FERTILITYROAD

ALL ABOUT IVF

EGG COLLECTION BEGINNER'S GUIDE | WORKPLACE SUPPORT | EGG DONATION ABROAD

Why do UK patients go abroad for IVF?

Male factor infertility – the IVF techniques that can help

Top tips on how improved nutrition can help avoid miscarriage

How donor conception is 'different' – in ways you might not expect

How to thrive, not just survive IVF

Our IVF story

Ten years of invasive tests and arduous treatment and yet we remain hopeful

Our change in title colours reflects our deep respect and admiration for the strength and courage of the Ukrainian people. #StandWithUkraine

ISSUE 55/2022

Welcome! We want you to know that you're not alone and we're here to help you on your IVF journey!

Our mission at Fertility Road is to empower you, at every stage of your fertility journey. So, whether you're starting out on your journey, are months (or years) into it or are experiencing a 'fork in the road' where new and alternative routes to parenthood are being considered – we're here for you. We'll endeavour to bring you the expertise, the guidance and the confidence to move forward safe in knowledge that you have the most up-to-date advice from the best in the fertility community at your fingertips.

So, what will you discover in this issue?

Our front cover story details one of the longest and most grueling IVF journeys imaginable. It was an honour to talk with Emma & Angus Menzies. The bravery, determination and sheer grit they have both demonstrated over a ten-year fertility struggle is awe inspiring. Check out their story on page 35 to discover how they are managing to thrive and not simply survive their ongoing IVF journey. Their ability to find the positives in an otherwise potentially soul-destroying IVF journey, change their professional lives for the better and to help others along the way is truly remarkable.

Mindful of the fact that some of you will be new to IVF, we asked Dr Carole Gilling-Smith, CEO, Medical Director and Founder of the Agora Clinic to create a Beginner's Guide to Egg Collection. Carole expertly guides you through the process, sharing her top tips on how best to prepare for egg collection and how to help yourself to recover quickly from the procedure. You'll find this on page 10.

Concerned about the possible side effects of the hormone treatment involved in IVF? Check out Dr Arianna D'Angelo's insightful Q&A on page 14.

For those men (and couples) facing male-factor infertility, the testing and treatment options can be bewildering. Professor Tim Child, Group Medical Director of The Fertility Partnership shines a light on the types of sperm testing available, what sperm testing can reveal and essentially the most successful male treatment options relating to IVF. Check it out on page 18. It's exceptionally expert advice and a must-read for men and their partners.

A common question is "How old is too old for IVF?" Well, if you are wondering about this, do read Professor Luciano Nardo's thoughts on this topic on page 22. Professor Nardo is a consultant gynaecologist and subspecialist in reproductive medicine and surgery and founder of NOW-fertility. Read his professional insights into the impacts of age on both female and male fertility.

In every issue, we cover a holistic, complementary therapy. This time around we're looking into acupuncture and its potential role in IVF. Can acupuncture help during an IVF cycle and if so, how and when? Check out Rachael Forrest's article on page 25 to find out. Rachael is the founder of the Natural Fertility Centre in Edinburgh.

Nutrition and how what you eat (and drink) impacts your fertility is an ever-important topic. In this issue, leading UK nutritionist, Dr Marilyn Glenville shares her expert advice on how improved nutrition can help avoid miscarriage (page 28).

In the next part of our series with the team at Fertility Matters at Work, we hear from Claire Ingle about what you may (or may not) be 'entitled to' from your employer when undergoing IVF treatment. Helen Burgess, Partner at Gateley Legal also offers her legal insight into this hot topic. It's a fascinating read. Check it out on page 31.

Within our Donor Route section in this issue, I'm delighted to introduce a fabulous new series contributor - Nina Barnsley, Director at Donor Conception Network (DCN). In the first part of the 3-part series, Nina explores how donor conception is different, how that might feel and what the implications might be at different stages in family life. Check it out on page 40.

Also within this issue's Donor Route section, we hear from Mel Johnson, coach and founder of 'The Stork and I' on the emotional aspects of taking the sperm donor route to solo parenthood (page 44). Sheila Lamb, author of the 'Fertility Books' series, shares her thoughts on what she wishes she'd known before taking the egg donor route. Check out my interview with Sheila on page 48. Continuing the theme of egg donation, we also hear from specialist fertility counsellor, Tracey Sainsbury about the considerations from both the donor and recipient perspectives as both are equally important (page 51).

Finally, our IVF Abroad section is packed with insights into why UK patients travel abroad for IVF (Emma Haslam, co-founder of Your IVF Abroad, page 55), essential questions to ask your clinic before travelling (Elisabeth Telega, page 58) and an excellent explanation from Ruth Pellow, fertility nurse and founder of IVF Treatment Abroad on Egg donation abroad: anonymous donor VS non-anonymous donor VS known donor. Check it out on page 61.

Enjoy the Issue!

Clare Goulty

Clare Goulty

Editor-in-Chief

Message from the Chairman of The European Fertility Society – EFS

Dear Friends!

On behalf of the European Fertility Society, which brings together members from all over the fertility world, I would like to express our solidarity with all representatives of the reproductive medicine and embryology society in Ukraine, as well as with all patients from this country. In view of the enormous tragedy that has befallen the entire Ukrainian people, we unequivocally express our condemnation and abhorrence of all Russian actions on the territory of the democratic and independent Ukrainian state.

In the 20th century, due to the two World Wars, my grandparents and great-grandparents experienced violence from Germans, Poles and Russians. They did not talk about their war experiences. They wanted to erase them from their memories. They, as well as my parents' generation, realized what a huge tragedy global war was for all humanity. Therefore, the post-war generations, including mine, were brought up in the spirit of "no more war". In 1989, through the "Round Table" in Poland, in a bloodless and non-violent way, as the first country from the Soviet bloc, started the process of change in Central and Eastern Europe. Many countries freed themselves from the domination of the Soviet Union and the division of Europe established after World War II at the Potsdam Conference ceased to exist. In order to guarantee security, some of the countries in the CEE region joined NATO. The milestone in European integration was the admission of 10 new members to the European Union in 2004. None of us thought that the war we know from the history books would start in Europe in the 21st century. A war in which the aggressor - Russia - violates all possible human rights. It carries out mass murders of civilians, it bombs houses, hospitals and schools, it rapes women and girls, it murders their parents in front of their children, it forcibly deports people, including Ukrainian children, deep into Russia, it does not allow humanitarian aid, it plunders and steals the belongings of individual Ukrainians. This list is much longer and as cruel and horrific as the examples cited.

July 1, 2022 is the 128th day of Russia's attack on Ukraine. Despite the assistance of unprecedented magnitude that Ukraine is receiving from around the world, the scale of the ongoing attack and destruction is so enormous that this assistance is insufficient. Therefore, I join Prof. Alexander Yuzko's appeal to take action appropriate to the current situation and to intensify joint international assistance to Ukraine. Ukraine is an integral part of free and independent Europe, and its brave soldiers defend the values we believe in every day.

Doctors of reproductive medicine, embryologists and staff of Ukrainian clinics have been helping patients from all over Europe and the world in recent years. Today, Ukraine needs our help.

Jakub Dejewski

Chairman
The European Fertility Society

Mrs Arianna D'Angelo, MD, Associate RCOG

Arianna works as Clinical Lead in Reproductive Medicine at Wales Fertility Institute, Cardiff and as Honorary Senior Clinical Lecturer in Obstetrics and Gynaecology at Cardiff University. She is a past Director of the postgraduate teaching Diploma/ Master in Ultrasound at Cardiff University. She has over 20 years' experience in Assisted Reproduction and Ultrasound.

Arianna is the current UK Clinician National Representative (CNR) for the European Society of Human Reproduction & Embryology (ESHRE), she is a member of the ESHRE Ethics Committee, past Coordinator of the ESHRE Special Interest Group (SIG) in Safety and Quality in ART (SQART). Arianna is a member, reviewer, co-reviewer and translator of the Cochrane Gynaecology and Fertility Group.
www.ariannadangelo.co.uk

Nina Barnsley

Nina Barnsley is the Director of the Donor Conception Network. The DC Network is a charity founded nearly 30 years ago to support people considering egg, sperm or embryo donation and donor conception families and children. Our aim is to offer peer support to break the isolation many people feel when navigating their complex and, often emotional, fertility journey. For those using donor conception, it's especially important to hear from others who have been through the journey and come out the other side, offering hope and guidance. The charity offers personal, tailored support and connections with others through a membership subscription and a dedicated team of volunteers. We publish a range of books for children and parents and run two specialist workshops, *Destination Parenthood*, which is aimed at people who are considering donor conception, and *Telling and Talking* workshops for parents of children up to 12yrs. We are a voice for donor conception families more widely and work closely with stakeholders and policy makers both in the UK and further afield.
www.dcnetwork.org

Helen Burgess

Helen Burgess is a Partner at Gateley Legal, specialising in employment law and HR advisory work. Helen went through IVF to have her first daughter and was acutely aware of the taboo around discussing the subject in the workplace. She was lucky to have a supportive employer at the time but there was no policy in place. On her return to work she asked for a policy to be implemented, advised on its contents, spoke out about her experience and encouraged others to do so. There is now a policy, support is signposted and personal accounts are available on a fertility page on her previous employer's intranet.
Helen has worked with Fertility Matters at Work and has spoken at webinars on the employment law aspects of fertility in the workplace.
She is also a member of the Workplace Fertility Community steering committee.
She is committed to raising awareness and encouraging employers to create a supportive environment for employees who may be dealing with fertility issues.

Professor Tim Child

Professor Tim Child is Group Medical Director of The Fertility Partnership (TFP) and Associate Professor of Reproductive Medicine at the University of Oxford. He is a board Member of the HFEA and chairs their SCAAC committee that considers IVF Add-Ons and produces the 'traffic light system' webpage. He is based at TFP Oxford Fertility where he sees patients and also undertakes research with the aim of simplifying treatment whilst maximising success rates. When not working Tim races historic single seater cars and plays guitar in his band.
www.tfp-fertility.com

Rachael Forrest

Rachael has been a qualified acupuncturist and member of the British Acupuncture Council (MBAcC) since 2000. After qualifying and having her first child, she set up the Natural Fertility Centre **www.thenaturalfertiltycentre.uk** in Edinburgh, a team of fertility specialists working in complementary health. With access to nutrition, abdominal massage, Chinese Herbal Medicine as well as acupuncture, the NFC can provide each couple with the best all-round treatment and support for their particular needs. Rachael has undertaken further training in fertility acupuncture and has worked with nutritionists to develop NFCEssentials **www.nfcessentials.com** a range of highest-quality, food-state supplements specifically for couples trying to conceive.

Dr Carole Gilling-Smith, MA (Cantab), FRCOG, PhD

Carole is the CEO, Medical Director and Founder of the Agora Clinic in Brighton, the largest Fertility Clinic in Sussex offering both NHS and privately funded treatments. She is a Consultant Gynaecologist and specialist in Fertility and Reproductive Medicine. She pioneered the first fertility program for patients in the UK living with HIV and believes that all individuals, whatever their ethnicity, sexual orientation or gender identity should be professionally supported and guided in their parenting journey. The Agora Clinic is renowned for embracing diversity and is currently leading the way in the provision of inclusive fertility care in the UK. **https://agoraclinic.co.uk/meet-the-team/medical-team/carole-gilling-smith**

Dr Marilyn Glenville PhD

Dr Marilyn Glenville PhD is the UK's leading nutritionist specialising in women's health. She is the former President of the Food and Health Forum at the Royal Society of Medicine and the author of a number of internationally best-selling books including 'Getting Pregnant Faster', 'Natural Solutions to PCOS' and 'The Natural Health Bible for Women' see www.marilynglenville.com. Dr Glenville runs a number of women's health clinics in Harley Street, London, Tunbridge Wells and Ireland. If you are interested in a consultation, you can contact Dr Glenville's clinic on 01892 515905 or by email: **reception@glenvillenutrition.com**

Emma Haslam

Emma Haslam is an expert in IVF abroad, following her own successful treatment in Europe which led her to set up Your IVF abroad Ltd with her husband, Adam. Emma is on a mission to make fertility treatment abroad more affordable, accessible, transparent and supported. Emma helps people around the world to create and expand their families by helping them find the most suitable, safe fertility clinics in Europe. Emma is a podcaster, blogger, book contributor and has been featured in UK national media.
www.yourivfabroad.co.uk
www.instagram.com/Yourivfabroad

Claire Ingle

Claire Ingle has worked in the field of HR at both an Operational and Strategic level for nearly 25 years across private, public and third sector organisations. She has a special interest in employee engagement and well-being and puts people at the heart of everything she does.
Claire had her daughter after three rounds of IVF treatment and is all too aware of the lack of narrative around this topic, especially in the workplace. Claire first wrote about her experience in late 2018 (the year she had her daughter) in a HR publication hoping her story would inspire others to ask for help and support after her own experience wasn't particularly positive. This article led to Claire meeting Natalie Silverman and Becky Kearns, both ex-infertility patients who also had the workplace agenda on their radars. Together, they formed 'Fertility Matters at Work', a company created to increase awareness for employers around fertility treatment through different mediums including a membership site and a unique e-learning package. The overarching aim of the organisation is that no one has a negative experience whilst navigating treatment and their career. **www.fertilitymatteratwork.com**

CONTRIBUTORS

Mel Johnson

Mel Johnson created **The Stork and I** following her own journey into solo motherhood. As a qualified coach, Mel supports single women looking to embark on the same journey as well as supporting solo mums to thrive. She offers **one to one**, and **group coaching**. She has a membership site: Thriving Solo which offers a supportive community of people in the same situation as well as useful resources and access to experts. Mel also documents 'a day in a life of' a solo mum on **The Stork and I Instagram**, to give an insight into what daily life is like and what you could expect if you choose this path to parenthood.

Sheila Lamb

Sheila Lamb had a six-year infertility journey that involved a diagnosis of unexplained infertility, two unsuccessful fertility treatment cycles, an early pregnancy loss, investigations into natural killer cells and thrombophilia, and a successful second donor egg cycle. Her rainbow baby was born in 2011, a week after her forty-seventh birthday. As an author, she now supports the trying-to-conceive and baby loss communities through her standalone book *Infertility doesn't care about ethnicity*, and her *Fertility Books series* – collections of real-life short stories about the emotional realities of infertility, fertility treatments, the Two Week Wait, pregnancy loss and pregnancy after infertility and loss.
Instagram: @fertilitybooks
https://www.facebook.com/SheilaLambAuthor/

Professor Luciano Nardo

Professor Luciano Nardo is board-certified in obstetrics, gynaecology, reproductive medicine and surgery, with a subspecialty in reproductive medicine and laparoscopic surgery. He has 20 years' clinical practice and academic focus in assisted conception, infertility, reproductive endocrinology, miscarriage and benign gynaecology. He has specific interests in decreased ovarian function, repeated embryo implantation failures, fertility preservation/egg freezing and unexplained infertility. Professor Nardo is an expert in hysteroscopic and laparoscopic surgery for the management of reproductive abnormalities and gynaecological conditions.
Professor Nardo is also the pioneering founder of NOW-fertility, a next generation IVF service, which is revolutionising the assisted conception journey:
https://now-fertility.com/

Ruth Pellow

Ruth Pellow has been a Fertility Nurse Specialist since 1992. Ruth's fertility work includes IVF wards at the Royal London Hospital, the London Women's Clinic, Harley Street, St, Bartholomew's Hospital London as senior sister in charge, and at a clinic in Marbella, Costa del Sol, where she was pivotal in raising awareness that travelling abroad for treatment was a viable alternative. In 2009, Ruth created IVF Treatment Abroad, where she now works with clinics in various countries helping couples and single women from around the world who either cannot get the relevant form of treatment in their home country, or it is prohibitively expensive there. **https://ivftreatmentabroad.com/**

Tracey Sainsbury

Tracey Sainsbury is a specialist fertility counsellor providing support to individuals and couples before, during and following fertility treatment. Tracey has over 20 years' experience of providing fertility support; she is an Accredited member of the British Infertility Counselling Association, a Counselling Mentor and a member of the Advisory Panel for Fertility Network UK. Tracey has a small private practice to enable clients to access ongoing support and accepts referrals from NHS and private clinics, EAPS and Surrogacy organisations. **www.fertilitycounselling.co.uk**

Elisabeth Telega

Elisabeth Telega is an experienced International Patient Manager. For the last 4 years she has been supporting patients struggling with fertility issues by helping them find the most appropriate fertility providers.
Working on the **www.FertiAlly.com** project Elisabeth shared expert interviews covering various aspects of fertility. Hot topics include: embryo transfer, IVF stimulation protocols, factors affecting female and male fertility and the emotional impact of fertility treatments.
Elisabeth graduated from the University of Silesia with a master's degree in Italian Linguistics. She has been working in customer care for more than 20 years with the "make the world a better place" motto in mind.

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INSTITUTO BERNABEU

INSTITUTO BERNABEU'S, GUARANTEE IS 100% COMMITTED TO ACHIEVING YOUR PREGNANCY

THE INSTITUTE'S 8 CLINICS HAVE GUARANTEED SUCCESS PROGRAMMES ADAPTED TO THE NEEDS OF EACH PATIENT AND REFUND THE MONEY IF PREGNANCY IS NOT ACHIEVED

All of us who have had to go through an **assisted reproduction** process know that it is a roller coaster ride in every way: *emotionally and financially.*

But what would happen if someone came along who could dispel all the uncertainties and guarantee that there'll be no surprises in store for us? That it'll all turn out fine, that not only will you get pregnant, but that you'll stay pregnant until your baby is born? That it won't cost you a pound more than agreed, that if you need anything unexpected, it's already included in the price?

This commitment exists. It was born 8 years ago as a result of **Instituto Bernabeu's** sense of responsibility towards its patients; it's called the **ÚNICA BERNABEU** programme. It is a guarantee of success for a job well done but if it is not successful, you get 100% of your money back.

ALL-INCLUSIVE AND NO SURPRISES

The programme includes all the necessary procedures for the best possible embryo development and care: a **Geri® time-lapse incubator** exclusively for you, **extended culture** up to blastocyst stage (day 5/6), **assisted hatching**, etc.

The **freezing and storage** of gametes and embryos and even a **pre-implantation genetic diagnosis or study (PGD-PGT)** of the embryo if your doctor recommends one!

