Fertility • Genomics • Clarity

Egg Donation and Freezing

Inquiry response by PET
9 January 2026

Our organisation

The **Progress Educational Trust** (**PET**) is an independent charity based in the UK, which seeks to improve choices for people affected by infertility and genetic conditions.

The vision of PET is to improve choices for people affected by infertility or genetic conditions. The mission of PET is to educate and to debate the responsible application of reproductive, developmental and genomic science.

Our precursor organisation – the **Progress Campaign for Research into Human Reproduction** – was founded in 1985, in opposition to a Private Member's Bill that had been tabled in 1984 by Enoch Powell (then an Ulster Unionist MP for South Down). Had it been passed, Powell's Unborn Children (Protection) Bill would have prohibited IVF and human embryo research in the UK.

Powell's Bill was ultimately defeated, and the Progress Campaign supported a preferable regulatory framework for fertility treatment and embryo research – one that had been proposed in 1984, by a Committee of Inquiry chaired by Mary Warnock (subsequently Baroness Warnock). The Committee's report, nowadays often referred to as the *Warnock Report*, formed the basis for Human Fertilisation and Embryology (HFE) Act in 1990. This in turn led to the establishment of the Human Fertilisation and Embryology Authority (HFEA) in 1991.

Once the HFE Act had been passed and the HFEA had been established, the objectives of the original Progress Campaign had been fulfilled. PET was launched in the Campaign's stead in 1992, and Baroness Warnock served as the Patron of PET from 2010 until her death in 2019.

Our reason for submitting evidence to this Inquiry

All of the activities and issues that fall within the scope of this Inquiry also fall within the remit of PET. Furthermore, some of these issues have been a major focus of our charity's work, including in the following instances.

- In 2008-2009, PET campaigned successfully – alongside the Turner Syndrome Support Society – to extend the duration for which frozen eggs may be been stored, in situations where the prospective recipient of donor eggs (rather than the person from whom the eggs are retrieved) is infertile, or likely to become so.

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This policy change enabled women whose daughters had been diagnosed with Turner syndrome – a condition whose symptoms include infertility – to store eggs for possible future use by their daughters, thereby giving women with Turner syndrome the option of having genetically related children.

- In 2019-2021, PET campaigned successfully to extend the duration for which eggs may be legally stored, if those eggs have been frozen for non-medical reasons (this is sometimes referred to as 'elective' or 'social' egg freezing). Such an extension was ultimately granted in the Health and Care Act 2022.

  This policy change improved women's reproductive options, giving them the latitude to decide whether and when to *freeze* their eggs, and – separately – whether and when to *use* their frozen eggs. The time limit that was in place prior to this change had perverse consequences – it could encourage a woman to freeze her eggs later than was advisable (given the decline of egg quality with age), to use her frozen eggs before she was ready to do so (because her eggs were due to be mandatorily destroyed), or to try to fund the transfer of her eggs to an overseas clinic.

- In 2022, PET commissioned the polling organisation Ipsos to carry out a nationally representative survey of the UK public, investigating what the public thinks and knows about assisted conception and related areas. The resulting report – entitled *Fertility, Genomics and Embryo Research: Public Attitudes and Understanding* – included findings related to donor conception.

  One such finding is that 45% of UK women would consider donating eggs in one or more circumstances, to help others have children.

Summary of our evidence

These are our concise answers to each of the questions posed by the Women and Equalities Committee in its Call for Evidence.

These are followed by some general observations, about the terms of this Inquiry (in our view these terms are perhaps overly broad) and about the significance of UK fertility treatment taking place within a very highly regulated environment, and then by fuller versions of our answers to the Committee's questions.

What are the short-term and long-term health impacts of donating or freezing eggs and embryos, and to what extent are they sufficiently researched and understood?

The health impacts of ovarian stimulation and egg retrieval are well researched and well understood. These risks are the same for any woman whose eggs are used in IVF (and/or are frozen), regardless of whether the woman's contribution is limited to being an egg donor, or whether she goes on to carry a pregnancy.

The most serious risk that a woman faces during the stimulation phase of a her fertility treatment cycle is the possibility of developing ovarian hyperstimulation syndrome (OHSS). This problem is not common in the UK (especially not in its severe forms), and UK egg donors are not at particular risk of this condition.

