FERTILITYROAD

ALL ABOUT IVF

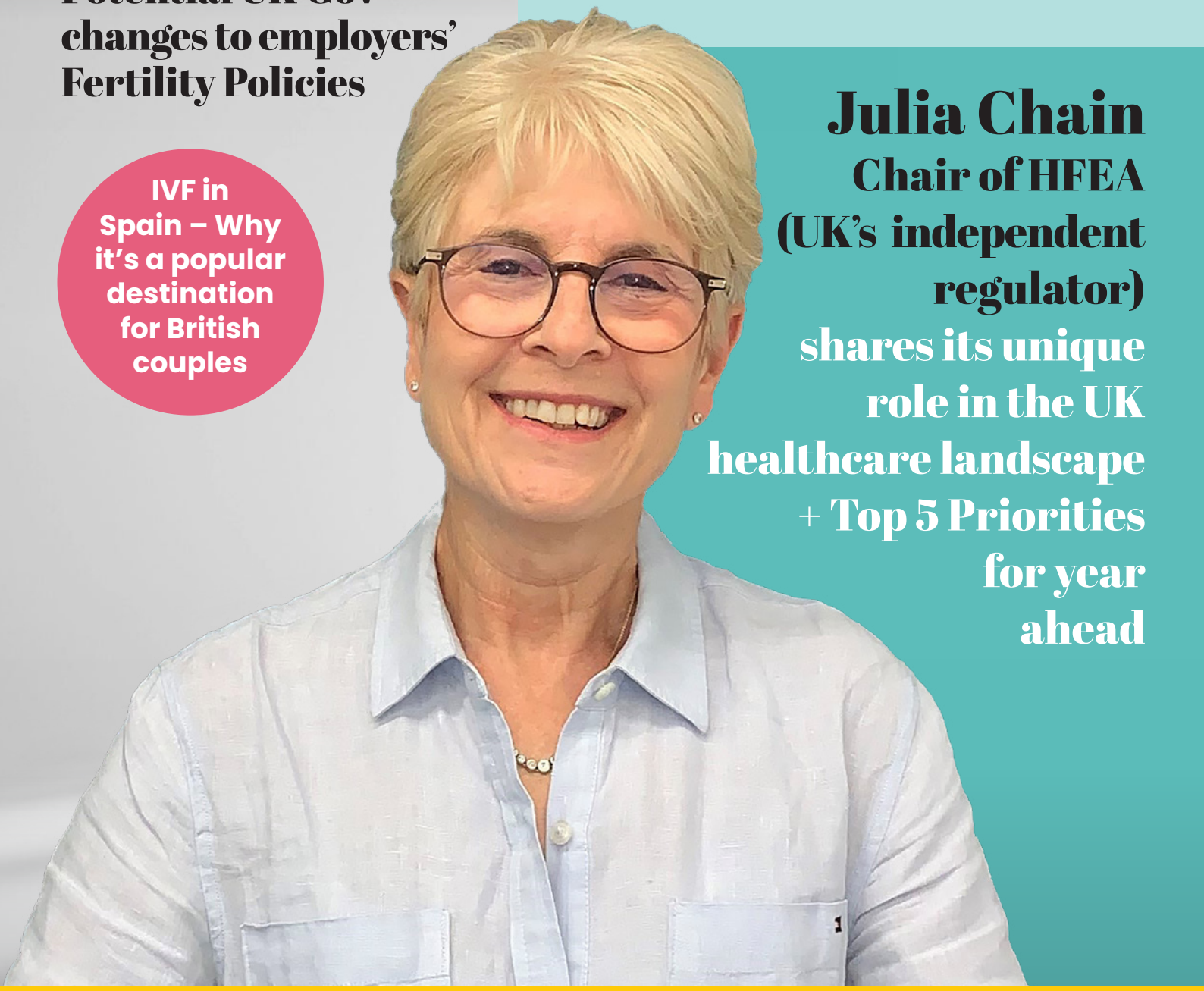
MALE INFERTILITY | SPERM DONOR – REAL-LIFE STORY | MANAGING THE TWO-WEEK WAIT

Egg Freezing – what's involved and who is it best suited to?

Potential UK Gov changes to employers' Fertility Policies

IVF in Spain – Why it's a popular destination for British couples

Embryo Transfer – How best to prepare for it + Risks associated with multiple embryo transfer



Julia Chain

Chair of HFEA (UK's independent regulator) shares its unique role in the UK healthcare landscape + Top 5 Priorities for year ahead

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

ISSUE 56/2022

Welcome to your new issue of Fertility Road magazine!

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?