The medical consultations, all the **ultrasounds, analyses** and **controls** until the **pregnancy** is confirmed by one of the world's most **qualified teams** of doctors in reproductive medicine. More than 200 doctors all working towards the same goal.

Your care will begin even before you arrive: you will be met at the airport and taken to your hotel or clinic. You will also have at your disposal **complementary therapies** such as a massage or acupuncture timed to coincide with your arrival, and a **clinical psychologist** who will accompany you on an emotional level during the treatment, as well as a **personal assistant** who will be there to accompany and help you, solving any doubts you may have before the treatment starts and supporting you through all the different stages. All this **at no additional cost and until you become pregnant.**

An all-inclusive package to avoid any unwanted surprises! Just the certainty that you're going to achieve your goal.

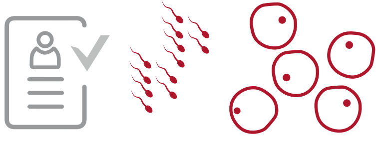
100% PERSONALISED ATTENTION IN ENGLISH

Your success starts with good communication, which is why your personal assistant and your doctor will be entirely at your disposal by telephone and direct email and, it goes without saying, in English!

The Instituto Bernabeu has 8 clinics; 7 in Spain in Alicante, Madrid, Mallorca, Cartagena, Albacete, Elche and Benidorm, and one in Venice, Italy. It enjoys an international reputation for tailoring its reproductive treatments to the real needs of each patient. Unlike most European clinics which have been taken over by investment funds, the Instituto Bernabeu is run by physicians, which means that all decisions are based exclusively on medical criteria.

METICULOUS DONOR SELECTION

If your treatment requires the **donation of a gamete**, the Instituto Bernabeu will make its own bank available to you with more than **900 egg donors and 540 sperm donors**, to ensure that it will be associated with the same physical characteristics. But perhaps the most important thing is the fact that before we accept a donor, they have to pass strict medical, psychological and genetic controls which include, for example, an analysis of carriers of the 3,000 most serious hereditary diseases (CGT)



We also make every effort to obtain a fresh egg donation, perfectly synchronising both treatments and including the cost of your medication in the programme fee.

WHAT HAPPENS IF THE PREGNANCY IS TERMINATED, OR A BIOCHEMICAL OR ANEMBRYONIC PREGNANCY ENSUES?

The **commitment** of the Única Bernabeu programme remains in force until the moment of birth, which means that if your pregnancy is interrupted involuntarily before delivery, if you have a miscarriage or there is an implantation failure or an anembryonic or biochemical pregnancy ensues, the commitment of the Única Bernabeu Guaranteed Success Programme will be re-established by starting a new treatment.

FIND 'ÚNICA BERNABEU' PREGNANCY PROGRAMME THAT IS JUST RIGHT FOR YOU

Each patient is unique, just as your "Única Bernabeu" programme will also be quite unique. Instituto Bernabeu patients enjoy a **treatment that is tailored** to their medical needs by a team of physicians who specialise in the main infertility pathologies: low ovarian reserve, embryo implantation failure, endometriosis, fertility endocrinology, reproductive immunology, etc.

The "Única Bernabeu" guaranteed success programme includes **three fresh treatments** and the transfers of the resulting cryopreserved embryos, with **18 months** to achieve gestation.

Find the programme that best suits your needs from among the **8 treatment programmes** which combine **IVF**, Embryo adoption, Ovodonation, ROPA IVF, Double IVF for low ovarian reserve, Double gamete donation, etc.

And don't waste precious time and money on unsuccessful treatments!

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Egg collection: a beginner's guide

By **Dr Carole Gilling-Smith** CEO, Medical Director and Founder of the Agora Clinic in Brighton

The one part of the IVF journey I find patients fear most is the egg collection stage, especially in their first cycle. It is easy to see why of course as it is the most invasive step of the whole procedure and some form of sedation is normally given, which for many women is their first experience of an 'operation' and 'anaesthetic'. Another big fear is that there might not be enough eggs. So, this article is designed to give you a clear and useful guide to what happens and how best to prepare and look after yourself during this key stage of your fertility journey.

The science behind it all

The daily hormone injections given during an IVF program allow the small follicles (sacs of fluid within the ovary that contain the eggs) to grow. Once they reach about 18 mm or more in size, the eggs inside are mature and ready to be collected. To prepare the eggs for collection, a 'trigger' injection has to be given. When scheduling your egg collection, your clinic will ask you to take this 'trigger' injection about 36 hours before your egg collection procedure. There is not much wiggle room here as if you take it too early you could end up ovulating before your egg collection is due to start but if you take it too late, then the eggs may be very difficult to collect. The trigger hormone mimics your natural ovulation hormone and allows certain key biological processes to be initiated within the egg which are critical to successful retrieval of the eggs and their subsequent fertilisation by fresh or frozen sperm. Forgetting to take the trigger injection at all (which does occasionally happen) could mean your egg collection has to be cancelled. So, it is really important to follow very precisely the instructions you are given for this injection.

Preparing for your egg collection

Once your egg collection day is confirmed, you will be told when you need to take your final doses of medication, including your trigger injection. Follow the instructions carefully and give yourself enough time to prepare your trigger, inject the solution at the correct time, perhaps getting your partner, relative or friend to help you.

The night before your egg collection, you should try to have a nice relaxing bath or shower and prepare everything you might need to bring with you on the day. As there may be some waiting around before and after the procedure, pack something to read and distract you, along with some headphones if you find listening to your favourite music helps you to relax. Drink plenty of fluid during the evening before egg collection as you will be told to stop taking food and fluids a few hours before you come to the clinic for your procedure. Being well hydrated will really help with your recovery. As for what to wear, something loose fitting and comfy like a loose t-shirt, jogging pants and trainers is ideal as you may feel a bit bloated as a result of the fertility injections. Many of my patients will tell you I am a great fan of egg collection 'lucky' socks, something fun and positive you can choose, perhaps with your partner, that might have a special meaning for you both, but will also keep your toes warm during the procedure (you will have to wear some form of hospital gown for your egg collection but you will be allowed to keep your socks on!).

What actually happens during the egg collection

When you arrive at the clinic, the nursing team will go through a routine admission process, including

checking your name and date of birth, blood pressure and weight and they will ask a few questions about your health and treatment. You will then be asked to change into a clinical gown before meeting the medical team who will talk you through the egg collection and sedation process, answer any questions you may have and take your consent for the procedure.

Once you are ready, you will be taken into the egg collection room and given some sedation to relax you. Although the types of sedation differ between IVF centres, most will provide a combination of two drugs; one which allows you to relax and, in most cases, sleep through the procedure and the other to provide some pain relief. Normally this medicine will be given through a small needle in the back of your hand. A few clinics offer a general anaesthetic rather than sedation for egg collection. If this is the case, your recovery may be a bit longer.

The egg collection will be carried out by a doctor who is a qualified Fertility Consultant or Specialist trained in gynaecological ultrasound-guided procedures. They will wait until you are asleep or sedated and then scan you internally. A fine needle attached to an ultrasound scanning probe will be passed through your vagina into each ovary to collect the eggs. The doctor will be able to see exactly what is happening on the ultrasound screen. The procedure takes on average between 10 and 30 minutes, depending on how many eggs are to be collected and at the end of the egg collection, you will be taken to the recovery bay where the nursing team will look after you until you are fully awake. You will be offered some fluids such as water or tea and a light meal before leaving the clinic.

Once your eggs have been collected, if they are to be frozen this will happen later that day. If they are being used in creating embryos, they will be placed in a dish with the sperm either from your partner or from a sperm donor for fertilisation to occur. If the sperm is low in numbers or of poor quality, the sperm will be injected into the eggs (known as intracytoplasmic injection or ICSI). This is a form of IVF where a single healthy sperm is injected directly into the centre of each egg to assist fertilisation. The treated eggs are then placed in an incubator overnight. This provides the optimum conditions to allow fertilisation to take place.

How will I feel afterwards?

Having your eggs collected is not normally a painful procedure. Some patients may feel some period pain for an hour or two afterwards and others may have no pain at all. However, everyone is different and just as no one person has the same reaction to an internal examination or a tooth extraction, the pain experienced after an egg collection can really vary quite a lot. Those who typically suffer severe period pains or who have endometriosis often experience more pain than those who never experience much menstrual

pain. This is why it is routine practice to give all patients having an egg collection some pain relief at the end of the procedure, usually in the form of Nurofen given as a rectal pessary or paracetamol given intravenously. A prophylactic antibiotic is also given rectally at the end of the procedure to minimise any risk of infection, which is a very small risk in this procedure (less than 0.1%). You might experience some light vaginal bleeding when you first go to the toilet but this will quickly tail off. If it is heavy, please let the nurse looking after you know. Like infection, post egg collection bleeding is a rare event, again occurring in less than 0.1% of cases, but it is important that you make the clinic aware of this so that they can act promptly to investigate why it is happening and deal with it.

Some people take longer to recover from the anaesthetic than others and some may feel nauseous and light headed. A medicine to stop nausea is often given with the sedation to prevent any unpleasant feelings of sickness after the egg collection. Feeling lightheaded often comes from the fact that you have not eaten for a few hours before your egg collection, so do remember to drink plenty the night before and make sure you take plenty of fluid and a light meal as you are recovering. You will be asked to empty your bladder before being discharged and this is usually a good time for the nursing team to check you are steady on your feet and back to your normal self before you leave the clinic.

If your partner is involved in your treatment, they will need to provide a sperm sample on the day of egg collection, often after they have accompanied you to the admissions lounge for your procedure. It is unusual for them to be allowed to stay with you during the procedure.

How will I feel once I get home?

If you have had any form of sedation, your ability to make decisions may be impaired and although you may feel very well in yourself, you should not drive or make any important decisions. You also need to have someone with you for 24 hours after any anaesthetic procedure to look after you in case you have any reaction to the anaesthetic, or drop in your blood pressure and feel faint. This can be your partner, relative or friend and they should contact the clinic if they have any concerns or worries.

This is a time to relax, put your feet up and watch TV or a film and not worry about anything that might be going on in your home or work life. Whatever the outcome of the egg collection, it is over and that in itself should leave you feeling more relaxed.

5 Do's and Don'ts before and after egg collection

DO'S

- Give yourself the full day off to focus on the procedure, recover and relax
- Make sure you have someone available to look after you after your egg collection
- Prepare some yummy food for egg collection day
- Have a hot water bottle and some paracetamol ready in case you need it when you get home
- Ensure you wear loose-fitting, comfortable clothes so you don't feel restricted

DON'TS

- Wear heavily scented perfume or nail varnish
- Go home by yourself or be left alone
- Panic - you have done all that you can and now you need to trust the team who are looking after you!
- Drink alcohol before or after egg collection
- Forget your lucky socks!

IVF Stimulation – potential side effects revealed

Editor-in-Chief of Fertility Road, **Clare Goulty** finds out what the potential risks are in her conversation with **Dr Arianna D'Angelo**, Clinical Lead in Reproductive Medicine at Wales Fertility Institute, Cardiff.

Many people considering undertaking IVF have concerns about the potential side-effects of the hormone stimulation medication involved.

Clare: Many thanks Arianna for talking to us at Fertility Road about this important topic. Let's start with discussing the most commonly used hormone stimulation drugs in IVF?
How do Gonadotropins work? What's their role in the IVF cycle?

Arianna: Ovarian stimulation drugs (also known as Gonadotropins) mimic the hormones produced by the woman's pituitary gland in order to stimulate the growth of the follicles in the ovaries. The follicles usually contain an egg which will develop and mature under the effect on these stimulating drugs.

These drugs can be "recombinant" meaning that they're created by high tech pharmaceutical laboratory procedures or "urinary" meaning processed from naturally produced human hormones. Both are equally effective and well tolerated.

There are mainly two categories of drugs used: the follicle stimulating hormone (FSH) and the luteinised hormone (LH). Since it is difficult to extract LH, some drugs use the "so called LH activity" produced by another hormone called human chorionic gonadotropin (HCG). Drugs can contain FSH alone (recombinant or urinary) or a mix of FSH/LH activity (only urinary). Recombinant drugs are usually available as an injection pen but urinary drugs have to be mixed and therefore injected using a syringe. All drugs are administered using a subcutaneous route (under the skin) with a small subcutaneous needle. The dose and frequency of the drugs will depend on the protocol allocated to you by your IVF doctor.

Clare: What are the different Stimulation Protocols most commonly used?

Arianna: There are two main stimulation protocols used in IVF: long and short. Each protocol involves using stimulation drugs as described above.

The long protocol (also known as "down regulation protocol") involves using injections or nasal sprays (GnRh-analogue agonist) for a minimum of two weeks to achieve the down regulation before starting the ovarian stimulation with the Gonadotropins. It is called "long" because it takes approx 4-5 weeks to get ready for the egg collection.

The short protocol (also known as "antagonist protocol") involves starting the ovarian stimulation drugs at the beginning of the menstrual cycle and adding a second drug called GnRH analogue antagonist approximately five days after the stimulation starts. The antagonist will be continued until ready for egg collection in order to avoid prematurely releasing the eggs. It is very important to understand that all these drugs mimic our hormones and are therefore time-sensitive; this is why it is important to follow the time-scales set by your fertility healthcare professional.

Clare: What are the most common, mild side effects of hormone stimulation?

Arianna: During the IVF cycle, it's normal to feel 'different' because the hormones given to stimulate the ovaries interfere with your own hormones causing mood changes for instance. Down

regulation which occurs during the long protocol is similar to menopause therefore hot flushes or nights sweats can be expected. These symptoms are temporary and will resolve once the ovarian stimulation drugs are started. However, stimulation drugs can also create minor symptoms such as feeling bloated and tired. Exercise might become more difficult and it is recommended to take it easy during this phase of treatment..

Clare: Do the majority of IVF patients experience mild side-effects?

Arianna: Yes, mild side effects are extremely common because hormonal drugs will cause a disruption of the woman's hormone balance. This is perfectly normal and reversible once the treatment is completed.

Clare: How can patients avoid or minimize these mild side-effects?

Arianna: Generally speaking, awareness is the key. If you are aware of what to expect you can manage better. Another important way to deal with these side effects is not to put too much pressure on yourself during this stage of the treatment. Trying to give yourself some relief and space by reducing work responsibilities might help. Some alternative treatments such as acupuncture might also be helpful. Counselling support is recommended.

Clare: How should patients expect to feel during the hormone stimulation stage of IVF? What's regarded as 'normal'?

Arianna: During the stimulation phase it is perfectly normal to start feeling aware of your ovaries in terms of feeling heavier and bloated. This happens because the follicles contained in the ovaries are growing under the effect of the drugs. The ovaries become larger, 2-3 times the normal size and occasionally become uncomfortable or painful. If that happens you should report it to your doctor to make sure that the stimulation is not too heavy, causing what is known as Ovarian Hyperstimulation Syndrome (OHSS).

Clare: Does the presence of mild side-effects determine the outcome of the cycle in any way?

Arianna: In a way it is more reassuring to experience mild symptoms as a result of the stimulation drugs because this is suggestive of the drugs being effective on the ovaries. However, some people experience no effects whatsoever and still have an appropriate ovarian response.

Clare: What are the most serious potential side-effects of hormone stimulation?

Arianna: The most serious drug related complication is Ovarian Hyperstimulation Syndrome (OHSS). In rare cases, OHSS can be life threatening. Fortunately, the incidence of the severe form of OHSS is less than 1% but moderate OHSS can range between 3-10%.

Severe Ovarian Hyperstimulation Syndrome (OHSS) presents the following symptoms: severe abdominal pain and bloating. Difficulties breathing, reduction of urine output and unable to eat and drink associated with sickness (vomiting). If a patient experiences any or all of these symptoms they must contact their IVF doctor immediately.

Moderate Ovarian Hyperstimulation Syndrome (OHSS) presents the following symptoms: abdominal discomfort, bloating and constipation. Feeling sick, occasionally unable to eat and/or vomiting. Feeling short of breath especially in the evening. If a patient experiences any or all of these symptoms they should contact their IVF doctor/clinic immediately.

Clare: How can these serious and moderate side-effects be treated?

Arianna: Moderate OHSS does not require hospitalisation in most cases but careful outpatient monitoring of the patient's symptoms via blood tests and ultrasound scans is important. Usually a high protein, low salt diet and fluid intake between 2-3 litres is enough to resolve the symptoms but sometimes anti sickness and blood thinner need to be administered.

The severe form of OHSS requires hospital admission to monitor kidneys and liver function alongside breathing and cardiovascular symptoms. Intravenous fluids are needed to make sure that appropriate hydration is maintained. Blood thinner to reduce the risk of blood clots is mandatory.

Clare: Is there anything patients can do to decrease their chances of serious side-effects?

Arianna: Despite your clinician's best efforts to plan the right dose and protocol for you, sometimes the response to the fertility drugs can be unexpected and therefore lead to OHSS. Luckily the syndrome has various degrees and it can be identified and managed at the earliest stage so that it does not develop any further. It is very important that you communicate with your clinic should you experience any symptoms of OHSS: abdominal pain and bloating, sickness, reduction in the urine output and difficulty to breath. High protein diet with low salt and appropriate fluid intake will help. Extreme exercise at the Stimulation phase of an IVF cycle should be avoided to reduce the risk of ovarian torsion or rupture leading to internal bleeding.

Clare: Does the presence of serious side-effects lead to the halting of an IVF cycle?

Arianna: Very rarely the IVF cycle will have to be cancelled due to high risk of OHSS. In most cases the treatment can go ahead by reducing the dose of stimulation drugs or sometimes stopping these drugs (so called 'Coasting'). Women at risk of developing OHSS should be given the short antagonist protocol, which has the possibility of using an ovulation trigger shot compatible with reducing the OHSS risk to less than 1%, therefore making the procedure very safe. Elective embryo freeze might need to occur should the risk of OHSS be deemed too high to continue.

Clare: Are there long-term health risks associated with the hormone stimulation involved in IVF?

Arianna: This is an area of continuous research since 1978 when the first IVF baby was born. Data so far is reassuring but long surveillance is needed as concluded in the book that I have recently edited: Long Term Safety of Assisted Reproduction.

Clare: Is there any link between IVF treatment and uterine or ovarian cancer?