None of the activities that fall within the scope of this Inquiry poses a significant long-term health risk to patients or to resulting children, provided that treatment is carried out diligently and in a well-regulated context.

Is the counselling provided ahead of egg donation adequate to ensure informed consent?

The terminology used in relation to counselling is not always consistent, and this can give rise to confusion. However, the fact is that counselling in relation to egg donation is adequate in the UK, and those who donate eggs in the UK do indeed offer informed and valid consent.

In order for a woman to donate eggs in the UK, she must – at minimum – be given information about medical aspects of donation (including ovarian stimulation, egg retrieval and any associated risks), and be offered counselling about the implications of her donation.

What level of compensation/payment should be provided to egg donors, if any?

35 years of evolving HFEA policy on donor compensation has arrived at a maximum level of compensation for egg donors – £985 per cycle of donation – that is appropriate.

We note that the HFEA has undertaken to review its rules concerning donor compensation periodically, or if there has been inflation of greater than 10% since the previous review. Again, in our view this is appropriate.

It is important to note that in the UK, egg donors receive *'compensation'* rather than *'payment'*. This distinction was encouraged by a European Directive in 2004, and the distinction continues to be upheld today (notwithstanding the UK's withdrawal from the European Union in 2020).

What evidence is there, if any, of vulnerable women being encouraged into egg donation or egg freezing?

Reproductive choice is highly valued by women in the UK. Donating eggs and freezing eggs are both legitimate reproductive choices.

According to HFEA data, it is not the case that women are being encouraged to donate eggs because they are poor, and nor is it the case that egg donors tend to be particularly young.

Women who are at risk of becoming prematurely infertile due to disease (and/or treatment for disease) are offered the opportunity to freeze their eggs in order to preserve their fertility. In our view, this is no bad thing, but rather is sound medical practice.

Is the regulatory regime on advertising, as it applies to egg donation and people wishing to freeze their eggs or embryos, sufficient?

Yes, the regulatory regime is sufficient. In addition to being subject to general UK laws and regulations concerning advertising, the activities that fall within the scope of this Inquiry are also governed by several other documents and bodies. Recent evidence suggests that UK fertility clinics are largely (and increasingly) compliant.

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What has been the impact of changes to the release of donor information, including support for the families involved? Is further legislation required?

It has been 22 years since a statutory instrument was made in the UK that the removed the possibility of anonymity for egg (and embryo and sperm) donors. In the meantime, the growth of direct-to-consumer genetic testing means that various parties involved in donor conception are now potentially able to identify one another, either deliberately or accidentally.

Research that our charity has commissioned, conducted by Ipsos, suggests that identifiability deters some people in the UK from donating eggs or sperm. However, almost two-thirds of people in the UK who are willing to consider donating remain willing, after being informed that they will become identifiable to any resulting child(ren) upon the latter reaching the age of 18.

Is the existing legislative framework, including the Human Fertilisation and Embryology Act 1990, effective in safeguarding the best interests of those undergoing treatment?

Yes the existing legislative framework is effective in safeguarding the best interests of those undergoing treatment.
The policies that are perhaps most inimical to the best interests of those seeking or undergoing fertility treatment are policies that impede people from accessing publicly funded treatment. This is not a matter that falls under the HFE Act, but it is a very much a matter that deserves the attention of the Women and Equalities Committee.

General observations

PET welcomes any opportunity to share facts and exchange ideas in relation to the issues within its remit, including this Inquiry. That said, responding is made difficult by the fact that the Inquiry's terms are so broad.

Eggs and embryos raise quite different issues within assisted conception, as do donation and freezing, as do freezing for medical reasons and freezing for non-medical reasons. To consider all these things and their interrelationships within a single Inquiry is to risk conflating quite different issues.

People who receive fertility-related medical treatment in the UK benefit from this treatment taking place within a very highly regulated environment. Since 1990, a specific UK law – the HFE Act – has governed anything done to or with human sperm, eggs and embryos outside the human body, whether in a treatment context or in a research context. Furthermore, a dedicated statutory regulator – the HFEA – oversees fertility treatment throughout the UK.

Activities that fall within the scope of this Inquiry can only be carried out lawfully in the UK under a licence from the HFEA. In addition to being governed by the HFE Act directly, these activities are also regulated by the HFEA's detailed *Code of Practice* (which is periodically updated and is currently in its ninth edition) and by supplementary HFEA documents.

