sperm banks, donor age must range between 18 and 35 years

(Álvarez, 2008), while the Scandinavian bank permits donors up to the age of 45 if their sperm quality is sufficient. The minimum age varies based on whether the donor is anonymous (18 years) or non-anonymous (25 years). The professional we interviewed at the Scandinavian sperm bank told us that «in order to be non-anonymous [as a donor] —the requirement is not legal— we require that they are aged at least 25 years, because they need a certain maturity». Other requirements include good physical and psychological health, no genetic disorders or hereditary illnesses in their own case or that of their direct family members, and, obviously, having high-quality sperm. Their samples must also be capable of adequately withstanding the freezing and thawing process. But once all the tests have been passed, how is the final decision to accept or reject a sperm donor taken?

In addition to the above-outlined conditions, there is demand for certain traits that are considered «acceptable», while reproductive samples capable of transferring less desired traits such as «strong features» or «dark skin» are rejected (Álvarez, 2008).

The symbolic condensation of the gamete allows one to think of transferring bodily elements of one's ancestors; the gametes are substances that create a permanent relationship between people. If the phenotype («normal features») does not match the genotype (family background from other «races»), it will be rejected out of fear that this non-matching will be clear. During our interview with a professional from the Scandinavian sperm bank, the interviewee identified the phenotypical aspects that recipients request:

Most of all they're Danes, but we also have other ethnicities. But it is true that there is lots of blonde hair and blue eyes in Denmark and we have demand in so many areas that we're also interested in these Danish donors for export. [...] They prefer a certain height of 1.70 or 1.75 (minimum). [...] As in general the doctor's going to talk with the person, they can have a bit of an idea of the donor's personality. If they have an idea, I don't know... not only the appearance ... But if they actually see an attitude, a very unpleasant manner, impoliteness ... And if he's obese as well, I imagine that they'll say no. But not to his face (professional, Scandinavian sperm bank, February 2015).

It is difficult to analyse the role played by phenotype in donor selection through a comparison of Spanish banks with the Scandinavian one. In the Spanish case, it is the clinic and not the user that makes the choice. In the Scandinavian case, meanwhile, the client chooses from the previously described range of options: anonymous/non-anonymous; basic/extended profile; and a broad range of information on physical, psychological

and emotional characteristics, including the subjective impressions of staff. The service offered by the Scandinavian bank extends to the possibility of reserving an exclusive donor, whose samples would only be used by the particular person or couple. This would require the acquisition of all the existing sperm belonging to the donor in question (the cost of which is €12,000)¹³. This option may be suitable when one wishes to have the same donor for more than one child and to ensure that others cannot use sperm from the same donor.

As stated, in addition to the phenotype, the impression that a donor creates will also play a role in the selection process. This role is express and public in the case of the Scandinavian sperm bank, while for Spanish sperm banks it will also be present, though not in such a visible manner. In the fieldwork conducted by Álvarez, reference was made to the impression created by sperm donors attending the bank:

When he attended his first appointment in 2004, Darío entered the laboratory of the sperm bank and we all agreed that he was a very attractive man. So then you heard, «we've got to take him!». He was 21 years old at the time of the interviews, [...] The attractive thing about Darío is not only his physical appearance; he's a man with social skills, friendly, well-mannered and helpful (Álvarez, 2008: 178).

This first impression, deriving solely from his physical appearance and behaviour with the staff at the bank, played an important role in the decision to accept him as a donor. Details are known about his socio-economic background (area of residence, tastes and interests) because he was asked and his responses recorded in his «clinical» history. In the case of this Spanish sperm bank, the information never reached the recipient, but it did reach the staff selecting the appropriate donor for that recipient. This is an informal system of in some way recording the donor's intellectual and personal skills.

The staff's impression is also a significant factor in the assessment of a «good donor» for the Scandinavian sperm bank. This was conveyed to us by its spokesperson (January 2015), who, when asked who was in charge of describing and recording on file their impressions of the donor's personality, responded:

At the offices [...] when the donor comes, they start to talk with the receptionist or with the lab staff [...] The donor has a degree of trust in us ... they chat a little and if you have known each other for a while, people have a bit of

13. Prices consulted on 23 April 2017 at the website of the Danish sperm bank: <https://dk-es.cryosinternational.com/esperma-de-donante/precios-y-formas-de-pago>

an impression of how someone is, don't they? Whether they have a sense of humour, or are shy ... they have this impression of the donor, which doesn't mean they know who he is, but you have something of an impression. Something like «I'd choose that donor for myself!» (professional, Scandinavian sperm bank, February 2015)

During our interview with the director of the Scandinavian sperm bank, the importance attributed to the impression that the donor made on the staff attending to him was again highlighted. The following observation of a donor by the surname of Almin, available on the bank's website, offers an example of the notes made regarding the impression that a donor makes:

Almin is always heading the staff with a smile. He is very down to earth and calm. He often wears a cap, and a windbreaker or raincoat. He is naturally handsome. Almin arranges teambuilding courses, and is also a teacher substitute. He seems to be a very social guy. Almin resembles Zachary Quinto with flat hair.

We can thus see how the binary distinctions that have been drawn over the course of this article are reproduced with the phenotype versus intuition dichotomy. They may be summarized, by way of recap, in the following table:

<i>Sperm bank</i>	<i>vs</i>	<i>Reproduction clinic</i>
Sale		Donation
Business entity		Healthcare institution
User: client		User: patient
Sperm: merchandise		Sperm: genetic material
Donor selection: client		Donor selection: biomedical staff
Profit: explicit		Profit: implicit
Reproductive autonomy and self-management		Healthcare management of reproductive process

Table 1. Author's own

Conclusions

Advances in ARTs, globalization and legislation have turned this area into a major business, with a powerful industry that accounts for millions of euros in Spain in spite of the economic crisis (Igarada, 2014:219).

Based on the approach outlined in Spanish law and in other parts of the world, clinics place the emphasis on the biological (genetic) character of the gametes. Therefore, their decisions in this regard form part of a healthcare process that views users as patients and places the biomedical staff in the ultimate decision-making position. It is presented as necessary for healthcare professionals to control the technical process and donor selection and for anonymity to be preserved, given the fear that removing it would lead to a lack of donations.

The emergence of business-focused sperm banks in the north of Europe, operating on the periphery or border of the healthcare system, has given rise to tensions between two differing (in many cases opposing) discourses and interpretations concerning male gametes. For sperm banks, sperm is provided on a strictly business rationale, pursuant to which it becomes merchandise that is offered to the European market as a whole given the existence of free movement of goods. In this market, the user is a client with the right to select what they «buy», and the business does not conceal its desire to make a profit.

We are faced here with a reproductive market that involves payment (from clinics/banks to donors, and from users to clinics/banks), which is presented in the case of clinics as «compensation» for donations and in the case of banks as remuneration. There is hence a concealed competition to attract users (and therefore revenue) and to control the reproductive process.

An open conflict has therefore arisen in Spain between sperm banks and clinics, expressed by the clinics in terms of traceability, consanguinity, and health and safety guarantees as regards samples. Sperm banks trumpet the rights of users to reproductive autonomy, arguing that citizens using these reproductive options should be able to self-manage the entirety of the process, allowing them to select how they reproduce and with whom.

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