Arianna: To date no link has been established with any of the female cancers including breast as well as uterine, cervical and ovarian. However, research is ongoing and large series are constantly reported to the annual scientific meetings and published on the Reproductive Medicine journals. A comprehensive summary of the latest evidence on this topic can be found in Chapter 2 (entitled: 'Evidence of the long term safety of ART and fertility drugs regarding cancer risk') in the book that I have recently edited: Long Term Safety of Assisted Reproduction.

Clare: What are the main health risks associated with IVF?

Arianna: IVF risks are not only related to fertility drugs but also to the actual procedure. For instance, the retrieval of the eggs is a small surgical procedure involving passing a fine needle through the vagina wall into each ovary with potential bleeding or injuries to internal organs. These side effects are extremely rare (less than 0.1%) but infections are more common hence antibiotics prophylaxis is recommended.
The process of transferring the embryo/s is safe but can be complicated by multiple pregnancies or ectopic and miscarriages. Finally, some patients experience high level of stress as a result of the treatment leading to anxiety and depression. More on this topic can be found in Chapter 18 (entitled: 'Psychological effects of undergoing ART') in the book that I have recently edited: Long Term Safety of Assisted Reproduction.

Clare: Are older women (40+) undertaking IVF more at risk?

Arianna: Generally speaking yes, but the degree of risk depends on whether they are using their own eggs or donated eggs. Donated eggs will reduce the risks of miscarriage but pregnancy complications such as preeclampsia and gestational hypertension have been reported in some recipients. If using their own eggs, the success rate is very low. These patients experience a risk of miscarriage or molar pregnancy at around 40% in addition to an increase risk of fetal abnormalities. More information can be found in Chapter 9 (entitled: 'Obstetrical risks and pregnancy outcomes specific to patients with very advanced maternal age (over 45)' in the book: *Long Term Safety of Assisted Reproduction*.

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IVF techniques to help male factor infertility

By Professor **Tim Child**, Group Medical Director of The Fertility Partnership (TFP) and Associate Professor of Reproductive Medicine at the University of Oxford

Whilst around one in six heterosexual couples fail to conceive after 12 months of regular intercourse (the medical definition of infertility), around half will go on to conceive without treatment in the second year of trying.

Fertility testing and the three aspects of conception

To assess whether continuing trying naturally or moving on to treatment is the best option it's important to arrange for the right fertility testing at the right time. Tests are focussed on the three aspects of conception- (1) motile sperm meeting an (2) egg in a (3) patent Fallopian tube. Therefore, tests include a semen analysis (the presence of motile sperm), confirmation of ovulation (is an egg being produced and released), and tubal patency testing (can the egg and sperm meet) by HyCoSy scan, hysterosalpingogram (HSG) or laparoscopy and dye operation. Usually, these tests are performed after 12 months of trying, but if a woman is beyond her mid-30s, her periods are irregular or absent (suggestive of lack of ovulation), there are symptoms increasing the likelihood of pelvic pathology (e.g., previous surgery, known or possible endometriosis or ovarian cysts, a history of Chlamydia), or a man has had testicular surgery or trauma, or was born with undescended testes, then investigation after only 6 months is appropriate.

Tests reveal no abnormalities in around a third of patients (unexplained infertility), primarily female in a third, and primarily male in a third. Sometimes there will be issues on both the male and female side. The rest of this article focusses on what to do when male fertility problems have been identified.

Three most important aspects of semen analysis

The three most important aspects of the semen analysis are the Count (should be >15 million/ml), the Volume of the sample (>=1.5ml) and the Motility (total percentage swimming forward ('progressively motile') >=30%). There are many other variables checked in a sperm test that may have minimal effect on the chance of success, for example the percentage of normal forms (morphology).

Dealing with sperm abnormalities

If an abnormality is found then the treatment plan depends on the severity of the result. If there are no sperm (azoospermia) or a very low count or motility, then the test should be repeated around 3 months later. Severe flu or other illness can temporarily affect sperm and the production cycle, around 10 weeks, needs to be given a chance. If there is again a lack of sperm then a testicular examination to confirm that the tubes draining the testes are present plus (1) genetic blood tests for karyotype (checking the number of chromosomes) and cystic fibrosis, plus (2) hormone tests are required. Depending on the results it is often possible to find sperm at a Surgical Sperm Retrieval (SSR). This sperm is used during IVF-ICSI treatment.

Male lifestyle factors

When a semen analysis returns with an abnormal result it is always worth looking at lifestyle factors. It is recognised that obesity, smoking and exces-

sive alcohol can negatively affect sperm quality and conception rates in ways we do not fully understand. Illicit drugs, steroids for bodybuilding, and some prescribed drugs can also reduce male fertility. For all patients trying to conceive it is worth optimising these factors, particularly when an abnormality has been found. In my opinion, there is no good evidence that one type of diet is better than another but reducing the amount of processed food makes sense. A popular obstetrics textbook from when I was a student (long ago!) said that pregnant women should eat food bought from the greengrocer, the butcher and the fishmonger. Whilst few such places now exist on the High Street the sentiment is the same, eat more freshly cooked and less processed food to optimise reproductive health. In my opinion, there is no good evidence that routine vitamin supplementation for men improves fertility. However, it is very unlikely vitamins will do harm and there is always the possibility of a benefit. I suggest buying supplements specially formulated for men from a Chemist or specialist drug company online, rather than buying high doses of individual vitamins.

Moving on to treatment

Moving on to treatment, there are relatively few men that will benefit from prescribed drugs to improve sperm. If a man has azoospermia (no sperm) and a blood test shows a lack of hormones driving sperm production, then hormone injections three times a week can lead to good levels of sperm. However, this is an uncommon cause of infertility. Sometimes men will be given drugs such as clomifene (usually used for women to treat ovulation) though the evidence for improved sperm production is currently unclear.

IUI

Intra-uterine insemination (IUI) was widely used for couples with mild to moderate male factor infertility. IUI involves concentrating a sperm sample and injecting it into the uterine cavity via the cervix at the time of ovulation. The 2013 NICE Fertility Guidelines reported that IUI for couples with male factor infertility was no more successful than trying naturally, and so IUI is now an uncommon treatment in the UK, apart from when donor sperm is used (when it can be very successful).

Main treatment for male factor infertility: IVF with ICSI

The main treatment for couples with male factor infertility is IVF usually with ICSI. The NICE Guidelines suggest that IVF is the most appropriate treatment for couples who have been trying unsuccessfully to conceive naturally for two years, whatever the cause of the fertility problem. This is why most NHS CCGs (clinical commissioning groups) use two years as a funding criterion. However, when there is azoospermia then, if sperm is found at SSR, moving straight to IVF with no delay is appropriate. When there is severe male factor infertility, but some sperm are present, the chance of natural conception may be very low but the CCGs still usually insist on a two year wait. Some couples may therefore go the self-funded route instead.

What IVF involves

IVF involves the woman having around 10-14 days of hormone injections to stimulate the ovaries. This is followed by an egg collection. If sperm quality is normal then conventional IVF (cIVF) is used, with around 100,000 motile sperm being mixed with each egg. If there is a male factor, then ICSI for insemination in which a single sperm is selected by the embryologist and injected into each egg is normally used. The fertilisation rate of ICSI when using reduced quality sperm is equivalent to that of cIVF when normal quality sperm is used, i.e.,

around 65%. ICSI is therefore an excellent treatment for male factor infertility. Fertilised eggs, called embryos, are then incubated for five days to the blastocyst stage when one or two, depending on female age, are transferred to the uterine cavity. The success rate of IVF +/- ICSI depends mainly on the woman's age, the quality of sperm has little effect since ICSI is available. Women in their mid-30s or below should have a livebirth rate per IVF cycle of around 40%. If donor sperm is used because a man has azoospermia and no sperm is found on SSR, or if a single woman or same-sex female couple are undergoing treatment, then ICSI may be used if the sperm quality is variable.

What ICSI involves

For ICSI the embryologist looks down a microscope for motile sperm of a normal shape (morphology) to select for insemination. There are additional techniques that can be used for sperm selection beyond this, including IMSI and PICSI. The theory is that these help improve success rates though evidence doesn't support their routine use. Some clinics suggest that men have a Sperm DNA Fragmentation test to assess sperm functionality beyond the standard measurements described above. Again, good data confirming the benefits of fragmentation testing are awaited but it may be of value in selected cases. If fragmentation levels are raised then optimising lifestyle factors, improving diet, taking anti-oxidant supplements and using sperm selection techniques such as ICSI, PICSI or IMSI are often recommended though proven benefits are again unclear. The HFEA (Human Fertilisation and Embryology Authority) has a website page on such 'add-ons' which assesses the evidence base and gives patients and clinics guidance. **www.hfea.gov.uk**

Conclusion

In summary, if conception is not happening then testing could identify the underlying cause, which may be male factor. If so, then look to optimise lifestyle factors, take some appropriate supplements, and discuss treatment options with a fertility specialist. Continuing to try naturally for a few months may be the best initial option for mild male factor. For azoospermia an SSR (surgical sperm retrieval) may be possible followed by IVF with ICSI. For moderate to severe male factor trying naturally or moving rapidly on to IVF with ICSI may be best, dependent on the severity of sperm quality, the duration of infertility, and female age. Donor sperm can be a very successful option via IUI, IVF or ICSI. Most cases of male factor infertility can result in livebirth either following natural conception or using one or more of the treatments described above. If concerned, speak first to your GP to arrange for a sperm test and then a fertility specialist to discuss options. The **www.hfea.gov.uk** website has a lot of information and links to trusted sites.

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How old is too old for IVF?

Professor **Luciano Nardo** consultant gynaecologist and subspecialist in reproductive medicine and surgery and founder of NOW-fertility

In this article, I will explain how age affects fertility for both men and women.

Female fertility

Let's start with talking about female fertility. Women are born with around 250,000 eggs and throughout their life, from when they have their first period to when they reach the menopause the body draws on these - you cannot produce more eggs beyond what you were born with. Only a few hundred thousand will still exist by puberty, and a mere few hundred will be released through ovulation.

The quantity and quality of eggs is called 'ovarian reserve' and this diminishes due to normal ageing, but also due to smoking, alcohol or drug use, treatment for cancer, or sometimes for no known reason. On average, female fertility will start declining from the age of 35 and most women will experience a steeper decline after the age of 39.

We know that women under the age of 35 may have a better chance of becoming pregnant naturally than somebody aged 37+ and generally speaking, the same age scale applies for assisted conception, with the chances of IVF success declining with advancing female chronological age. As a result, I would strongly recommend women over 35 looking to have a baby should consider conception support sooner rather than later.

Older women tend to have eggs of poor quality, and poor quality eggs are more likely than not to create poor quality embryos. A woman's lifestyle plays a role too. Studies have shown us that parents-to-be who smoke, drink excessively, and take drugs can affect the quality of their eggs. However, ovarian and chronological ageing are the main determining factors.

This is due to oxidative stress, which is an imbalance between free radicals and antioxidants in the body. As you get older, your body ages, and this is the same for your cells. We know that oxidative stress accumulates within the body, and that this causes damage, including to your DNA. We know that DNA damage affects fertilisation, and the quality of embryos created. The reason why older women have more problems getting pregnant is because of the breakdown of cells. If the same eggs were fertilised at the age of 20, there is a higher chance of producing a healthy baby than at 45. This is the reason why I discourage my patients older than 37 to freeze their eggs, because realistically the chances of those eggs surviving the freezing and defrosting process and being fertilised, and then creating a healthy embryo that could implant and grow to a healthy pregnancy are very slim.

While there currently is no female age limit in the UK, in my medical practice I apply common sense, and clinically sound advice. I would not put someone through IVF who has very, very low ovarian function, and I certainly wouldn't recommend IVF to somebody who has had IVF before and didn't produce any healthy eggs.

If a woman is thinking about preserving her fertility, she might want to consider freezing her eggs, ideally before she reaches age 35. Freezing eggs after this age is unlikely to give the same success rate. Egg freezing involves collecting a woman's eggs, freezing them and thawing them at a later date in order to fertilise during treatment. The younger a woman is when she has the procedure, the better quality the

eggs and the chances of pregnancy.

I think the statistics around IVF can be quite depressing; we know that IVF is successful in one third of cases. However, when embarking on treatment, you need to remember: you are not a statistic. You are an individual case, with individual lifestyles and your own health background.

What's more, age isn't the only determining factor when it comes to success. We need to consider ovarian reserve and reducing ovarian function, which can be assessed by a blood test and ultrasound scan.

Embarking on fertility treatment is one of the biggest, and perhaps most daunting, life decisions many couples and individuals will ever make. It can be an emotional rollercoaster and physically stressful; that's why NOW-fertility believes it is crucial to offer tailored expertise alongside as much support as possible, so that a positive and life changing outcome is achieved.

Male Fertility

We need to talk about male fertility too. Is the sperm healthy, and does it have any DNA damage? Discussing statistics around the woman's age is just one small piece of the puzzle. Male fertility declines like female fertility. But the difference is, female fertility is normally associated with running out of eggs. In men, the testicles produce sperm constantly, so male fertility issues are less likely to be related to running out of sperm, it's more to do with sperm quality. Men's fertility declines with age at a more constant, slower rate than women's and as such society has led us to believe that fertility is a female issue. However, the health of the sperm is significant to IVF success too. Older men may still be producing and overall have a good quantity and concentration of sperm, but the quality – including motility and morphology - may decline over time.

As well as age, it's important for men to know smoking and excessive alcohol intake can also cause DNA fragmentation. This means that the sperm becomes damaged and that can lead to subfertility, to miscarriage and potentially to a birth defect.

From the very first appointment with your GP, the focus is often weighted for women. Women may have multiple tests, and gynaecological care, while a man may simply have a semen analysis. This can have a detrimental effect on a man's confidence, relationships, and his emotional state. Men are not encouraged to ask questions and find out what's going on from their point of view. Some men can end up feeling like a spare part throughout the fertility journey.

While men don't experience a drop in fertility after a certain age in the same way women do, sperm counts do deteriorate. I would encourage any man facing potential fertility issues to get thoroughly tested, and go and see a urologist if you can. Once we understand medically what the problem may be, we can act accordingly.

There are many changes that can be made to improve sperm count and quality. Sperm are generally very easily influenced by simple lifestyle tweaks. Sperm have a 60-90 day development cycle so three to four months of little changes and you may well see a big difference:

- Eat a healthy diet, and increase your intake of fresh fruits and vegetables, including tomatoes. Tomatoes are packed with lycopene; which stud-

ies suggest can improve sperm quality. Cut out processed meats and sugars and limit caffeine and alcohol.

- Quit smoking and taking any recreational drugs.
- Exercise regularly, making sure you're staying well hydrated.
- Avoid putting laptops on your lap, and don't keep mobile phones in your pocket.
- Ejaculate every three to five days

Tracey Sainsbury is a specialist fertility counsellor who works with a growing number of clients for whom age related fertility issues are a concern, and recognises that the right age to try and conceive often is at odds with fertility being optimal:.

"This is not just because women are focussing on their career, more often because they are choosing not to settle for the wrong relationship in which to try and conceive. Where there is a desire to become parents, as in to conceive with someone in a relationship, finding the right partner can take time. Often the desire for a family outweighs waiting, hence more women choose to embrace solo motherhood or try to conceive later than was hoped."
Tracey Sainsbury, Specialist Fertility Counsellor

"I had to attend counselling as we were using donor sperm with IVF, I've stayed with it on a regular basis as the treatment has stirred up so many other aspects of life where I feel conflicted, counselling has really helped me to cope better and to have a space to make sense of things."
June, a fertility patient

Tracey adds:
"Counselling can help to promote robustness and resilience as a fertility journey continues, promoting staying with treatment to give the best chance of a successful outcome, or to feel supported if treatment does not feel right."

Tracey is keen to highlight that attending counselling is not just helpful before or during fertility treatment, it can be as helpful for people who decide that treatment is not for them, or who decide to explore alternative parenting options, support around fertility decisions should always be available and this has recently been highlighted in fertility patients care guidance report published by the European Fertility Society. **https://www.europeanfertilitysociety.com/publications/EFS-Fertility-Patients-Care-Guidance-2022-rev-1.pdf** which reinforced the need for clinics to be more patient centred. In the UK the HFEA stipulate that it is a mandatory requirement for counselling to be offered by clinics.

Tracey advised that as with her client June, who is quoted, independent counselling can sometimes be more helpful than in-clinic counselling so continuous support can be in place if treatment triggers emotions relating to other situations in life that have felt out of control, or where the need arises to change clinics.

The International Infertility Counselling Organisation lists the different accrediting bodies around the world **http://www.iico-infertilitycounseling.org/1216-2/** and in the UK you can find a fertility counsellor at **www.bica.net**

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www.now-fertility.com

How acupuncture can help you during IVF

By **Rachael Forrest** (DipAc, MBAcC), qualified acupuncturist and founder of the Natural Fertility Centre in Edinburgh

Over the last 20+ years, there has been increased understanding of and respect for the practice of acupuncture. Acupuncture has become an accepted adjunct to Assisted Reproductive Techniques (ARTs).

Traditional Chinese Medicine, of which acupuncture is just one part, is a highly sophisticated system of diagnosing and treating patients. It might sound unusual because acupuncturists use terms devised thousands of years ago but that doesn't take away from its efficacy. Tiny pins are used to stimulate the body's healing response, balance hormones, reduce pain and much more.

In terms of IVF, an acupuncturist can help most effectively if patients seek treatment at least three months before starting the fertility drugs because this gives time to address the potential causes of infertility or sub-fertility. However, many couples choose to book in when they are about to start the protocols or around embryo transfer and everyone should be supported, whatever their choices.

In addition to fertility issues there are the other symptoms a fertility patient might present with - migraines, IBS and insomnia being the most common. We can't ignore these because Chinese Medicine sees each individual as a 'whole' organism and these presentations, even though they may seem unrelated, could potentially have an impact on fertility and the efficacy of any fertility treatment. For example, A patient whom I'd seen three years previously got in touch and wanted me to 'just do the same as before' but Chinese Medicine doesn't work like that. The passing of time and, not least, a pregnancy and childbirth would have altered how her body responds. Acupuncturists are trained to take all these things into account and they are vital for us to provide effective treatment.

At the Natural Fertility Centre, we treat men, women, same sex couples and single women. It is mainly women who come for treatment, but sperm issues can be addressed with acupuncture (no, we don't put needles 'there') as well as erectile dysfunction or premature ejaculation. Men can find the IVF process stressful and they can be a better support for their partners if they are calm and feel heard.