Providers of fertility treatment are also subject to oversight by other regulatory bodies. These include the Care Quality Commission (which, like the HFEA, is a non-departmental public body of the Department of Health and Social Care) and the Information Commissioner's Office (a non-departmental public body of the Department for Science, Innovation and Technology).

What are the short-term and long-term health impacts of donating or freezing eggs and embryos, and to what extent are they sufficiently researched and understood?

The health impacts of ovarian stimulation and egg retrieval are well researched and well understood. These risks are the same for any woman whose eggs are used in IVF (and/or are frozen), regardless of whether the woman's contribution is limited to being an egg donor, or whether she goes on to carry a pregnancy.

Since the world's first IVF baby was born in the UK in 1978, at least 12 million IVF babies are estimated to have been born worldwide. According to the HFEA, around 1.3 million IVF cycles were carried out in the UK between 1991 and 2019. If either ovarian stimulation or egg retrieval posed a major risk to women's health, then this would have become apparent by now.

Ordinarily, a woman produces one mature egg per month. Ovarian stimulation leads to the production of multiple (commonly 8-12) eggs, which are then retrieved from the ovaries. During the stimulation phase of a woman's fertility treatment cycle, her health is monitored by regular blood tests and ultrasound scans.

A typical example of the process is as follows.

- Daily injections, to stimulate the ovaries to produce more than one egg.
- An additional injection beginning on day 4-5 of stimulation, to prevent the spontaneous premature release of eggs.
- A single further injection, which is carefully timed to begin the process of ovulation, followed by egg retrieval.

As with any medical treatment in the UK, this process and any associated risks must be explained to the patient prior to treatment, in order for the patient to give valid consent. Additionally, many UK fertility clinics provide information about this process on their websites, where it can be accessed by people who have yet to seek treatment.

The most serious risk that a woman faces during the stimulation phase of her fertility treatment cycle is the possibility of developing ovarian hyperstimulation syndrome (OHSS). According to the latest HFEA data, more than 100,000 cycles of fertility treatment took place at in UK fertility clinics in 2024/2025, and there were 67 cases of severe and critical OHSS during that time. This suggests that the problem of OHSS is not common in the UK (especially not in its severe forms), although every effort should continue to be made to minimise the risk.

It is also worth noting that none of the 67 cases of severe and critical OHSS in 2024/2025 concerned an egg donor. This suggests that egg donors in the UK are not at particular risk of OHSS.

When it comes to donating or freezing retrieved eggs – or IVF embryos created by fertilising retrieved eggs – these practices are very well established, all of them having been pioneered in Australia 40 years ago or more.

- The first birth following egg donation occurred in Australia 43 years ago, in 1983. The donation was described as *'embryo donation'* when reported the following year, but the donor egg was fertilised by sperm from the recipient's husband, and would constitute egg donation in today's terminology.

- The first birth following the freezing and thawing of an embryo occurred in Australia 42 years ago, in 1984, and was reported the following year.

- The first births following the fertilisation of previously frozen eggs occurred in Australia 40 years ago, in 1986, and the pregnancy that resulted in these twin births was reported that same year.

In the decades that have followed, the freezing and thawing of eggs and embryos have continued to be improved and standardised, not least with the advent of vitrification (a faster and more reliable approach to freezing) during the 1990s.

Evidence to date suggests that none of the activities that fall within the scope of this Inquiry poses a significant long-term health risk – either in terms of physiological health or in terms of psychological health – to patients (whether donors or prospective parents), or to resulting children (including donor-conceived children), provided that treatment is carried out diligently and in a well-regulated context (such as exists in the UK).

Continued research and surveillance are always to be encouraged. However, one can be confident that current practice – in ovarian stimulation, egg retrieval, egg freezing and thawing, embryo freezing and thawing, and donor conception (including egg donation) – is well supported by evidence.

Is the counselling provided ahead of egg donation adequate to ensure informed consent?

Several different types of counselling may be sought, offered, recommended or required in relation to assisted conception, including in relation to the activities that fall within the remit of this Inquiry. The terminology used in relation to counselling is not always consistent, and this can give rise to confusion. However, the fact is that counselling in relation to egg donation is adequate in the UK, and those who donate eggs in the UK do indeed offer informed and valid consent.