Acupuncture can be used during various stages of IVF to achieve different objectives but there are a couple - calming stress/anxiety and boosting circulation - that are overriding constants throughout the fertility drug protocols, whether that's for ICSI (Inter-cytoplasmic Sperm Injection), IVF (In-vitro Fertilisation) or an FET (Frozen Embryo Transfer)/donor conception.

Acupuncture is highly successful at lowering levels of adrenaline in the body and this is a priority. If your sympathetic nervous system (aka 'fight or flight') is dominating, then the body will not be optimal for conception. After an acupuncture session, patients should leave the clinic feeling very content and relaxed because the parasympathetic nervous system (aka 'calm and connect') has been activated. This is vital for fertility as it helps blood flow properly and allows the organs to relax and respond.

At initial consultation, an acupuncturist will ask: are you having a fresh cycle and is it your first or subsequent attempt(s)? How old are you and your partner and what are your lifestyle choices in terms of stress, rest, activity and diet? Is this an FET and are you using donor eggs or sperm? Is ICSI required and what is the background to that? If it is a Male Factor issue, do we need to look at DNA Fragmentation testing? Answers to these questions will help us to target the treatment to your specific requirements but there are also general protocols we use depending on where you are in your ART (Assisted Reproductive Technique).

'Down Regs'

During the 'down regs', aka 'down regulation', phase an acupuncturist will concentrate on reducing side effects of the fertility drugs. In the past, women potentially suffered in this phase, with hot flushes, headaches, mood swings and insomnia.
Since AMH (Anti-Mullarian Hormone) testing was developed, IVF consultants have guidance as to the drug dosage appropriate for you, and side-effects from the down-regulators are not as severe. We use acupuncture during this time to work on any background fertility issues as much as we can, but so much depends on how long this phase is, your response to the drugs and any issues with endometrial lining (some might not be thin enough and others might be too thin). All these issues will inform what we, as acupuncturists, need to do to support you in the best way possible during this time. The focus is on balancing your body and getting you ready for the stimulation phase.

The 'Stims' Phase

The 'Stims', or 'stimulation phase' focuses on the ovaries and preparing for egg collection. There are specific acupuncture points over the ovaries (called 'Palace of the Foetus') which we can stimulate either just using the needles or with the addition of a TENS machine, depending on the results of each scan.
Women respond differently to the fertility drugs and an experienced acupuncturist will know how to adapt treatment to what is going on and the potential risk of either a low response or OHSS (Ovarian Hyper Stimulation Syndrome). If there are early signs of OHSS, acupuncture can be used to reduce the risk of accumulating body fluids. Abdominal tightness can be alleviated. An acupuncturist will be alert to signs of thirst in patients and for more serious symptoms like breathlessness.

Egg Collection

Egg collection can be the most difficult part for a woman to go through physically, depending on the quantity of eggs retrieved. Harvesting even a few eggs can result in abdominal bruising, cramping and pain.
Acupuncture can be used post egg-collection to 'calm the uterus' and to promote healing and good circulation. By stimulating blood flow, we can speed up the healing process.
This can be a very stressful time as the couple waits for news of how many eggs have fertilised or thawed and there is also an element of 'no turning back'. For older couples where this might be the last chance, this time is fraught with emotion and tension so we focus on emotional support and lots of time to talk.
For a FET (Frozen Embryo Transfer) we don't need to stimulate the ovaries or worry about egg collection and instead use acupuncture to build up the womb lining and to promote production of progesterone closer to the time of embryo transfer.

Embryo Transfer

At this stage, I recommend acupuncture before and after the procedure. Sometimes we see women the day before and the day after the ET (Embryo Transfer) and this seems to work well but we go with what you feel you can manage. The focus during this time is encouraging the body to hold onto the embryo, and keeping you calm and supported. There are particular acupuncture points which are for 'raising energy' and can be used for piles and prolapses as well as post embryo transfer.

The Two Week Wait

During the period of waiting, which varies in length depending on the stage of the embryo at transfer, acupuncture can be used to support your body and mind. We know that so much rests on the results of the blood tests and trained acupuncturists are experienced in helping you through euphoria or despair. Acupuncture affects mental and emotional states as well as the physical and we use the strength and subtleties of Chinese Medicine at our disposal to support you, come what may.
I witness acupuncture's effectiveness all the time in my clinic (www.thenaturalfertiltycentre.uk) but I am aware that, in terms of fertility, we also need to engage the best nutritional support to ensure optimum egg and sperm quality and a high level of nutrients in the womb lining. This allows for higher chances of your treatment having a successful outcome. With enough time, we can put a really effective eating plan in place but our patients are also advised to take a good, food-state (ie non-synthetic and as un-processed as possible) multivitamin, like our NFC Essentials (nfcessentials.com) and CoQ10, as a base, plus other supplements if they are indicated.
An experienced fertility acupuncturist will be able to give you the best treatment to suit your needs as well as information, guidance and support. Check the British Acupuncture Council website (**acupuncture.org.uk**) for experienced fertility acupuncturists in your area.

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How improved nutrition can help avoid miscarriage

By **Dr Marilyn Glenville** PhD, leading UK Nutritionist specialising in Women's Health

Miscarriage is far more common than many people realise. An estimated one in four women experience miscarriage and one in three hundred have had three or four miscarriages. Suffering a miscarriage is one of the most devastating things that can happen to a woman, and to her partner.

A miscarriage can occur after natural conception and also after IVF treatment. A miscarriage is when a baby is lost before the 24th week of pregnancy. There are three other kinds of foetal loss that aren't strictly miscarriages since the woman's body doesn't expel anything spontaneously: they are the "blighted ovum", "missed abortion" and "chemical pregnancy". A blighted ovum occurs when an ultrasound shows an amniotic sac, but no embryo within it. A 'missed abortion' is where the embryo or foetus has died but has not been expelled from the uterus. In a chemical pregnancy, hormone levels indicate a pregnancy, but loss occurred before the fifth week.

After miscarriage

It is important before you start aiming to conceive again to make sure that you have rested and feel well enough before trying again. You may have lost a lot of blood during the miscarriage and your doctor may check that you are not anemic and if you are, you will need to take iron supplements and be re-tested to make sure that your level is back to normal.

Also make sure that you are feeling emotionally recharged before you try again. Give yourself time to grieve and try to bond with your partner, too. Grief can become so all-consuming that it's easy to forget that you are in this together and can offer support to each other for the loss of the baby you made together. You may also experience feelings of guilt but it's important to know that miscarriage is not your fault.

It is normally suggested that you wait until you have had your first period before trying again so that it's easy to date the next pregnancy. But my recommendation would be to give yourself longer (ideally to have three menstrual cycles) to help you feel both physically and emotionally ready.

It takes your egg three months to mature before it is released at ovulation, so you have a three-month window of opportunity to get yourself and your eggs really healthy before you get pregnant again.

Lifestyle Factors

Smoking

Smoking is known to increase the risk of miscarriage. It is also thought that chemicals in tobacco smoke can damage the DNA in the sperm leading to increased miscarriage rate.

Alcohol

It is known that alcohol consumption during pregnancy can increase the risk of miscarriage. And more than 5 units a week has a negative effect on sperm quality which can increase the risk.

Caffeine

Caffeine intake has been found to increase the risk of a miscarriage. Drinking only 2 cups of coffee (200 mg of caffeine) a day is associated with a 25% increased risk of miscarriage.[1] And problems with sperm health are connected with caffeine intake which could increase the risk of miscarriage.[2]

Men need to look after their health too

Something that may not be usually mentioned concerning miscarriage is that your male partner needs to look after himself too. Although it is the woman who miscarries it is important that your partner eats well, stops smoking and also reduces alcohol intake because a miscarriage can also occur if the sperm is not as healthy as it could be.

The three-month rule

As mentioned above, it takes at least three months for immature eggs to be ready for ovulation and also three months for sperm cells to mature, ready to be ejaculated so it is worthwhile both of you preparing for the next pregnancy.

It is important that both the man and woman eat as healthily as possible and your diet should be supplemented in order to ensure that both you and your male partner have good levels of specific nutrients that are vital for preventing miscarriage.

Folic Acid

Most women trying to become pregnant know about the importance of folic acid, which has been proven to prevent spina bifida. But folic acid is extremely important if you have experienced miscarriage. A high level of an amino acid called homocysteine (which damages blood vessels) has been found in women who experience recurrent miscarriage. It is, therefore, important that folic acid (in the active methyl folate form) and the vitamins B6 and B12 form a part of a good supplement plan as these three nutrients help to reduce homocysteine.

Vitamins C and E

These vitamins are important antioxidants and can help prevent chromosome damage and abnormal blood clotting.

Zinc

Zinc is an essential component of genetic material and a zinc deficiency can cause chromosome changes in both partners, leading to an increased risk of miscarriage.

What's more, zinc plays a vital role in normal cell division, so it is particularly important that adequate levels are available at the time of conception in order to prevent a miscarriage.

Selenium

Researchers have found that women who miscarry have low levels of selenium in their blood compared to women who don't miscarry. Selenium is a powerful antioxidant and it can prevent chromosome breakage and DNA damage, which are known to be a cause of miscarriage.

Selenium is also needed for healthy sperm formation and as an antioxidant, selenium can also protect against possible DNA damage to sperm.

Vitamin D

Vitamin D helps to balance your immune system which is important for reducing the risk of miscarriage. Vitamin D decreases the Th1 autoimmune response, but it also helps to promote the Th2 cells which your body needs to maintain a pregnancy.

A deficiency of vitamin D has been linked to recurrent pregnancy losses.[3]

Vitamin D is also important for male fertility as low levels of this nutrient is associated with low sperm motility and more abnormal forms which again could increase the risk of miscarriage.

Take a good fertility supplement (e.g., NHP's Advanced Fertility Support for Women from **www.naturalhealthpractice.com**) which contains folic acid in the active methyl folate form, zinc, selenium, vitamin E, vitamin D as well as other important nutrients.

Omega-3 fatty acids

The omega 3 fatty acids have far-reaching effects for miscarriage. Sometimes immune problems may be affecting a woman's ability to stay pregnant. The theory is that in order for you to stay

pregnant, your immune system has to quieten down because half the baby's DNA is not yours. Normally if the body detects something foreign it aims to reject it and expel it from the body. For some women, their immune systems do not quieten down and so they can't stay pregnant.

One of the immune antibodies measured is called antiphospholipid antibodies (APAs). These blood-clotting antibodies can prevent implantation and cause recurrent miscarriage by attacking the cells that build the placenta. The medical treatment for this is blood thinners like aspirin and heparin. But research has shown that fish oil given to 22 women with APAs who already had 3 or more miscarriages went on to have 23 pregnancies (one woman has twins) without a further miscarriage.

Natural Killer (NK) cells

Higher levels of natural killer (NK) cells have been linked to miscarriage and it is known that NK cells are often higher due to inflammation. Research has shown that taking fish oil helps to reduce placental inflammation during pregnancy.[4]

Omega 3 fatty acids are also important for male fertility because semen is rich in prostaglandins, which are produced from these omega 3 fatty acids. Men with poor sperm quality, abnormal sperm, poor motility or low count, can have inadequate levels of these beneficial prostaglandins.

As well as eating well, taking supplements, avoiding alcohol and smoking, it is important to think about your weight. You stand the best chance of staying pregnant if you are not under or overweight. It is also known that if a man is overweight it can increase sperm DNA fragmentation which can increase the risk of miscarriage.

It is normal to feel concerned that another miscarriage may happen and if your fears are taking over your life then it is important to speak to your doctor who may refer you for counselling. Ideally, you want to be able to enjoy the pregnancy as much as possible.

[1] Weng X et al, 2008, Maternal caffeine consumption during pregnancy and the risk of miscarriage: a prospective cohort study, Am J Obstet Gynecol, 198, 3, 279, e1-8

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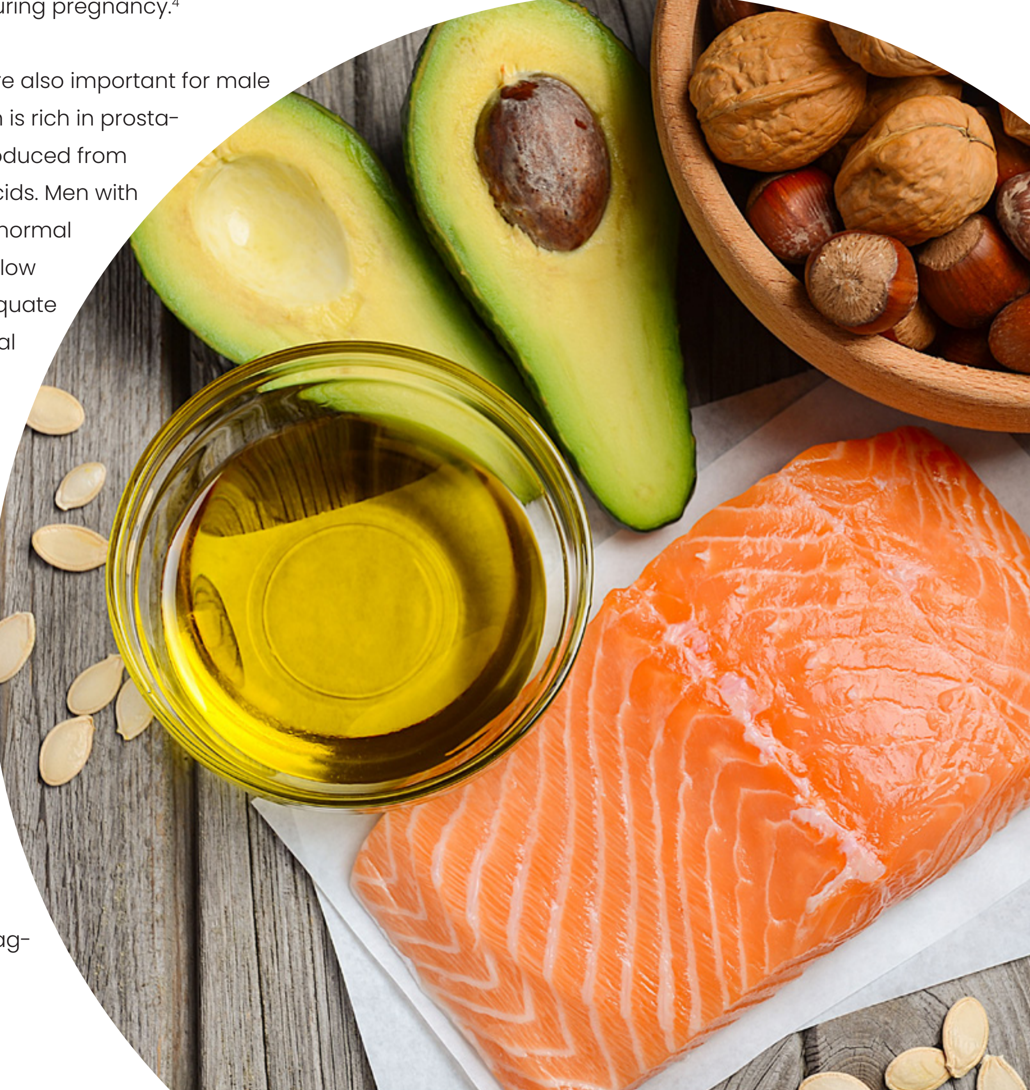

What am I entitled to as an employee going through fertility treatment?

By **Claire Ingle**, Co-founder at Fertility Matters at Work & **Helen Burgess**, Partner at Gateley Legal

The word 'entitlement' carries so much weight in the world of work. When you are sick you want to know what you are 'entitled' to in terms of pay. When you have time off for a planned operation you need to know your entitlements on a supportive working plan when you come back to work. When you are pregnant you look to policies and terms and conditions for information on what you are 'entitled' to in terms of time and money.

For fertility treatment there is no such luxury and currently no 'entitlement'. Research tells us very clearly that the majority of people who are going through fertility treatment are scared to tell their employer and so go through the experience in secret, often covering the truth with varying excuses that are tied to the entitlements that already exist so that in some way they can feel a sense of validation in what they are doing. I did this. I lied my way through two cycles of fertility treatment after checking within our work policies to see that there was nothing at all to even recognise that fertility treatment existed. That in itself felt incredibly isolating. With the absence of words on a page that could help me I also knew that there was no such 'entitlement' available, making me even more determined to be able to take time off and be paid, no matter how I had to manipulate the situation to make it happen.

The truth is this is 'not me'. I am not out to 'get' what I can from any organisation. I have always been exceptionally loyal to the people I work for, am conscientious beyond belief and hate letting people down. This however, was different. I felt backed into a corner; my struggle was very real. I felt like wanting a baby and having this fertility treatment (my only option) wasn't recognised or deemed important enough to attach support to in my workplace.
This feeling, I have since learned, is all too common and I was never alone in how I felt. Despite an array of legislative changes over the years to support more 'family friendly' topics we are still not seeing enough changes in the time in people's lives 'before a family'. There is a distinctly hidden space where people who are trying to *get* pregnant don't even get an ounce of recognition.

At Fertility Matters at Work, we are contacted frequently by people via our social media platforms outlining their career conundrums and the huge impact that fertility treatment has had and is having on their work; solicitors, doctors, teachers, engineers, finance experts; the list is endless. There is a real ignorance around what small changes could be made and ought to be made to enable these people to have an all-round better experience in the world of work.

When people feel backed into a corner, they formally complain via the grievance procedure which takes time and has a mental health toll on all of those involved and is often indicative of a poor culture which then causes even more challenges. They call in sick, or worse, they just decide to leave. Some of the quotes below are just a glimpse of the messages we receive at Fertility Matters at Work from people and serve to highlight the need for more robust legislation around fertility treatment.

"The culture at my work is one of fear, almost bullying so they (employees) feel reluctant to speak out. I spoke out with HR and my management as

I thought it was the right thing to do for not just me. I am having to battle the grievance case which I could do without, but it's not in my nature to give up. Alongside this they have declined my request to work part time (literally asking them to do three hours less a week) so all in all a really bad, unsupportive employer."

"I work(ed) as a Specialist Pharmacist in an NHS hospital; I told my line manager about our treatment and when I called her I'd also prepared myself to hand in my notice."

"My counsellor has said when doing IVF you can get signed off work..I'm seriously considering doing this for our next round."

"I handed in my notice. I've not been working for a few months now and don't regret it (the decision to quit) as I had totally underestimated how stressed and anxious I was feeling in my job."

Helen Burgess, an employment lawyer, explains how, from a legal perspective, there is very little that exists at the moment.

Legally there's nothing an employer has to give to or do for an employee who's going through fertility treatment.

There is a potential argument that because the female has to undergo most of the fertility treatment procedures, she could bring a claim for indirect sex discrimination if her employer refused her time off to attend for those appointments. However, that argument hasn't been tested. There is actually also no legal entitlement to attend medical or dental appointments during working hours but most employers allow this and some more progressive employers have extended this to cover fertility treatment appointments as well – but they don't have to by law.

Once an employee is pregnant the usual rights and protections kick in – time off to attend antenatal appointments, not to be discriminated against because they're pregnant, their role has to be risk assessed, etc. – but when is an employee going through fertility treatment considered to be pregnant?

The cases of Mayr* and Sahota* are helpful and the following points can be elicited:

- An employee is 'pregnant' at the point of embryo transfer
- If implantation is unsuccessful and the pregnancy ends, she continues to be protected under pregnancy discrimination legislation for a further two weeks following the end of the pregnancy
- The female employee is also protected from sex discrimination if her employer does anything unfavourable to her as a result of her having fertility treatment. This protection is limited to the time it takes for the ova to be collected, fertilised and the embryos transferred to her uterus. However, she will only be protected if the transfer is imminent and not if the embryos are frozen with a view to implanting them at a later date.

The employer of course has to know that the employee is undergoing fertility treatment or is pregnant for the protection/s to bite.

We know what the impact of a lack of legislation feels like and we know that recognising fertility treatment as a valid reason to attend appointments is highly likely to have a positive affect/effect on how psychologically safe people feel at work around disclosing treatment to their employer.

At Fertility Matters at Work, we have recently joined forces with Nickie

Aiken, MP for Westminster, who is supporting us in taking our request for statutory entitlements to Parliament via a Private Member's Bill. We are starting with an ask for statutory time off for people who have to attend appointments for the assisted reproductive treatment that will enable them to create their family. We recognise organisations need to balance their business and the associated costs, but it doesn't necessarily have to be paid; just recognised and allowed, just like time off for family and dependents is.

Some organisations already stipulate time off for appointments in their policies but they are few and far between. A change in law is the next step to either identify infertility as a 'protected characteristic' and be recognised under the Equality Act as a disability which will bring more protection against discrimination. The US already recognise infertility as a disability under the ADA (Americans with Disabilities Act) which is more in line with the WHO (World Health Organisation) definition of infertility which notes that it is a disability and a 'disease of the reproductive system defined by the failure to achieve a clinical pregnancy after 12 months or more of regular unprotected sexual intercourse.' The WHO is reportedly reviewing this definition of infertility to recognise that everyone has the 'right to reproduce', signalling the changes that are needed to support those who are unable to conceive naturally.

Whatever happens in the future, the amount of people using assisted reproduction treatment is only set to increase. With it, we are hopeful that employees will commonly see more entitlements start to emerge as organisations realise the extent to which people within their organisations are needing time off and support. It's a huge goal of ours at Fertility Matters at Work, to ensure that those going through fertility treatment in the future don't have to hide appointments and sneak around at work, but they can attend these appointments safe in the knowledge that they have the right to do so. How wonderful would that be?!

**Mayr v Bäckerei und Konditorei Gerhard Flöckner OHG C-506/06 (ECJ); [2008] IRLR 387*

Sahota v Home Office and Pipkin [2009] UKEAT/0342/09

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Our IVF story
How to thrive and not simply survive a long and challenging fertility journey

How to thrive and not simply survive a long and challenging fertility journey

Editor-in-Chief at Fertility Road, **Clare Goulty** had the great pleasure of talking to remarkable couple, Emma & Angus Menzies about how their ongoing, arduous fertility journey is shaping their lives for the better

Emma & Angus Menzies began their fertility journey over ten years ago. Years of investing both financially and emotionally in invasive tests, IUI, IVF, ICSI, and virtually every treatment 'add-on' possible has sadly resulted in recurrent miscarriage, pain and heartbreak. And yet, they stand strong together having found the positives in an otherwise cripplingly disappointing fertility journey. They are a shining example of 'courage in the face of adversity' and are uniquely using their experiences and professional skills to help others.

Clare: When did your fertility journey start?

Emma: We started trying for a family just after we married in September 2011 - so a long time ago!

Angus: Yes, over ten and a half years ago at the time we're speaking.

Clare: What challenges have you encountered on your journey?

Emma: We've had difficulties conceiving and unfortunately, when we have conceived, I've miscarried.

Angus: We certainly didn't expect to encounter any challenges. We had no reason to believe we would have any issues and we were very relaxed about it all to begin with. After a year of not conceiving, we became more diligent in our efforts, and conceived naturally in early 2013. We took for granted that everything would work out well from there.

Clare: What happened?

Emma: We went to our scan at around 12 weeks and there was no heart-beat. We'd had a missed miscarriage. Ultimately this needed to be managed with surgery. It was an enormous shock and absolutely devastating. It still haunts us both today.

Angus: The medics were quick to reassure us that in the not-too-distant future, we would be on a labour ward welcoming a baby into the world, but actually, things just seemed to go from bad to worse. It became more difficult for us to conceive and subsequent pregnancies ended in miscarriage at an even earlier stage.

Clare: When did you decide to start fertility treatment?

Emma: After the missed miscarriage we were more desperate than ever for me to be pregnant again. We tried naturally for around seven months, without success, then registered with a fertility clinic in early 2014. We had all of the initial screening, consultations and investigations, then decided to start fertility treatment straight away.

Clare: What fertility treatment did you have?

Angus: We started with IUI and when that wasn't successful, we moved on to IVF, then ICSI and frozen embryo transfers. For a time, we accepted all of the "add-ons" offered to us and heav-

ily indulged the controversial immune therapy treatments too. Sadly, none of it changed our outcome.

Emma: And when we weren't getting anywhere with fertility treatments alone, we also changed our diet, took vast qualities of supplements daily, changed our exercise habits, swapped all of our toiletries, cosmetics and household cleaning products for natural alternatives and experimented with acupuncture, hypnotherapy and other complementary therapies too. Many of these things helped us personally, but unfortunately, they didn't result in us becoming parents.

Angus: There was a time when we just threw everything at it - too much. We realise now that we were too desperate, too militant and too disciplined. It was unsustainable.

Emma: Yes, over the years we've become far more discerning about what we will and won't do, inside and outside of fertility clinics, to try for our family. We do our research and we listen to experts, but we trust our instincts too. It's definitely made the journey more manageable and it's enabled us to persevere for as long as we have. We've continued with various fertility treatment cycles, interspersed with periods of trying naturally, and actually, the majority of our pregnancies have been conceived naturally. We've also continued to engage in whatever self-care feels right for us.

Clare: Have you ever received a clear diagnosis?

Angus: No! We've been thoroughly investigated in several fertility clinics and the recurrent miscarriage clinic. We're not aware of any tests, evidence based or otherwise, that we haven't had, but our diagnosis remains 'unexplained'. It's a diagnosis that felt like a blessing at the beginning - we were relieved there seemed to be nothing wrong with either of us. But over the years it has felt more like a curse. With no clear problem, there's no clear solution - nothing to fix. I've found that deeply frustrating.

Clare: It's been a long journey with a lot of disappointment. What impact has this had on you both?

Emma: I used to say the fertility journey was the worst thing that's ever happened to me. But for the last five years I've said it's the worst and the best thing that's ever happened to me.

It's been difficult, for sure - physically painful and uncomfortable at times, financially demanding, socially isolating and most of all, mentally and emotionally draining. I wouldn't wish it on anyone. I've been consumed by grief and overwhelmed by sadness. I've felt incredibly lost and lonely. I've been chronically stressed and exhausted and several years ago I completely burnt out.

But that was a real turning point for me. That was when the journey became a catalyst for discovering who I really wanted to be and the life I really want to lead, and for taking responsibility to make it happen. I started to think differently, feel differently, behave differently, make different choices and take different action and ultimately, I became a happier person living a more fulfilling life than I ever imagined possible without having my own baby. To that extent the journey has been a real gift, for which I am truly thankful.

Angus: The journey has definitely impacted all aspects of our lives, personal and professional, and it's been a real challenge. I've found it particularly difficult feeling so helpless - unable to provide any solutions as I've watched Emma bear the brunt of the physical aspects of the process only to be left devastated by the outcomes.

But it's also been great to watch and support her personal transformation and to make positive changes in my own life too - changes I'm not convinced I would otherwise have made. We've learnt a lot about ourselves and each other and I think it's brought us even closer together. It's also enabled us to have other adventures that we now remember fondly.

I still hope we eventually find ourselves as parents, but even if we don't, I'm proud of what we've achieved on the journey and I'm grateful for how much we've grown as individuals and as a couple. I would never choose to go back to the people we were and the life we led before the journey started.

Clare: What are the most significant changes you've made in your life as a result of your fertility journey?

Emma: I've made the most significant changes in my professional life. I used to practice employment law in a large corporate in central London, but it wasn't true to me or the life I wanted. As I struggled to manage the fertility journey alongside my career, it became increasingly obvious that this wasn't the work I wanted to do, where I wanted to do it, or how I wanted to do it. I now work for myself, from home, running my own Coaching and Consultancy business, Ready Steady Coach, and I love it.

Angus: I've also made the most significant changes in my professional life. Unlike Emma, I still practice employment law, but I now co-run my own law firm, Horsfield Menzies. It was important to me to be able to exercise more control over my life - the fertility journey, which can leave you feeling very out of control, helped me to realise that - and running my own business makes this possible. I can fit my work around my life far more easily now than I ever could when I worked for large law and accountancy firms, although working practices seem to be improving in such organisations, especially since the pandemic.

Clare: You both now use your work as a means to support others on a fertility journey. Tell me more about that.

Emma: As employment lawyers on a fertility journey, we both identified with the current lack of support for fertility in the workplace. This is something we want to change and we use our training, qualifications, skills and experiences to do just that.

Through my coaching programmes, I help people to manage the impact of fertility challenges on their career and working life, and through my consultancy work, I help organisations to manage fertility in the workplace.

Angus: And where an individual or organisation requires legal advice on fertility at work matters, that's where I come in. We're also both keen to be involved in lobbying government for changes to employment legislation to improve the support that is available to those for whom starting or extending a family doesn't come easy.

Emma: We're a real husband and wife team! We originally met at work and it's lovely to be working together again on something we're both passionate about, that enables us to make a positive difference to others who are struggling as we have done.

Clare: What's one piece of advice you would you offer others on a fertility journey?

Angus: Make it even more of a priority to do the things you enjoy in life, both individually and together. It will help you to cope.

Emma: Work on being the person you want to be, living the life you want to live and bring a baby into, now, while you're on your journey. It will help you to look forward to the possibility of a baby coming along and enhancing your life, without you waiting for it, and relying on it, to *save* your life.

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Heartfelt thanks to Emma & Angus for sharing their inspirational story with Fertility Road.

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Donor Conception is different

- Part 1 of 3-part series

By **Nina Barnsley**, Director
at Donor Conception Network

Donors, difference and decision-making

This is the first of a three-part series, with Parts 2 and 3 appearing in the next editions of Fertility Road magazine. What the series aims to do is to explore how donor conception is different, how that might feel and what the implications might be at different stages in family life. The articles follow the lifespan of a family from decision-making (this article) through to pregnancy and a child's early years, before continuing the story in Part 3 to see what might come up for families with a teenager and beyond. The element of 'difference' permeates those stages in various ways and relates to some of the questions people ask and the things that need to be considered.

Difference

The word 'difference' is important in this series because I think this is a big part of what people struggle with. It might be the difference in terms of what you expected and hoped for, or it might be the difference in relation to the more 'conventional' way that babies are made or family structures. What does that difference mean, to you, your partner if you have one, your friends and family and what might it mean for any child you conceive? Does difference come with judgement or curiosity? Does it mean a break from trusted norms or an invitation to something new?
Having a child who was made in a different way or being a different kind of family, can feel uncomfortable for some people. If you already have a child and are considering donor conception for a second child, you may be thinking about how to balance that difference within the family. You may wonder if others will treat you or your child differently. People, including children, often want to be similar to everyone else and fit in.

Dreams and Plan A

Most people, assuming they want children, will have a vision of how they imagine their family to be.
Part of this is a lovely day-dreaming of the future, wondering about a boy or a girl, thinking about what those children might be like and imagining life as a parent. This dreaming is probably more common for women, but men can also have a picture of what they imagine family life to look like, especially once they start seriously thinking they would like to start trying for a baby.
For many people, particularly women, the longing for a child can be intense and when things don't go smoothly the resulting emotional turbulence can be overwhelming. This is often the point at which people are considering donor conception. Things haven't gone quite to plan and now you are being offered an alternative (different) plan and you need to work out if this is the right way forward for you.
Letting go of Plan A can be hard and grieving may be part of that process.

What makes a family?

What is a family and what makes a parent? Is it genes or is it intention and turning up to do the job? Maybe it's both. It's certainly a thought-provoking question. In most families there will be a mum and dad who are also the genetic parents and this can be the assumption of what defines a family. But we also know that this isn't always the case. We know there are step children and adopted children who are most certainly family. It's true that in donor conception families parents may not have a genetic connection to their children and the children will

definitely be genetically related to the sperm, egg or embryo donor. But what are the deeper questions and feelings around the relationship between genetics and family?

You might be wondering: will I feel like a 'real' parent if I'm not genetically related to my child? How will I feel raising a child who isn't genetically connected to me and my side of the family? Where do I place this other person, the donor, in our family story? You may also be wondering whether you need to share this information with other people, including friends and family. And you may wonder how children feel about being conceived this way.

Different family types

Single men and women and same-sex couples will always need help from a sperm or egg donor and potentially also a surrogate. For these families, on the one hand there can be a sense of delight that there is a way to have a child, thanks to medical advances and a relaxing of societal expectations. But there are still decisions to make and questions that come up. Some single people would have preferred to do this with a partner. Same-sex couples would probably ideally like to be able to make a baby together with their partner, but biology makes that impossible. So, in these situations, even where there can be a real sense of excitement about having the option to be a parent, people may share some of the feelings and questions with heterosexual couples. And, like heterosexual couples, there can be worries about whether, if you're the non-genetic parent, you'll feel like the 'real' mum or dad.

Decisions, decisions

Donor conception comes with a raft of decisions that couples using their own eggs and sperm don't need to think about. The number of decisions, in itself, can make people want to bypass the thinking and just get on with the treatment, whatever is the quickest and most likely to result in a baby. But thinking things through is important. Your choices will have life-long implications for you and your child. It may be hard, possibly painful, to think about the needs of a child who isn't even conceived yet. You may worry that you will jinx your chances of pregnancy by imagining that child too soon. But it's really worth investing the time to feel confident in your choices.

The first decision might be what kind of donor to use. Should it be someone known to you, a friend or family member, for example? Do you plan to use an anonymous donor who is expecting to remain anonymous forever? Or is the donor going to be unknown to you but willing to share their identity in the future – 'ID release'?

You may be weighing up where to have treatment, what country and what clinic, or making a private arrangement. Your decision will affect what other choices are available to you and the legal framework you're operating under, including what rights and expectations the donor, you and your child will have.

With ID release donors, a child will have the right to get information about their donor and any half siblings if they wish in the future. That might be important to you or your child in the future. But if that option isn't available, how do you feel about an anonymous donor?

And then there are more decisions

Choosing characteristics to match with the donor is something else to add to the list. Often parents will be looking for physical characteristics (like colouring and height) so that any child will look like they 'fit' with the family. You may have specific things you are hoping for, perhaps relating to ethnicity, religion, education, personality or interests. Having more requirements might mean you struggle to find a match, or not within a time-frame or in a country that suits your other requirements. What compromises do you feel able to make? Some countries or clinics won't offer any choice of donor, or only very limited. Having the clinic take over that decision might be a huge relief, or the lack of involvement might feel more stressful.

On a more practical level, there are conversations around how much this will cost and what funds you have available. Not to mention how much emotional energy you have for what can be a long process. Fertility treatment isn't cheap and can be gruelling. What is the time frame you're working to? Weighing up all these choices can be a real challenge, not least because they themselves are sometimes in conflict with each other which means you may have to let some things go.

Navigating the differences

Looking at the things raised here it might feel like it's just a minefield of questions. These are probably not the questions people imagined when they were day-dreaming about a future family. And, if you have a partner, they may be thinking about it differently, adding another layer.

A big part of what can be tough is having to make these complex, important decisions at a time when emotions are running high. Clear thinking may feel impossible and the drive to get pregnant seems like all that matters. Let's just say, it's not ideal. And if you're finding it tricky, it's no wonder.

What helps people move forward?

It's helpful to remember that people have navigated through this before. There isn't just one roadmap for the journey, there are lots. People choose different things, making compromises where necessary, to find something that works for them. Parents need to be comfortable with their decisions and the aim is finding a way forward that you can feel positive about and proud of and that you feel able to share openly with your child. So, how can that be achieved?

Preparation is your friend

What is often most beneficial is peer support from people who are in a similar situation, or a little further along the journey and who can really understand what you are going through. You may not know anyone in your family or friendship group that has done this. You may be different in that regard and it can feel lonely and hard to know where to go for help. That's partly why our charity, the Donor Conception Network was founded: to help break the isolation people feel and connect them with others over a shared experience. The guidance and support offered can be transformative, both at the decision-making stage and beyond.

They say it takes a village to raise children. Well, sometimes it takes a village to help you even contemplate that journey. Everyone needs support and community at different stages of life. For those considering egg, sperm or embryo donation, or raising a family after donor conception, we know that is especially true.

Because people have chosen something different it is important to have a space where that difference is shared. A space where the difference isn't different. That is what we try to create at the Donor Conception Network.

Counselling is also incredibly useful, providing professional support and dedicated time to explore difficult feelings. Our Destination Parenthood workshops offer another helpful space for people considering donor conception and we know they can be transformational. There are also some really great books on the topic and, of course, in today's digital world there are wonderful blogs, webinars and podcasts telling stories, offering wise reflections and hope.