The HFE Act, as originally enacted in 1990, sets out various contexts in which people involved in assisted conception must be *'given a suitable opportunity to receive proper counselling about the implications'*. In 1991, the relevant parts of the Act were interpreted in the first edition of the HFEA *Code of Practice* (specifically in Part 6), which defined several distinct types of counselling that should be offered *'in appropriate cases'* – including *'implications counselling'* (echoing the wording of the Act), plus also *'support counselling'* and *'therapeutic counselling'*.

Today's HFE Act, as amended, retains the original requirements for *'a suitable opportunity to receive proper counselling about the implications'* and also refers to counselling in certain additional contexts. The relevant parts of the Act are interpreted in the current (ninth) edition of the HFEA *Code of Practice* (principally in Guidance Note 9), which no longer distinguishes between several types of counselling as the initial *Code of Practice* did, but nonetheless continues to emphasise *'implications'*.

The current *Code of Practice* makes it clear that donors of eggs (or embryos or sperm) must be offered *'counselling about the implications of donation'*, and that recipients of donor eggs (or embryos or sperm) must be offered *'counselling about the implications of treatment with donated material'*. In both cases, the *Code* makes it clear that such counselling must be offered distinctly from – and not conflated with – more general *'counselling about the implications of treatment'*.

It is worth noting that today's counselling professionals often find it helpful to distinguish between different types of counselling, including *'implications counselling'* and *'therapeutic counselling'*, but contemporary definitions of these may differ from those that were employed by the HFEA in 1991.

It is also worth noting that the provision of information to a prospective donor or prospective patient – as is required (in assisted conception and in medicine more broadly) in order for the consent of the donor or patient to be valid – is sometimes referred to as *'information counselling'*. This is the case, even if such information is not (typically) provided by a professional counsellor, and even though such information provision is addressed in different parts of the HFE Act and the HFEA *Code of Practice* than the parts that address counselling (as the term is more commonly understood).

The picture that emerges from all of this is a reassuring one. In order for a woman to donate eggs in the UK, she must – at minimum – be given information about medical aspects of donation (including ovarian stimulation, egg retrieval and any associated risks), and be offered counselling about the implications of her donation.

What level of compensation/payment should be provided to egg donors, if any?

In order to answer this question, it is helpful to understand the past 35 years of donor compensation policy in the UK.

We begin with the HFE Act, which states that *'no money or other benefit shall be given or received in respect of any supply of gametes... unless authorised by directions'*. Consequently, it has always been for the HFEA to decide the specifics of permitted donor compensation.

Between 1991 (when the HFEA was first established) and 2006, egg donors and sperm donors alike were permitted by the HFEA to receive up to £15 per donation, plus *'reasonable expenses'*. The HFEA specified what constituted *'reasonable expenses'*, requiring donors to submit receipts for any expenses exceeding £15, and also giving detailed specifications for maximum permitted reimbursement in categories including *'subsistence rates'*, *'financial loss allowance'* and *'childminding expenses'*. The resulting administrative burden – on donors, clinics and the HFEA – was considerable.

In 2004, the European Parliament adopted a Tissues and Cells Directive which stipulated that *'Member States shall endeavour to ensure voluntary and unpaid donations of tissues and cells'*, and that *'Donors may receive compensation, which is strictly limited to making good the expenses and inconveniences related to the donation'*.

This Directive encouraged a clearer distinction between *'compensation'* and *'payment'* for donor eggs (and embryos and sperm) in the UK. *'Compensation'* is permitted (but is subject to restrictions), while *'payment'* is not permitted. This distinction continues to be upheld today, notwithstanding the UK's withdrawal from the European Union in 2020.

Shortly after the Directive was adopted in 2004, a statutory instrument was made in the UK that removed anonymity for egg (and embryo and sperm) donors.

In 2006 – taking account of the aforementioned developments, and following a public consultation – the HFEA made its first substantial change to rules concerning donor compensation. Donors could now be reimbursed for *'all reasonable expenses incurred'* (provided that they could produce corresponding receipts), and also for *'loss of earnings'* (with reimbursement in this category capped at £61.28 per day – a figure chosen to correspond with permitted compensation for jury service). At the same time, an overall limit of £250 was imposed *'for each course or cycle of donation'*.

In 2011, a report by the Nuffield Council on Bioethics – entitled *Human Bodies: Donation for Medicine and Research* – concluded that maximum permitted levels of compensation for egg donors were inadequate. The report stated that *'Egg donors, in particular, may... be out-of-pocket as a result of their donation'*, and made the following recommendation.

> *'Where time has to be taken off work in order to donate gametes, particularly in the more invasive procedures involved in egg donation, we recommend that the current cap of £250 on lost earnings that may be reimbursed should be removed, and that lost earnings, where applicable, should be reimbursed in full in the same way as other expenses such as travel costs.'*

2011 also saw the HFEA conduct another public consultation on donor compensation, whereupon it made its second substantial change to the rules. Clinics were now permitted to offer fixed sums to donors, and the need for donors to provide receipts to clinics was removed. Furthermore, the significant differences between sperm donation and egg donation were now reflected in the fact that different limits were placed upon the fixed sums offered to donors. For egg donors the maximum was *'£750 per cycle of donation'*, while for sperm donors the maximum was *'£35 per clinic visit'*.

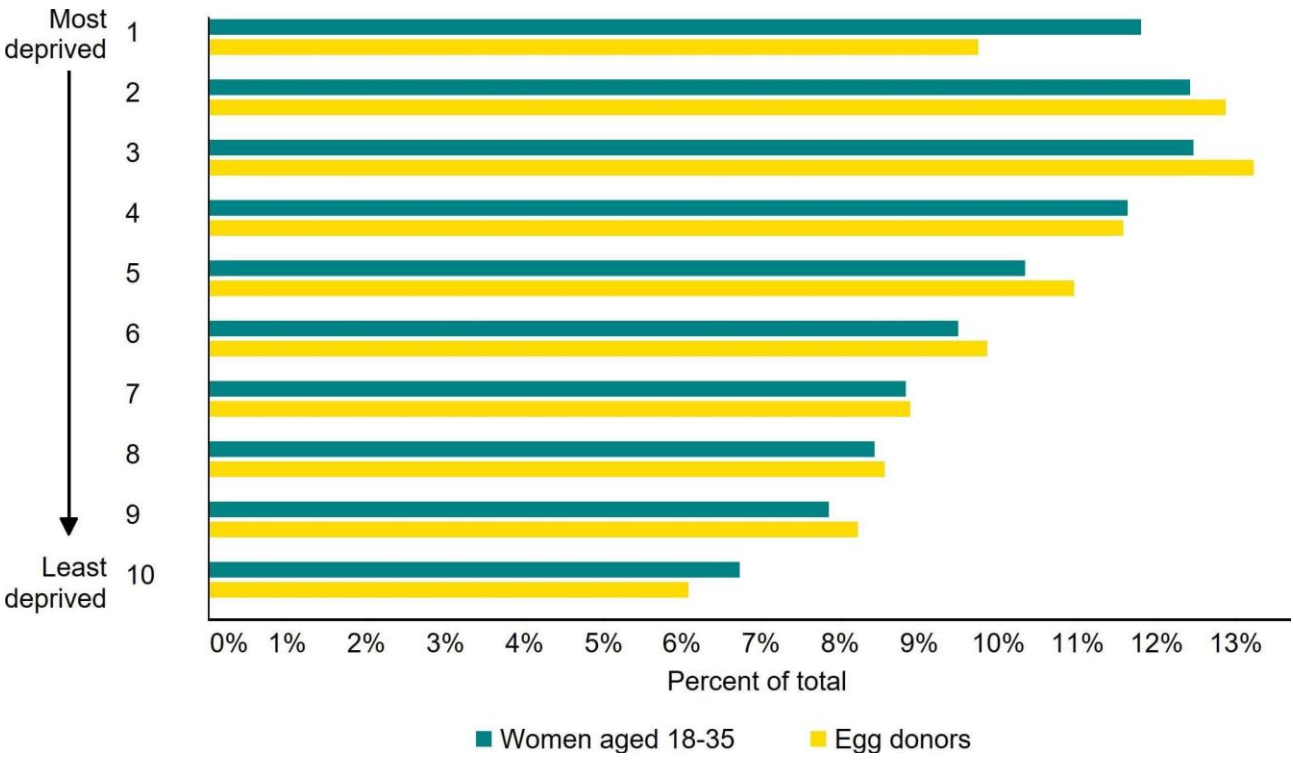
This arrangement remained unchanged for more than a decade, until the HFEA made its third substantial change to rules concerning donor compensation in 2024. The limits placed upon the fixed sums were belatedly increased in line with inflation (and associated increases in the cost of living), so that for egg donors the maximum is now *'£985 per cycle of donation'*, while for sperm donors the maximum is now *'£45 per clinic visit'*.