Final thoughts

So, apart from checking out the DC Network website and the support we offer, what would I say to people who are at this 'thinking and trying' stage?

Firstly, if you're feeling under pressure, slow down. People are often coming to this after a long period of failed treatments or thinking long and hard about whether to go forward with the plan for a family, and there is a strong urge to get cracking. Make sure you give yourself time to grieve for what was not to be. It might take time to let Plan A go and open up to a different possibility for the future. Of course, you don't want to spend the next 5 years in limbo, but pressing pause and dedicating a few months to this should mean you can move forward with confidence in your choices.

Secondly, even if you aren't feeling under pressure and already feel very positive about your decision, make sure you give yourself time and space to think through your options, particularly holding your future child in mind. This is possibly the most important decision you're ever going to make, so it's worth giving it focus and attention.

You'll be really glad you did and so will your child.

In the next issue, Part 2 will look at 'difference' once you're pregnant or have a young child.

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The emotional aspects of taking the donor route to solo parenthood and how best to access support

By **Mel Johnson**, Coach and Founder of 'The Stork and I'

It's becoming increasingly common for women in their mid to late 30s and 40s to find that they have not met a suitable partner that they would consider having a baby with and feel they are getting to an age biologically where they might miss out on motherhood due to this circumstance.
I know this because this was my exact situation and I now offer coaching to hundreds of women in the same position. These women don't necessarily have any medical fertility issues (although often they are not aware if they will experience medical infertility as they haven't got to this stage of even trying yet) but rather are falling into a category that is being termed 'social infertility'.

Love the term or hate it, it is being used to describe the situation where you are unable to conceive naturally due to not having a partner and every year, we see more and more women finding themselves falling into this category.

For some in this situation the decision to try to become a solo parent using a sperm donor is an easy one as it provides the opportunity to try to ensure they don't miss out on motherhood altogether. For others it takes a great deal of careful consideration. Many women spend several years deciding whether this is the right path for them. Personally, it took me nearly 3 years from it being a potential option, to fully deciding and starting treatment.

So why does it take so long to decide to take the donor route to solo parenthood?

Often there are a few different factors at play when deciding whether to pursue solo motherhood using donor conception, many of them emotional considerations.

The first is overcoming feelings of failure and shame that many admit to feeling about the fact they have not met a suitable partner to try to conceive naturally with. It can feel like everyone around you has managed to find a partner and they are all starting to have children together and for whatever reason, you just have not managed to be in the same position. Many women have shared with me that they have started to question what is wrong with them, particularly when it feels to them like everyone else, they know has achieved the goal of meeting a partner. You can start feeling left behind from your friendship group who all seem to be getting married and having children.

The second aspect is letting go of the fairy-tale of how you thought you would become a parent. We grew up surrounded by stories of meeting 'Prince Charming' and living happily ever after together. What we grew up being told, turns into our life script. By that I mean, the path in which we presume our life will take. Anything else will be deemed a failure. Any deviation from this script can challenge us.

Although most of us are realistic enough to know that our lives might not play out exactly in this way, we often don't realise how deeply embedded some of those stories we have grown up with have become. The fairy-tale, the Rom Coms, the chick lit, the way the media portrays single, childless women, the list goes on. This can sometimes be so deeply embedded into our psyche that we don't question it.

We start off by presuming we will follow the 'traditional route' of meeting a partner, getting married, buying a house and having children together, maybe one boy, then one girl, maybe getting a dog. When it becomes apparent this might not be going to happen for us, at least not in this order, we start

wondering if we might miss out on motherhood altogether. Everything else can happen in its own time. We could meet someone in our 50s, or 60s or beyond. But there is a timescale for having children. So that's what causes us to feel pressure.

Not wanting to consider the possibility of not becoming a parent, it's at this point that people often start exploring the solo parenting route using donor sperm and sometimes depending on the circumstances also donor eggs. Often, there is a lot of emotional work to do, to start letting go of the way you originally presumed you would become a parent and to start working to embrace an alternative journey to parenthood.

This can be something that doesn't come easily. For years and years, basically throughout our entire life to date, we might have made an assumption of how our journey to parenthood would play out. We have been led to believe that there is one path that is the most desired path and that any other paths will not allow us to be as happy. So, if we need to choose a different path, there can be an automatic assumption that it won't be as desirable.

We have bought into the 'Bridget Jones' character, where single people are represented as unhappy and flawed. It can be for these reasons that for many in this situation, it can be easy to assume that happily ever after is no longer possible if you haven't met a partner in time to have a baby with them. The only way to achieve happiness is to somehow manage to achieve your original life plan.

I help coach people on this topic and help them to let go of how they thought they would become a parent and embrace an alternative version. Different, but equally positive. If you have a deeply embedded belief of how you thought it would happen for you, it can take quite some work letting go of that idea and rewriting of that script, but it is totally possible.

It can be common to rewrite the script but at first struggle to see how it could possibly be as positive as the original plan. It takes a lot of work to look for the positives. You will find what you look for so if you keep looking for the things that are worse about your situation, you will be sure to find them. The tip in this instance is to look for the amazing elements about your own situation and how you can make that as good as it could be..

Will others judge you?

Another one of the emotional elements relating to this decision to use a sperm donor to become a solo parent is the worry about the judgement of what others will think of your decision. It's common to worry that others might not agree with our decision or look down on us for making it. Maybe they think we are being selfish. Maybe they think it will be detrimental to our child's emotional wellbeing. This can often be linked with our own judgements, our own insecurities and doubts.

The good news is that many women report that they built up a big fear of sharing their story with others and in actual fact when they did share that they have used a donor to conceive the vast majority of the reactions have been overwhelmingly positive. This in turn allows us to feel more positive about our decision to use donor conception.

There can be a huge concern about the impact to your child of not growing up with a father in their life. Making the decision to use a sperm donor to conceive as a solo parent means that your child will not know their biological father (unless a known donor is used) There may be an opportunity to connect with them at a later date, but this is not guaranteed and would only be possible from age 18 onwards.

In this circumstance, not only will they be donor conceived, but they will also not grow up with a father figure in their life. This is where role models can be hugely important. There may not be a father, but having plenty of inspiring role models can help to ensure they don't feel they are missing out.

Another thing I recommend to people in this situation is to read Susan Golombok's book, 'We Are Family', to fully understand the research that has been done in this area. Professor Golombok is a researcher who visits lesbian mothers, gay fathers, single parents, solo parents, donor conception parents, surrogates, and donors and more importantly, their children, to find out if they are as well adjusted, happy and emotionally stable as children from nuclear families. And she discovers the answer is yes - and sometimes even more so.

Also, what is really powerful is listening to donor conceived peoples' voices. Series 5 of the **Stork and I** podcast features donor conceived people who were raised by solo parents, so we can hear from their lived experience and learn from it.

Accessing emotional support

When embarking on a journey of solo motherhood, a support network can become absolutely critical. You might not have a partner by your side to walk the journey with you, but by no means does this mean that you have to do it alone.

Will you feel lonely as a solo parent?

Many people worry that they will feel lonely, but this doesn't have to be the case at all. It is possible to build an incredible support network and surround yourself by amazing people who are all there for you and supporting you on your journey in a variety of different ways.

Some people are lucky that they already have a support network in place, maybe your own parents, siblings or friends, but others worry that they don't have a big network of people who would either be willing or able to help. This is something that you can absolutely create. Many of my closest friends are from since my daughter was born. It's amazing how quickly you can build a friendship, especially if you're in similar situations and really 'get' what each other is going through.

For this reason, one amazing source of support can be the solo parent community. Nothing beats connecting with people in similar circumstances who really 'get it' This can either be online or in person. The good thing about emotional support is that it can be either in person or remote: on a facebook group, a WhatsApp group or a Zoom call. This means that emotional support can be sought from global resources.

That is the exact reason why I created The Stork and I. To enable women in this situation to connect with each other, form part of each other's support networks and ensure that no-one going through this feels alone.

If you are single and feel like you might miss out on motherhood if you wait for a suitable partner there are plenty of ways that you can connect with others in the same situation as you and get support and advice.

Thriving Solo is a Solo Mum Membership Group that includes access to **monthly live events** on relevant solo mother topics as well as a monthly connection call for all members to attend as well as many useful downloadable resources.

The Stork and I Mum Tribe is a global Facebook Group that is set up to connect solo mums and those considering solo parenthood using donor conception. The group includes access to WhatsApp groups connecting people who live nearby to each other.

Single Mothers By Choice UK, is a similar group exclusively for those living in the UK.

If you embark on a solo parent journey using donor conception, you will have a mandatory counselling session if you are using a UK clinic with a qualified counsellor. You can opt for additional sessions if there is more you need to talk through with a **BICA qualified counsellor**.

It can sometimes feel like we are alone on this journey. Whilst everyone around us is meeting a partner, getting married and conceiving naturally, we can feel stuck and out of options. I can reassure you as someone who has been there, travelled the journey, and now has an amazing 4-year-old daughter conceived using donor sperm, that this doesn't have to be the 'second best' option. This was the perfect choice for me, and it could be for you too.

Mel is running **Choosing Solo**, her group Coaching Course for those considering solo motherhood on 22nd August 2022. Please check her website for details **www.thestorkandi.com**

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Egg donation – what I wish I'd known

By **Sheila Lamb**, author of *My Fertility Book* and the 'Fertility Books' series

Sheila shares her valuable insights into being a mother to her donor-conceived daughter. Sheila talks to Fertility Road about what she wished she'd known prior to taking the egg donor route to parenthood. Here she explores her thoughts and feelings before, during and after donor IVF.

Fertility Road: Sheila, thank you so much for talking to us at Fertility Road. At what age did you start to consider egg donation?

Sheila: Initially when I was forty-two, then seriously when I was forty-five.

Fertility Road: What were your fertility circumstances at the time? Why was egg donation on your radar?

Sheila: We were diagnosed with 'unexplained infertility' when I was forty-two and after our first unsuccessful ICSI cycle, our UK clinic mentioned we might need egg donation because out of six embryos, only one was chromosomally normal.

Fertility Road: Was it a difficult decision to make? How did you go about finding out about egg donation?

Sheila: After that unsuccessful cycle with my own eggs, we carried on trying naturally for three years because there was no known reason, but during that time egg donation was in the back of my mind. I don't remember grieving that any child I had wouldn't be mine biologically. I always knew that I would love the child I gave birth to as I'd always wanted to be a Mum, and here I was, well into my 40's and still trying. I wasn't actively looking for information and there wasn't a lot available, certainly no-one was openly talking about it back in 2009. Then, one Sunday in August I was reading a Sunday paper supplement, and there was an article about egg donation in Spain. An English nurse from a Spanish clinic was interviewed and it just felt like I was supposed to read this article. My husband and I don't speak Spanish so knowing there would be someone there who was English was reassuring. In the UK, egg donation was no longer anonymous, so there would've been a couple of years wait, and we didn't have time on our side.

Fertility Road: Were there particular sources of information which helped you to make the decision to go ahead with egg donation?

Sheila: I knew about the Donor Conception Network but I didn't get around to contacting them, and there was Fertility Friends, but I don't remember there being much information about the clinic we had in mind and egg donation in Spain. I had an appointment with Fertility & Pregnancy expert, Zita West in early 2009 and she also advised that egg donation was likely to be our best option to become parents. So, most of our information came from the clinic in southern Spain when we had our first appointment.

Fertility Road: Did you have good sources of emotional support at the time?

Sheila: Not really. We didn't know anyone else who had been through egg donation and we didn't speak to a counsellor. Counselling wasn't suggested by our clinic. I think we'd been trying for so many years that we had got used to the idea and we talked about it together a lot. We were just relieved that this could be the route to becoming parents.

Fertility Road: Looking back, were there things you wished you'd known at the decision-making stage?

Sheila: Yes, there were, but because I can't change it, I don't look back. I now understand that my daughter may want to know more about the egg donor as she gets older and any biological half-siblings. But this was never discussed and it never crossed my mind, or if it did, I didn't know if these were normal feelings. If she wants to know in the future, of course I'll support her in the way that is best for her. Now my daughter is here and she's a person, it would be nice to have more information about the donor, as we have very little information other than her hair and eye colour, height, weight, age and interests.

Fertility Road: Is there an opportunity to ask the clinic in Spain for more information on your donor? Was your donor anonymous?

Sheila: Yes, our donor was anonymous. Like a lot of parents-to-be who have to consider that a donor is their only way to have a family, one worry we had was that if the donor was known, would our child see me as their mother? Now that I have my daughter, I know this worry was totally needless because I am her Mum. But we can't help these thoughts. Unfortunately, the clinic in Spain only gave us the minimum information mentioned previously, and as far as I'm aware, there are no plans to change the law in Spain around the anonymity of egg donors.

Fertility Road: Looking back at the IVF/egg donation cycle, what do you recall as being the highs and lows?

Sheila: I felt more optimistic with both egg donor cycles because it seemed the issue was my eggs, so it felt like we were getting closer to being parents. Then when I lost the baby after the first cycle at six weeks, that was definitely a very low time. It was the first time I'd ever been pregnant and I was devastated. As there were no frozen embryos we had to start again with a new donor, and we'd decided this would be our last attempt so it was an intense time. We threw everything we could at this cycle so we knew we'd tried out best, including blood tests for thrombophilia, NK cells and Factor V Leiden, and although the results were within normal ranges, I was prescribed medication to reduce the risk anyway. The highest of highs was seeing our future baby as a four-cell, two-day old embryo (in our case), before transfer. Priceless.

Fertility Road: With the benefit of hindsight, what would you have said to yourself at the time?

Sheila: I would have told myself to get professional counselling help to navigate the negative emotions I had of infertility, the feelings surrounding loss and grief, the anxiety and of losing who I had been. Nowadays all these feelings are out in the open and shared in the TTC (trying to conceive) community which is fantastic. It is also the reason I put together my 'Fertility Books' series which is available globally.

Fertility Road: Tell us more about your books. Who are they aimed at and what topics do they cover?

Sheila: My books to help people who are struggling to conceive is my passion! The first book I self-published in 2018 is *My Fertility Book; all the fertility and infertility explanations you will ever need from A to Z*, and it's a glossary of medical and non-medical terms that are explained for someone who doesn't have a medical degree! So really useful for preparing for appointments, and understanding male and female fertility. Understanding the fertility lingo, i.e. abbreviations and acronyms is very stressful at the beginning of your journey, so I have a free eBook of over 200 infertility abbreviations that are used on social media, blogs, websites etc, and it can be downloaded from **www.mfsbooks.co.uk**
I started to publish my *Fertility Books series* in 2019, and each book is a collection of true-life, short stories and experiences about the emotions and frustrations when getting pregnant isn't easy. Reading other women's and men's stories really helps us to know we are not alone and validates our feelings. Even now, all these years later, other people's stories help me because there wasn't much to read fifteen years ago. The first book, *This is Trying To Conceive*, is only about infertility. The second is *This is IVF and Other Fertility Treatments*; the third book is *This is the Two-Week Wait*; the next is *This is Pregnancy and Baby Loss* (I didn't use 'miscarriage' in the title because I don't like the word); and the latest book published in May 2022 is *This is Pregnancy after Infertility and Loss*. There will be at least two further books which I plan to publish over the next eighteen months, hopefully. I also co-authored a book with fertility nurse Yemi Adegbile titled *Infertility Doesn't Care About Ethnicity*, and it's as the title says - a collection of true-life stories from ethnic women who

have experienced infertility, pregnancy and baby loss, fertility treatments, donor conception, surrogacy and child-free after infertility. Although women in all countries feel the same devastating emotions when conceiving just isn't happening, ethnic women often experience additional stress from their own families, communities, cultures and the medical profession, so we wanted to put their stories into a book to not only support ethnic women but to also raise awareness of their additional struggles. All my books support women who are personally experiencing a difficult path to parenthood, because other women who've trodden the same path have been strong and compassionate in sharing their stories. But equally as important, the books also educate their families and friends, healthcare professionals (who see these women, and men, when they are at their most vulnerable), such as clinic staff, ultrasound staff, nurses, doctors, midwives, counsellors, nutritionists, even receptionists. I am so grateful to all the contributors who understood my vision for the series. As a thank you to them, a small donation is made to a relevant charity for each sale. All the books are available as eBooks and paperbacks.

Fertility Road: After the birth of your daughter, what were your feelings about the egg donation process?

Sheila: I felt so very grateful that egg donation was possible and that another woman was kind enough to help. Like most women I never thought this would be my story and that I would become a Mum through egg donation, but from the moment I saw my daughter as an embryo, I was in love, and that love has only grown.

Fertility Road: How did you plan to talk to your daughter about her donor-conceived origins?

Sheila: Back when we were considering egg donation and when I was pregnant, there was little information that I knew of about how to talk to donor conceived children. It was never going to be a secret because family and friends knew so that wouldn't have been right. I don't think we had a plan as such, but I'm glad donor conceived people are now sharing about how they feel as it's very helpful.

Fertility Road: What age was your daughter when you started the conversation?

Sheila: I talked to her from the moment she was born. I used to say that Mummy's eggs were old and didn't work, and a kind lady wanted to help someone like me, so she gave us one of her eggs and that egg became you. She didn't understand of course but it helped me get used to talking to her. I was open with new Mums I met that she was conceived using a donor's egg, so she probably heard this as well, even though not fully understanding.

Fertility Road: Is this an ongoing conversation which evolves as your daughter grows?

Sheila: Absolutely. When she was eight, my husband and I told her about the 'birds and the bees' – again about my eggs not working, that a lady we didn't know went to a clinic in Spain wanting to help Mummy and Daddy become parents. She didn't ask much at the time, only if that meant she had two Mums. We told her I was her Mummy whose tummy she grew in. Then she asked if she could go and play! It's not something we talk about every day, in fact it's quite rare, she doesn't usually bring it up. But when she asked where did she get her tanned skin from, I told her as the donor was from Spain, probably from her. If she has any questions or wants to try and find out more in the future regards trying to contact the donor, we'll definitely support her. But at the moment, it isn't something that interests her at all.

Fertility Road: What advice would you give to parents of donor-conceived children?

Sheila: I would definitely recommend finding a counsellor who is trained in donor conception, as they have experience with helping parents-to-be to navigate their emotions and the future with a donor conceived child. Attend support groups or workshops specifically for those considering donor conception, because the concerns are different, and you can connect with others who are on the same journey as you. Start your own book of your child's beginnings – this is such a beautiful keepsake and you'll forget things if you don't either write them down or take a photo. I deeply regret I just have a few random pieces of information about the donor. Find children's books that you like that tell the story of donor conception and start reading them to your baby as soon as you've welcomed her or him into the world.

Egg Donation - Considerations from both recipient and donor perspectives

By **Tracey Sainsbury**, specialist fertility counsellor

Your pathway to parenthood with egg donation may seem quite straightforward in a practical way, the eggs are collected from a young, healthy donor, fertilized with the sperm of your choice and the resulting embryo transferred when the conditions are optimal to give a pregnancy the best chance of success; but here we will consider the emotional stages of your journey too, encouraging you to understand the potential highs and lows, accepting both as your plans move forward.

When do people tend to consider egg donation?

Egg donation for females, individually or those in a relationship, might be suggested at the end of a long fertility journey or after initial fertility tests show a low chance of success with a patient's own egg treatment. The patient's initial response can often be shock. Disbelief at the suggestion of using someone else's egg, and sometimes at the other end of the spectrum, relief, knowing you will have a better chance of success and not need to go through stimulation and egg collection yourself. There are no rights or wrongs, it's just about how you feel.

In my experience as a fertility counsellor, it can take time to feel comfortable with the concept of donor conception, especially if you are in a relationship as you may both process the decision in different ways, and over different lengths of time.

I was so very ready to go down the donor route, my husband was confused as he thought I'd be devastated that it wasn't my egg. He hadn't had the firsthand experience of the hormones, the physical sense of loss when treatment hadn't worked, the hideous period after another loss. I was very ready to move on. In counselling it became apparent that he had only just started to accept it wasn't going to work with my eggs. We needed time so he could play catch up.
Rose, embracing UK egg donation treatment.

Once the decision has been made to embrace donor conception the first question asked is often where in the world to have treatment? Which country, which clinic, which donor...

The regulatory framework around donor conception differs around the world, there is a growing global trend towards the ethos used in the UK, around openness and transparency, very much driven by donor conceived people. But wherever you go, whichever clinic you attend, one thing is common – the donor will have *wanted* to donate.

What motivates women to donate their eggs?

There may be different reasons why people donate their eggs to help others who wish to try and conceive, but awareness of the importance of family and a desire to want to help are commonplace and essential in the UK where donors are compensated for altruistic donation, rather than there being a significant financial incentive.

Not all women who want to donate their eggs are able to do so. Family history is explored, genetic tests performed, and fertility tests undertaken to ensure the potential for a successful outcome. Clinics would not put a person through ovarian stimulation if there was not a good chance of success suggested by the initial tests. Each clinic

will have their own criteria around donor recruitment, and questions are routinely welcomed, often helping to promote your emotional comfort in the process ahead of treatment.

I felt like I was being difficult wanting to know how they recruited donors and why the clinic had suggested a particular donor. On paper it didn't sound right, but by explaining their thought processes around what I'd shared about me and why they thought the match was right, it reinforced why I chose the clinic in the first place.
Roberta, egg donation in Greece

Donors have to be aware of the rights for offspring in many countries to be able to access their identifying information as adults, the impact this may have on them, their wider families including their own children is explored ahead of treatment being planned. In the UK and for people conceiving with eggs imported from overseas, the donors are able to find out the gender and year of birth of children born from the eggs donated; this can be so useful for them, but also for their own children too.

Emotional support is equally important for both egg recipient and egg donor

Research undertaken by the Morgan Centre for Research into Everyday Lives, University of Manchester, has confirmed how much more widespread the impact of donating gametes can be felt; wondering about offspring isn't a bad thing, it's just something donors and their families may do when they are curious. Counselling is a routine part of the pathway for donors, providing a space to consider that the genetic connection can be felt in different ways for different people, not just parents, donors and offspring. **Being an egg or sperm donor - School of Social Sciences - The University of Manchester**

I was so pleased I could donate my eggs. An advert popped up on my social media and it made me think about what a waste it was each month when my eggs weren't being used; more so now my family is complete. The counsellor suggested I talk about my donation with my children from a young age, I did think that was a bit odd, but the books for children from the Donor Conception Network really helped make sense of it, for my children – and my wider family to, especially my Grandad, he thought it was amazing.
Jo, egg donor UK

The Donor Conception Network have a wide range of resources for parents through donor conception and a dedicated selection of books for donors too to share with their own children: **Books for donors | Donor Conception Network (dcnetwork.org)**

Donors able to donate can feel really positive about the potential to create a new life, but they may have a moment of uncertainty or curiosity and then, just as support is available for patients, donors may continue to access support after treatment too. Thoughts and feelings can change where children are born, or not. Informed consent provides a moment in time to reflect back on, evidencing that at the time of conception a donor was very comfortable with their decisions and had progressed with awareness of the implications, and of support being there for them.

For people trying to conceive it can be surprising if once treatment becomes a reality, they grieve the loss of the fantasy about how they'd hoped to conceive. This in itself can trigger other losses they have experienced, or difficult times they have lived through. The grief process can also heighten the awareness of other emotions once the shock subsides. Shame and embarrassment can be in the mix, along with anger and a sense of failing. We know, our conscious self knows, we have not done anything wrong, but often we need a focus to vent our frustration, and sadly often we turn the criticism to ourselves.

Self-care is key. If we try to constantly think positively and remain optimistic we can set ourselves up to fail. Being real is so important, especially when you are choosing your donor.

For a moment I wanted to run away and forget it, but I had a known sperm donor and there was just the egg donor selection to be able to move forwards, I had to find the one, in the end I'd got a choice of two, one liked candy floss, that did it for me, it's my absolute favorite comfort food.
Paulette, embracing solo motherhood, UK

How to select your egg donor

When selecting your donor, there may or may not be an obvious choice of a donor. If there is it can be a little more straightforward, but it need not be complicated. Clinics routinely suggest a very basic approach to donor selection: start with physical characteristics and use the other information to short list.

When people are struggling to make a donor selection I suggest working backwards: thinking of the adult conceived from the treatment, and the narrative parents will share in the future about their decision. Physical characteristics and a good familial fit enable a parent, when asked why they chose their donor, to reply 'they were a good fit for the family and…' The 'and' being whatever makes the selected donor appear 'good enough' to move to the next step. For Paulette (quoted above) it was the candy floss connection that made her smile, and made the decision feel right for her too.

Single men and male couples embracing egg donation and surrogacy as part of their pathway to parenthood can also experience a wide range of emotions, from a purely practical straightforward decision, to a recognition that however impossible, life would be so much easier if they could just make a baby without the need for assistance.

The decision to have treatment, where to have it, donor selection and when to start, may all only feel 51% right at the time. 49% wondering what if… would a different clinic be better, will a better match of donor be available next week… next month…next year? In my opinion, 49% 'what if's' is good enough to move forwards, reinforcing that no clinic, no matter how good, can guarantee a successful cycle outcome. You don't need to feel 100% certain – life is rarely that straightforward.

The emotional rollercoaster of taking the egg donor route to parenthood contains highs - you want to create a new life, and lows - there may not be a new life. The experience strikes at our most basic primal desires. However, having an appreciation for the potential emotional stages equips you to face the journey feeling empowered.

Whatever stage of your egg donation journey you are at please remember:

- There may always be a little uncertainty, that is OK
- It can routinely be stressful, that too is OK, embrace the stress, manage it well.
- Specialist support is available

In the UK you can find a specialist fertility counsellor via the British Infertility Counselling Association **www.bica.net**

The International Infertility Counselling Organisation can be found at **https://www.iico-infertility-counseling.org/** which lists specialist counselling organisations around the world.

You can also reach me, Tracey Sainsbury at: **www.fertilitycounselling.co.uk**

Find Top Fertility Clinics Abroad

We provide all the information you need to find the best fertility clinic for you in Europe. We have helpful guides to help you understand more about fertility treatment abroad.

Find IVF Clinic Abroad

Why do UK patients travel abroad for IVF?

By **Emma Haslam**, Co-founder of Your IVF Abroad

I had my first (and last) cycle of IVF abroad in 2016 and I chose to go abroad for a variety of reasons, having not met the UK NHS criteria for NHS funded treatment. In my view, going abroad for fertility treatment is becoming an increasingly popular choice for many UK fertility patients. Let's take a look at some of the reasons why I believe that trend is happening..

Availability of NHS funded treatment

National Institute of Clinical Excellent (NICE) guidelines in the UK state that:
Women aged under 40 years who meet the criteria for in vitro fertilisation (IVF) are offered 3 full cycles of IVF and those between 40-42 years who meet the criteria for in vitro fertilisation (IVF) are offered 1 full cycle of IVF. (Nice Quality Statement)

However, these are only UK guidelines and sadly do not reflect the reality for so many people. NHS healthcare budgets are controlled by the Clinical Commissioning Groups (CCGs) who make decisions on how budgets are allocated.

CCGs are responsible for achieving the best possible health outcomes for their local population with the funds they have available. They decide how to allocate their budgets, which means they determine on a local level how many rounds of IVF (if any) are offered to residents living in their postcode area. CCGs also decide on the criteria for treatment and this sometimes results in limited or no funded treatment at all being offered. I personally find this frustrating particularly when WHO (World Health Organisation) recognise infertility as being 'a disease'. WHO formally recognised infertility as a disease in its international glossary of Assistive Reproduction Technologies (ART) terminology in 2009.

Cuts to Government funding to CCGs have added further pressure. In my view, this goes some way to explain why many people feel under pressure to fund their fertility treatment themselves.

Eligibility criteria

Eligibility criteria is also a key factor. The eligibility criteria for NHS funded IVF treatment include: time already spent trying to conceive, whether you smoke or not, BMI (body mass index), whether you're single or in a relationship, whether your partner (if you have one) already has a child, whether you're in a same-sex relationship or not and whether you have a disability which prevents you from having sexual intercourse. In comparison and in my view, privately funded fertility testing and IVF treatment is not subject to so many eligibility criteria.

Cost of fertility testing and treatment in the UK

Costs for privately funded fertility testing and treatment in the UK can be prohibitive for many people. There are however companies who are looking to change the way people pay for access to fertility testing and treatments by providing personalised insurance and financing plans. These companies include: Gaia Family, Access Fertility and Redia IVF.

Cost of fertility testing and treatment abroad

In my experience, fertility testing and treatment is often cheaper abroad. I also find that there tends to be transparency and clarity for patients choosing a clinic abroad regarding the full costs involved in fertility testing and treatment. Of course, it's important for UK patients considering going abroad to ask the right questions at the start of the process and essentially *before* travelling.

Success rates

There is a perception that success rates abroad are higher than those in the UK and vice versa. It is impossible to accurately compare success rates abroad to those in the UK due to differences in the way success rates may be reported and if they are independently verified.

Waiting times

Covid-19 has had a negative impact on increasing waiting times for treatment on the NHS in the UK and in some cases privately in the UK too. These can be particularly long for those who require egg donation and for those who are not Caucasian and/or who may want anonymous donation. In my experience, when patients go abroad there are either no waiting lists or short waiting lists for testing and treatment.

Donor-assisted treatment options

In my experience, there are generally more options available abroad for donor-assisted treatment. Please be aware that different countries have different regulations regarding egg and/or sperm donation. It's vital to do your research.

Combine fertility treatment with a holiday abroad

Undertaking fertility testing and treatment can undoubtedly be emotionally and physically stressful. Some people find the experience abroad to be more relaxing purely due to the change of scene and time spent away from the pressures of work. Others may find comfort in the reassurances afforded by being 'at home' in the UK when going through testing and treatment. What's important is to plan and do what feels right for you.

Flights and accommodation

Low-cost flights, particularly to Europe make fertility testing and treatment abroad a financially viable option for many. My advice is to plan ahead and to make full use of any accommodation recommendations from your clinic abroad. Proximity to the clinic site is important, particularly at key stages of an IVF cycle.

Standards of healthcare and patient care abroad

In my view, many countries outside of the UK offer similar standards of healthcare to here in the UK. Many clinics abroad are experienced in dealing with international patients and often speak excellent English. Some clinics abroad offer state-of-the-art facilities. Research is key. Get to the know the clinic you're considering. Ideally, speak with other patients who have used the clinic's services.

In conclusion

The decision to go abroad for fertility testing and treatment is ultimately a personal one. My main advice is to do your research – both on the country's fertility legislation and on the clinic you have in mind. Reputable clinics abroad will offer you an opportunity to ask all of your questions in advance. A reputable clinic will share full, transparent costs up-front, before you travel.

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Our database of IVF centres includes only trusted infertility clinics that have experience in providing high-quality service to international patients.

Find Egg Donation Clinic Abroad

Questions to ask your clinic before going abroad for IVF

By **Elisabeth Telega**,
International Patient Manager

Contemplating IVF abroad can feel like a leap of faith. Research is the key. The better informed you are, the more empowered you'll feel. One of your key sources of information will be the clinic you're considering for your treatment. Reputable clinics abroad will give you the opportunity to ask *all* of your questions *in advance* of travel. Let's explore what those all-important questions should be with the help of some handy print-off and keep checklists

Checklist 1

The BEFORE TRAVEL essential questions to ask your clinic

Will the clinic treat YOU?

Different countries have different regulations re: who they will treat. For example, some countries won't treat same-sex couples or single women. There are also restrictions based on BMI (Body Mass Index) and other physical factors such as age – some countries are more relaxed than others. In **Russia** the upper age limit for treatment is 50. In Turkey there is no law restricting the age limit, with 46 being the recommended cut off point. Others offer treatment up until the age of menopause.
The good news is there are over 500 clinics offering treatment in excess of 50 countries, so it is likely whatever your circumstances, there will be a high-quality clinic able to offer you the treatment you are looking for.

What are the full costs of YOUR testing and treatment?

IVF abroad can be cheaper than the UK but it's imperative to get a full picture of all costs involved in your testing and treatment plan. Ensure that there are no 'hidden' costs. Bear in mind that advertised clinic costs may not include the cost of initial consultations, blood tests and medications. Ensure that you find out what the entire package cost will be.
Keep in mind that your costs for IVF abroad will need to include your flight and accommodation costs. Ask your clinic for accurate dates/timings of your treatment cycle so that you have a clear idea of how many nights' accommodation you'll need to cover. Also note that accommodation costs can quickly spiral if your treatment is extended for any medical reason. It's worth asking your clinic if they have any special room rates/deals agreed with local hotels in their area.

What are the clinic's success rates and how are they calculated?

Some people choose to go abroad because they think that they've found a clinic which claims to have very high success rates. You should be cautious in these cases as there are lots of different ways to present success data. For example, they may only be presenting data for women under 35 or their data may relate to pregnancies rather than live-births.
Success rates can also be affected by the 'types' of patients a clinic treats. For example, if a clinic treats a large number of younger women with mild fertility problems, their success rates will inevitably be higher than clinics treating older women or those with more complex diagnoses.

What is the clinic's record on standards and safety?

In the majority of countries, a basic standard of quality is regulated by the ministry or department of health, and all infertility clinics in these countries should be registered. Be aware that the level of inspection and testing required for registration will vary from country to country, so you should check out the details to see exactly what national registration means and what reassurances it gives you when comparing quality.

Checklist 2

The essential BEFORE TRAVEL 'treatment' questions to ask your clinic

- **What initial testing will happen and when?**
- **Can any of the initial testing happen in your home country? If so, how and where will that be arranged?**
- **What is your full treatment plan? And what are the full costs?**
- **How many embryos will be transferred? Do they have a 'single' or 'multiple' transfer policy?**
- **What are the embryo freezing and storage options? And what are the ongoing costs of storage?**
- **If you're taking the donor route, ensure you have the full-picture regarding every stage of the process. For example, are there early stages that can be completed from your home country? Exactly how long will you need to be abroad for? And which of the later stages can be carried out once you've returned home? For example, how long after embryo transfer do you need to remain abroad? Can you return home prior to the pregnancy test?**
- **Also if you're taking the donor route, what assistance will the clinic provide in terms of donor matching services? And what are the costs and waiting times involved?**

Checklist 3

The 'handy to know' Questions to your clinic

- **Are the majority of clinic staff English-speaking?**
- **Do they have previous UK patients who you can chat to?**
- **Can they recommend good, convenient local accommodation?**
- **Do they offer online consultations and who are those consultations with? For example, are they with a treatment co-ordinator, a midwife or doctor?**

Conclusion

As an experienced International Patient Manager, my key advice is to ask a wide selection of questions prior to going abroad for treatment. Please also remember that there's no such thing as a 'silly' question. Ask for clarity if it's required. Reputable international clinics will always take the time to answer your questions fully. I wish you well on your fertility journey.

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Egg donation abroad:

anonymous donor VS non-anonymous donor VS known donor

By **Ruth Pellow**, Fertility Nurse and founder of IVF Treatment Abroad

Many more people are considering egg donation abroad, and from my own experience of helping people undergo this treatment since I moved abroad in 2004, and then set up IVF Treatment Abroad in 2009 to now, the numbers are increasing each year, the Covid-19 pandemic being the one thing that has altered this trend.

People are travelling from further afield with more coming from the United States and Canada where the cost of egg donation is prohibitive, and from Australia where the number of available egg donors is low, meaning longer waiting times are experienced.

For anyone considering the egg donor route whether at home or abroad, the first question that needs to be considered is what type of donor you want, and this is a good place to start so that we can understand the different types of donors available.

What are the different types of egg donor?

Anonymous donor

An anonymous donor is exactly that. You do not know them, and they do not know you. You are provided with limited non-identifying information on them such as hair colour, eye colour, height, weight, and a few other parameters depending on the clinic you are working with and what information they provide for patients. There is no additional information for you, or any resulting child and that child has no access to the donor in the future.

Non-anonymous donor

Non-anonymous or 'identity released' donor is a donor that you still do not know and they do not know you. However, you often receive a higher level of information about the donor with, in some cases an extended profile detailing extended family information too. The main difference is that any resulting child does have the option to have contact with that donor after they reach the age of 18, and this is done through the clinic that organized the donor for you.

Known donor

A known donor is most often someone you know; a family member or friend who has offered to donate eggs to you.