It has taken a long time to arrive at the present arrangement, with various systems and considerations explored along the way. Our answer to the question of what level of compensation/payment should be provided to egg donors is that the present maximum level of compensation – £985 per cycle of donation – is appropriate.
We note that the HFEA has undertaken to review its rules concerning donor compensation periodically, or if there has been inflation of greater than 10% since the previous review. Again, in our view this is appropriate.

What evidence is there, if any, of vulnerable women being encouraged into egg donation or egg freezing?

Reproductive choice is highly valued by women in the UK. Donating eggs and freezing eggs are both legitimate reproductive choices.

It is not the case that women in the UK are being encouraged to donate eggs because they are poor. Data from the HFEA – including the chart reproduced below – shows that during the years 2011-2020, the distribution of egg donors across deprivation deciles in England was similar to the distribution of women aged 18-35 considered as a whole. Furthermore, egg donors were actually underrepresented in the most deprived decile.



Nor is it the case that UK egg donors tend to be particularly young. The same HFEA dataset shows that egg donors in the UK had a consistent median age of 31-32 between 1991 and 2020.

Donor type and time period	Age 18-25	Age 26-30	Age 31-35	Age 36-40	Age 41-45	Age 46-50	Other or unknown age	Median age
Egg donors, 1991-2000	736	2,203	3,683	673	181	92	12	32
Egg donors, 2001-2010	1,100	2,781	4,893	1,591	402	121	37	32
Egg donors, 2011-2020	2,803	4,265	5,737	1,499	380	122	12	31

We are not aware of any compelling evidence that women with particular vulnerabilities are being encouraged to freeze their eggs, except inasmuch as women who are at risk of becoming become prematurely infertile due to disease – and/or treatment for disease – are offered the opportunity to freeze their eggs in order to preserve their fertility.

In our view, this is no bad thing, but rather is sound medical practice.

Is the regulatory regime on advertising, as it applies to egg donation and people wishing to freeze their eggs or embryos, sufficient?

Yes, the regulatory regime is sufficient. In addition to being subject to general UK laws and regulations concerning advertising, the activities that fall within the scope of this Inquiry are also governed by the following documents.

- The HFEA *Code of Practice*.
- Guidance entitled *Fertility Clinics: Complying with Consumer Law*, issued by the Competition and Markets Authority (CMA) in 2021.
- An Enforcement Notice entitled *Advertising of Fertility Treatments*, issued jointly by the Committee of Advertising Practice, the CMA and the HFEA in 2021.

Additionally, an Enforcement Report entitled *Misleading Claims in Paid Ads for Fertility Clinics* – published in 2025 – indicates that UK fertility clinics are largely (and increasingly) compliant with the Enforcement Notice referred to above.

What has been the impact of changes to the release of donor information, including support for the families involved? Is further legislation required?

It has been 22 years since a statutory instrument was made in the UK that the removed the possibility of anonymity for egg (and embryo and sperm) donors. Under the resulting regime, donor-conceived people are entitled – upon reaching the age of 18 – to request identifying information about the donor(s) of the egg and/or sperm with which they were conceived (or the donor of the embryo from which they resulted).

In the meantime, the growth of direct-to-consumer genetic testing means that various parties involved in donor conception – donors, donor-conceived people, and the genetic half-siblings of donor-conceived people – are now all potentially able to identify one another, either deliberately or accidentally. Furthermore, such identification can potentially occur without the knowledge or prior consent of the other party.

This situation is addressed in several parts of the current (ninth) edition of the HFEA *Code of Practice*. For example, Guidance Note 11 requires prospective donors to be apprised of the fact that *'there is the potential at any time for donors, donor-conceived people and their close genetic relatives to become identifiable, or for their identity to be inferred, through direct-to-consumer DNA testing and matching services'*, while Guidance Note 30 requires staff at fertility clinics to

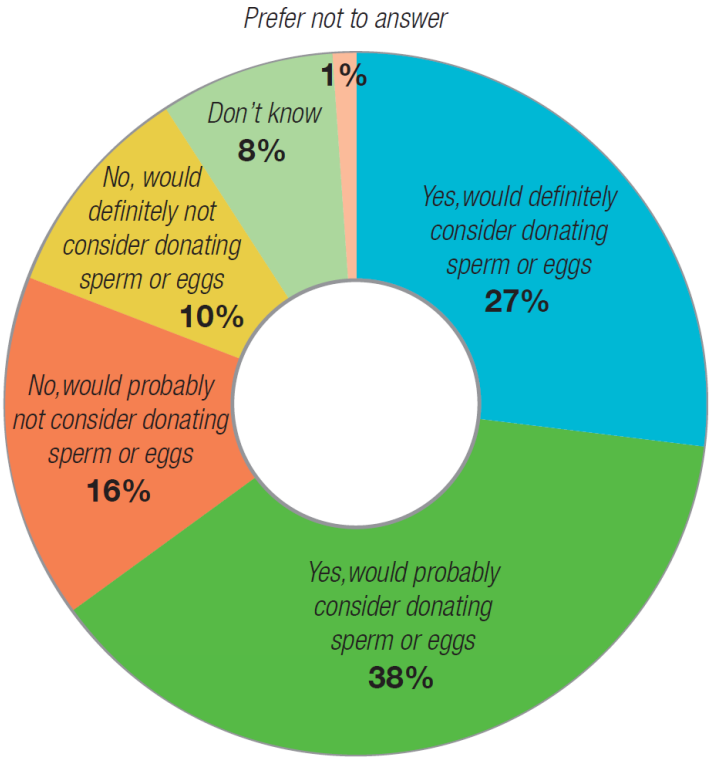
'familiarise themselves with direct-to-consumer DNA sites' and *'have a basic understanding of how they operate, so that they are able to provide appropriate information to donors and patients*'. The HFEA is attentive to the phenomenon of direct-to-consumer genetic testing, and it still has considerable latitude to modify its policies if necessary. We are not persuaded that further legislation is required to address this area at present.

Furthermore, we are wary of any suggestion that donors should become mandatorily identifiable *before* children conceived from their donation reach the age of 18. Granted, identifiability is already possible via direct-to-consumer genetic testing, but that is not sufficient reason to make it an inevitability. If prospective parents wish to guarantee that a donor is identifiable from the outset of their child's life, then they already have the option of using a 'known' donor in order to achieve this.

Additionally, there is nothing in the HFE Act or related legislation that precludes some other arrangement, in which a donor waives their entitlement to temporary anonymity. If donors, recipients, clinics or the HFEA (separately or in concert) wished to experiment with new models along these lines, this would not require legislative permission. Further legislation is not required.

When entitlement to anonymity was removed from UK donors 22 years ago, it was anticipated that this might deter people from donating. The research that our charity commissioned Ipsos to conduct in 2022 found that some potential donors are indeed deterred by identifiability, but by no means all.

A subset of respondents who had already expressed their willingness (in principle) to conder donating eggs or sperm was asked by Ipsos whether they would still consider doing so, knowing that they would be identifiable to any resulting child(ren) upon the latter reaching the age of 18. Responses were as follows.



Base: n=1083 UK Adults aged 16-75, who would consider donating their sperm or eggs under one or more circumstances, online fieldwork conducted: 24-27 March 2022.

The loss of anonymity resulted in 26% of this subset of people saying they would no longer (either *'definitely not'* – 10%, or *'probably not'* – 16%) consider donating in light of identifiability. However, 64% said that they would still consider donating (27% said *'definitely'*, 39% said *'probably'*).

Is the existing legislative framework, including the Human Fertilisation and Embryology Act 1990, effective in safeguarding the best interests of those undergoing treatment?

There are many reasons why the HFE Act should be updated, but the issues that fall within the scope of this Inquiry are not among them. For the most part, the existing legislative framework – including not just the HFE Act, but also the Warnock settlement underpinning it – is indeed effective in safeguarding the best interests of those undergoing treatment.

The policies that are perhaps most inimical to the best interests of those seeking or undergoing fertility treatment are policies that impede people from accessing publicly funded treatment. Since 2004, the National Institute for Health and Care Excellence has recommended that the NHS should provide three full cycles of IVF to a woman, under 40 years of age, who needs them.

Disgracefully, this recommendation has never been fully implemented across the UK, despite having been in place for more than two decades. This is not a matter that falls under the HFE Act, and it is not in the gift of the HFEA to address it, but it is a very much a matter that deserves the attention of the Women and Equalities Committee.

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