In most cases these days, it is either an anonymous donor or a non-anonymous donor that is used and both have pros and cons. In both of these options, photos of donors are not provided so you are reliant on the clinic to make the matching of the donor to you, based on your requirements. I will often discuss with patients what are their top 3 priorities/needs in a donor so that we can focus on those. As in any donation cycle, we are not looking for a doppelganger, but someone that will provide the essence of a woman's characteristics. Do always ask if your chosen clinic wants photos of you to aid in the matching process as this is something I feel can be beneficial for both patients and clinics.

Very few countries provide non-anonymous

donors outside of the UK, Portugal being the main one as the change in their laws on the 24th of April 2018, meaning the Portuguese Constitutional Court brought their legislation in line with the UK's. The identity of the donor can be provided at an appropriate time, and the child's right to that information is protected by law with the donor's information being kept on record for 75 years. More comprehensive information is provided on the donors, so the feeling of a greater connection with the donor can be achieved. Unfortunately, there are very few clinics in Portugal and the same goes for Denmark where non-anonymous donation is also permitted depending on the donor's preference as the donor decides whether they wish to be anonymous or non-anonymous. I can see that waiting times for donors will increase as this form of donation becomes more popular and preferred, and the cost is higher than in some countries, so there is a financial consideration too.

Anonymous donors are more accessible abroad

Anonymous donation is more accessible as most countries in Europe provide this option, including Spain, Greece, North Cyprus, and the Czech Republic. In some clinics, we are starting to see waiting times as in this post-pandemic period many more people are feeling safer travelling for treatment. However, this has impacted donor availability as clinics have also had their donor recruitment affected over the last two years. Overall, though, in most places, there is little or no waiting time for treatment, and this is a great advantage for most as when the decision has been made to go ahead with treatment, sooner is often preferred rather than later.

What information is provided on anonymous donors?

The information provided on anonymous donors is dependent on the individual clinics and countries' policies. Some will give non-identifying information well ahead of time so that you can feel a connection to the person going through the process on your behalf, while others will give very limited information such as age and blood group alone at a later point of treatment. What level of information you want about any possible donor is important to have in mind, and check that the clinic you are looking at going to can provide it. That information is the only information you or any child will be given, and for a lot of people that is enough, whether they intend to tell a child about their origins or not. For those not intending to tell a child, it can also reassure them that a third party or donor is not going to come into their lives later.

Financial cost of taking the egg donation route

Cost can be an important factor with egg donation treatment and as we saw in the article in our last issue, prices can vary quite a lot from country to country. It is important to ensure you are looking at 'like for like' as we are seeing a greater preference for egg and blastocyst guarantee packages. This is so that several embryos can be created, and spare embryos are frozen for future use in case the initial treatment is unsuccessful or for a sibling pregnancy so that children will have the same

genetic origins. We cannot assume that an egg donor will want to donate again a couple of years down the line. This is one of the questions I often ask at the beginning of working with my clients - whether the preference is for one pregnancy/child or more. We all have our ideal family plan in our heads, and just because egg donation is needed, this should not have to be dismissed.

Known donation is most often performed in your home country for the convenience of both the recipient and the donor. As mentioned previously, this is normally when a friend or relative offers to donate their eggs to you. On the positive side for the recipient, you know the donor, who they are as a person, and what they look like so there is a reduction of the 'un-knowns'. On the negative side, that person is already in your life and is likely to stay there, so would seeing them over the years be a good or bad reminder of the treatment you underwent? These are important considerations.

What can potentially go wrong?

It's important to be aware that in some cases, the donor fails the assessment process carried out by the clinic. This results in them no longer being able to donate. In other scenarios, donors may not respond to the medications, or the treatment simply does not work. All these aspects need to be considered.

From the known donor's perspective, how will they feel if unable to donate or the treatment does not work? Undergoing IVF treatment is not easy, physically or emotionally, and how they may feel must be considered. If it does work, how will they feel seeing a child they know was created with their egg? Do they have existing children, and will they know about the link to any child created? This can all affect the friendship or family connection, sometimes for the better in creating a stronger link between all involved but the reverse can also occur, so time, thought and counselling for all parties are strongly recommended.

The Donor Conception Network (DCN) is a UK national charity supporting anyone at any stage of their donor conception journey. DCN have an abundance of useful online resources at **www.dcnetwork.org**

Whatever form of egg donation you decide to undergo, take the time to do your research. If you feel comfortable doing it, speak to others. This is something we advise and have a list of amazing previous patients happy to discuss their experiences. There are so many sources of information and support forums out there to tap into. I have always said that those patients considering treatment abroad are often the most knowledgeable as they tend to do so much research to make sure what they decide is right for them and it is the same with egg donation. Take that time, give yourselves space to think and then go for it. Your family is out there waiting for you to create it.

How long do you need to take progesterone after IVF?

Access full version online ›

Here we share some of our fertility experts' answers.

Progesterone prepares the lining of the endometrium to help the embryo implant. When you're going through IVF treatment, fertility experts prescribe progesterone starting from the time of the egg retrieval, and once you get pregnant, it is advisable to continue. For how long should you be taking progesterone after the IVF cycle?

Answer from:

Raúl Olivares, MD
Gynaecologist, Medical Director & Owner Barcelona IVF

For how long should progesterone be taken is still a controversial issue. In the majority of treatment cycles, it is recommended to continue it until the patient is 8 weeks pregnant. It is not uncommon to continue the progesterone until the pregnancy reaches the 12th week because that is when the placenta 'takes over' from the ovaries and then it is safer to stop the progesterone.
However, there are clinics that advise stopping the progesterone intake as soon as the patient is pregnant because they consider that the ovaries can produce enough progesterone to support the pregnancy. However, this is a not very common opinion and, as I've mentioned, in the majority of cases it is recommended to continue at least until the patient is 8 weeks pregnant.

Answer from:

Harry Karpouzis, MD, MRCOG, DIUE
Gynaecologist, Founder & Scientific Director Pelargos IVF Medical Group

Progesterone is a very important hormone in an IVF cycle. In natural conception, after ovulation (release of an egg), a cyst is naturally created. This cyst is called the corpus luteum and it produces progesterone.
During an IVF cycle, at the time of egg collection, all the follicles are sucked so that the eggs can be retrieved, therefore no cyst is created, no progesterone is produced and there is nothing to support the pregnancy. This is why we need to give additional progesterone.
Progesterone can be given in many ways: orally, vaginally, subcutaneously, intramuscularly. A woman definitely needs to take progesterone in large doses for about 12 days – until the time that she does a pregnancy test to find out if she is pregnant or not. After that, if the woman is pregnant, we need to carry on with progesterone during pregnancy. The doses can gradually be reduced but not abruptly, and the duration of progesterone supplementation may take up to 12 weeks.

Answer from:

Matthew Prior, PhD, MBBS
Gynaecologist, Reproductive Medical Consultant, Founder of The Big Fertility Project

Progesterone is the hormone that normally the ovary produces after it has released an egg. With an IVF cycle, the natural cycle has been altered, so

with a fresh cycle of IVF where you've had an egg collection, your ovaries are still much bigger than normal and will be producing some progester-one to some extent, however it's thought that that progesterone may be insufficient and therefore, it's encouraged to take extra progesterone. In our clinic, we normally would do that for about two weeks or up until the pregnancy test.

With a frozen cycle of IVF, treatment is a little bit different because there's lots of different ways you can you transfer the embryo. For example, you can do it in a natural cycle or a medicated cycle. Different clinics will have different ways of going about it but in some medicated cycles, the supressed ovaries are prevented from producing any progesterone at all. In some cases, it's abso-lutely vital to take progesterone supplementation and in those circumstances, I prescribe it for up to 12 weeks of pregnancy. So, that's the reason why you take progesterone because the body is not producing enough due to the treatment protocol.

It's always worth discussing with your IVF doctor whether progesterone will be supplemented and for how long.

Answer from:

Kristine Kempe, MD
Gynaecologist, Obstetrician,
IVF Specialist EGV Clinic

When we're talking about medication after the embryo transfer for better response, we usual-ly use progesterone. We have several types of progesterone, such as an intramuscular injection, oral, or vaginal option. For better comfort for pa-tients, usually, here in Latvia, we use more vaginal progesterone. This support is necessary during the luteal phase in the ART procedure. We don't have as much progesterone from the corpus luteum as in a natural menstrual cycle.

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The Association of Reproductive Reflexologists

Members of the Association of Reproductive Reflexologists (ARR) are specially trained, using structured and prescriptive treatment protocols, to support couples and individuals on their fertility journey. Reproductive reflexology can be used to support natural conception, ovulation induction, IUI, IVF/ICSI and donor cycles. The ARR is a professional body with a passion for setting a kitemark for excellence in the field of reproductive reflexology and for supporting patients at any stage of their journey.
https://reproductivereflexologists.org/

DefiningMum

DefiningMum is a personal blog hosted by Becky Kearns @definingmum, a mum to three girls all thanks to egg donation. Here she shares her own story and reflections on this path to parenthood, as well as the stories and perspectives of others who are touched by donor conception as a path to parenthood.
https://definingmum.com/

Donor Conception Network

DC Network is a charity offering information, support and community to donor conception families and prospective families. It was started in 1993 by five families with children conceived with the help of sperm donation. They decided, against the advice of the day, to be honest with their children about how they were conceived. They wanted to come together to break the isolation felt by so many using donor conception and support each other in their decision to be open.
https://www.dcnetwork.org/
enquiries@dcnetwork.org

EggDonationFriends.com

Information, guides and IVF clinics worldwide directory for patients looking for egg donation IVF options abroad. We support patients with knowledge, faqs and tools to help them to make informed decisions, including unique IVF clinic profile, Clinic Matching Test and country-specific information related to costs, limits and availability of IVF with donor eggs programs. Egg donor availability per country, detailed costs of egg donation programs and more can be found here:
https://www.eggdonationfriends.com/

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https://www.efp.clinic
andreia@efp.clinic

European Fertility Society

The European Fertility Society is an evidence based society that gives tools, support and education to patients and fertility clinics. EFS aims at facilitating and increasing patients' support and positive experience during their fertility journey. The European Fertility Society (EFS) advocates universal improvements in patient care.
https://www.europeanfertilitysociety.com/

FertiAlly.com

We pose a specific question to a hand-picked group of fertility experts to answer. The specialists are from clinics and community settings throughout the world which provides a comprehensive and balanced perspective. All the answers are recorded in the form of a video and are published on our website and YouTube channel. All videos are available for you to access at any time from the comfort of your own home. Importantly, accessing this help will come at no cost to you.
https://www.fertially.com/

FertilityClinicsAbroad.com

An online database of IVF clinics worldwide where you may find information related to IVF treatment abroad including guides, tips and hints. Must see website for anyone looking for IVF treatment options abroad - including IVF with own eggs, IVF with donor eggs, embryo donation and sperm donation. We help more than 3,000 patients a year to find the right clinic abroad.
https://www.fertilityclinicsabroad.com/

Fertility Genomics

Fertility Genomics is a specialist DNA company which offers a simple DNA saliva test identifying genetic causes of infertility and failed assisted reproductive technology (ART), using state of the art DNA sequencing technology to analyse all protein coding genes. Following bioinformatic analysis, we calculate a unique fertility probability score for each customer to advise them as to the best and most likely to succeed method of assisted reproductive technique (ART) to undergo.
The ultimate goal of Fertility Genomics is to research and highlight the genetic causes of infertility while helping others achieve their dreams of having happy and healthy babies.
https://fertilitygenomics.com/
info@fertilitygenomics.com

Fertility Hub

Fertility Hub is a one stop resource for information on assisted reproduction. Whether you are a patient who is coming to terms with a recent diagnosis or a healthcare professional who wants to keep abreast of developments in the field.
https://thefertilityhub.com/
contact@thefertilityhub.com

International Fertility Company

IFC works across 21 countries, providing a bespoke clinic finding service for patients wishing to travel for fertility treatment and a support service led by patients who have received treatment outside their country of residence. IFC also supports and promotes fertility clinics, products and specialist services as well as developing cross boarder collaboration. Led by Andrew Coutts, one of the world's leading fertility travel experts IFC is supported by a team of medics, coaches and therapists and has offices in the U.K., Netherlands and the U.S.
https://internationalfertilitycompany.com/
andrew@internationalfertilitycompany.com

IVF Abroad - Patient's Guide

A unique guide to help IVF patients easily find treatment abroad. Up to now, there's been no shortcut to compare countries as destinations for fertility treatment. Now for the first time patients have a fast way to figure out the regulations, permitted treatments and costs for each of the most popular countries.
The Guide is entirely objective and impartial and a one-of-a-kind resource for patients seeking IVF abroad. 98 pages, comprehensive report, can be downloaded free.
https://www.fertilityclinicsabroad.com/ivf-abroad-guide/

FertiSupport

Kinderwens Buitenland / FertiSupport

FertiSupport is an independent organisation that informs people about the possibilities of fertility treatment abroad. We have years of experience and therefore we are very well aware of the laws and regulations, the processes and procedures of IVF/ ICSI or donation treatments and, of course, we can also inform you about the prices. With this information, you can make a well-considered choice and together we will make sure you will find a clinic that fits your needs and budget. We will also remain available to answer your questions during your procedure. We are here for you!
https://kinderwensbuitenland.nl/
info@kinderwensbuitenland.nl

MyIVFanswers.com

MyIVFAnswers.com is first aid online support to all IVF patients in need. We manage online events with top IVF experts worldwide where patients may ask questions live. All events are recorded and published for easy access for anyone interested. With more than 400 webinars published and more than 6,000 questions answered during our events - the platform is perfect choice for all patients interested in fertility and IVF.
https://www.myivfanswers.com/

Monica Bivas Mindset and Holistic Fertility Coach

Monica Bivas is a Mindset and Holistic Fertility Coach, writer, and founder of The IVF Journey, an online support community for couples seeking or undergoing IVF treatment. She helps women and couples that want to conceive naturally or reframe their IVF experiences, using positivity and mindfulness to help them affirm their choices and manifest successful outcomes. When not supporting her IVF Tribe, she is a joyful, hands-on mom to her two daughters, and finds any excuse she can, to go out dancing with her husband. You can find more about her coaching methodology here:
https://monicabivas.com/

NOW-fertility

The future of IVF with NOW-fertility is: Less waiting time, less stress, no unnecessary costs or clinic visits. NOW-fertility is not a clinic - it is a trail-blazing new digital platform, which is going to revolutionise the assisted conception journey for individuals and couples.
Each NOW-fertility patient will receive personalised and supportive care, 24-hours a day, seven days a week throughout their fertility journey via their own dedicated team of multi-lingual fertility physicians, nurses, counsellors, and advisors.
We will also offer a transparent, fixed-price service to ensure our patients know what the cost of their treatment will be right from the start of their fertility journey.
https://now-fertility.com/
info@now-fertility.com

Paths to Parenthub

Paths to Parenthub is a virtual membership support platform focusing on the emotional aspects of using a donor to conceive. Curated by Becky @ definingmum, with monthly webinars featuring professionals focusing on the big questions and fears, regular story sharing and conversations focusing on different perspectives and a community app with the opportunity to build connections with others and attend virtual support groups. Wherever you are in the world, Paths to Parenthub provides a space to learn, connect and share this path to parenthood with those who truly get it.
https://members.definingmum.com/

Pebble Fertility

Pebble Fertility - giving couples the best possible chance of a successful outcome with our holistic fertility programmes. Clinical hypnotherapy, RTT therapy, fertility coaching, nutritionists, naturopaths and bespoke holistic fertility retreats.
https://pebblefertility.com/
andrea@pebblefertility.com

Pebble Sanctuary

The only membership that supports couples through their entire fertility journey. Masterclasses, guest experts, Q&A sessions, coaching, hypnosis tracks, meditations and community. Taking you from infertility, all the way through pregnancy, birth and on into parenthood. Giving you the tools and support to become the best parents you can.
https://pebblesanctuary.com/
andrea@pebblesanctuary.comg

Pride Angel

Pride Angel is a leading worldwide connection site, fertility forum and blog for lesbian, gay, single and infertile couples, wishing to become parents through co-parenting and donor conception. Specialising in health screening advice, fertility law support, along with artificial insemination and fertility products available to purchase. Registration is free.
https://www.prideangel.com/
info@prideangel.com

Sandy Christiansen Fertility Coach

Sandy Christiansen became a fertility coach after a 10 year career working as a clinical embryologist in multiple fertility clinics. Recognising the gap in patient support, she started her own business dedicated to supporting those with fertility issues and undergoing fertility treatments. She is a certified NLP and life coach, helping women, men and couples on their fertility journey, providing them with fertility expertise and emotional support. In addition to coaching, she attends conferences and training courses for professional growth and helps promote fertility awareness and education.
https://www.sandychristiansen.com/
hello@sandychristiansen.com

S A R A H
B A N K S
coaching

Sarah Banks Coaching

Sarah Banks is a Fertility Coach and Mentor who works with patients and clinics to offer a broad range of support to suit each individual's needs. She has written and published the IVF Positivity Planner, a journal combined with coping strategies and coaching tools to help you feel happier and stronger whilst TTC and going through IVF.
https://sarahbanks.coach/
sarah@sarahbanks.coach

Your Fertility Journey Ltd

Your Fertility Journey is an independent clinic supporting the fertility and women's health needs of individuals across the UK. YFJ prides itself on offering high-quality fertility and women's health advice and support on all aspects of fertility, IVF and specific women's health conditions such as PCOS, endometriosis, PMS and PMDD, early pregnancy, early and normal age menopause, to name just a few. Director and nurse consultant Kate Davies is the co-host of The Fertility Podcast and also provides fertility in the workplace awareness and training to corporate organisations.
http://www.yourfertilityjourney.com/
kate@yourfertilityjourney.com

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https://www.fertilityclinicsabroad.com/ivf-abroad-guide/

International Fertility Clinics

Instituto Bernabeu

Country: Spain
City: Alicante, Madrid, Mallorca, Albacete, Elche, Cartagena, Benidorm
https://www.institutobernabeu.com/en/

Pelargos IVF

Country: Greece
City: Athens
https://pelargosivf.com/

UR Vistahermosa

Country: Spain
City: Alicante
https://urvistahermosainternational.com/en/

Ferticentro

Country: Portugal
City: Coimbra
https://www.ferticentro.pt/en/

Dunya IVF Clinic

Country: North Cyprus
Location: Kyrenia
https://www.dunyaivf.com/en/

Gynem

Country: Czech Republic
City: Prague
https://gynem.co.uk/

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https://fertilityroad.com/contact-us/

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