We're delighted to feature Julia Chain on our front cover. Julia is the recently-appointed Chair of the HFEA (Human Fertilisation and Embryology Authority). As the UK's independent regulator, the HFEA holds a unique role in the UK healthcare landscape. Check out my interview with Julia (p. 32) where we explore the HFEA's top 5 priorities for the year ahead.
As our readers have come to expect of us, our IVF ROAD section continues to deliver on all the top IVF topics. In this Issue, we're covering the important topic of Embryo Transfer: How best to prepare for it, the Do's & Don'ts before and after transfer and the risks of multiple embryo transfer. Julia Chain also helpfully explains the HFEA guidelines on multiple embryo transfer.
Linked to Embryo Transfer is of course the 'Two Week Wait' – the time period between embryo transfer and pregnancy test. Mindful of how many fertility patients may struggle with the 'Two Week Wait', we invited Connie Stark, Director and Lead Fertility Coach at Robyn to share her top 10 tips for thriving and not just surviving this crucial 'waiting time'. You can find Connie's expert advice on p. 18.
In every issue, we cover a holistic, complementary therapy. This time around we're looking into Reflexology as a way of supporting IVF. Barbara Scott, Chair of The Association of Reproductive Reflexologists shares her expert insights into this subject. Check it out on p. 21.
Egg Freezing is a hot topic. Aware of the increasing interest in this treatment, I invited the Medical Director at Lister Fertility Clinic at The Portland Hospital, Mr Rehan Salim to share his knowledge of what's involved in Egg Freezing and who it's best suited to. It's a fascinating read, do check it out on p. 24.
Male infertility is often overlooked. At Fertility Road, we feel that it's important to address balance and give focus to both male and female fertility issues. We're therefore delighted to introduce a new contributor, Dr Geetha Venkat. In her capacity as Director of Harley Street Fertility, Dr Venkat shares her expert insights into two of the most common male infertility conditions: Varicocele and Azoospermia. Dr Venkat explores how these male fertility conditions can be managed to improve chances of IVF success (p. 29).
In the final part of our series with the team at Fertility Matters at Work, we hear from Becky Kearns about potential UK Government changes and recommendations to employers' fertility policies. Head to p.34 to read about these important developments and crucially, how YOU can help make them happen!
Within our Donor Route section in this issue, I'm delighted to introduce the second part of our 3-part series on why/how Donor Conception is different. Series contributor, Nina Barnsley, Director at Donor Conception Network (DCN) continues to share her valuable insights into this important topic. The focus this time is on the stages of Pregnancy and the Early Years – how you may feel and what the implications may be at this stage. Check out Nina's helpful advice on p. 38.
Also, within this issue's Donor Route section, we welcome new Contributor, Professor Alan Thornhill. Professor Thornhill addresses a common question for those taking the Egg Donor route: Will the baby look like me? Drawing on his extensive clinical experience in embryology, Professor Thornhill unpicks this tricky question and shines a light on both the facts and likelihoods. It's a vital read for anyone considering the Egg Donor route. Check it out on p. 42.
Ever wondered what 'Double Donation' means and how it works? Let expert, clinical scientist Venessa Smith guide you on p. 46.
We round off the Donor Route section with a Real-life story. Many thanks to Eloise Edington, Founder and CEO of Fertility Help Hub for sharing her experience of becoming a mother with the help of sperm donation, p. 50.
Finally, our IVF Abroad section is packed with insights into: Donor availability in Spain, ROPA in Spain explained and IVF in Spain – Pros, Cons, Costs and Availability. Many thanks to expert Contributors, Luis Jose Arenaz, Dr Yvonne Frankfurth and Aleksander Wiecki for delivering this unique focus on IVF in Spain.

Enjoy the Issue!

Clare Goulty
Editor-in-Chief

CONTRIBUTORS

Luis Jose Arenaz

Luis José Arenaz, CEO of Fenomatch, currently involved in leading AI products in the field of Human Reproduction and Health. Luis's main goal is to introduce innovative technology into IVF clinics and sperm/egg banks in order to improve IVF treatment for intended parents. Luis has a Bachelor's Degree in Business Administration and two Master's Degrees, one in finance and other in Education in Economics. However, his interest for new technologies has led him to specialize in AI and Big Data Analysis. Luis has held roles such as Data Scientist, Product Owner, Project Manager, Business consultant and has founded several companies.

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* work-shops 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

Julia Chain

Julia joined the HFEA as Chair in April 2021 with over 30 years' experience in legal and managerial roles in both private practice and industry. Among many senior roles she became the first woman managing partner of a top 100 law firm, Andersen Legal, and most recently led the UK and European operations of Advanced Discovery Inc.
Julia is also active in the charitable and public sector. She was for over 8 years Deputy Chair of Norwood, a leading learning disability and children's charity, and was previously a Deputy Chair of the Commission for Racial Equality. Currently Julia chairs Sadeh, an environmental education charity and the Human Dignity Trust, leading charity in fighting for and securing the decriminalisation of LGBT people.

Eloise Edington

Eloise is the Founder and CEO of **Fertility Help Hub**. Following her husband's Klinefelter Syndrome infertility diagnosis while trying to conceive, they now have three young sperm donor-conceived children. The experience completely shifted Eloise's outlook and purpose.
Driven to support the TTC and fertility community, Eloise created Fertility Help Hub in 2019. Her goal was to pull together and give easy access to the expert, holistic and game-changing resources that she wishes she'd had when TTC, using IVF and going for sperm donation.
As a creator and just like her own journey to parenthood, Fertility Help Hub is evolving and will soon start its new life as The Ribbon Box, covering fertility, wellbeing, pregnancy and inclusive parenting. **The Ribbon Box** is for people starting the journey, on the journey and anyone with a question along the way. It's for all the people we've helped so far, and those we haven't met just yet.
Subscribe to hear what's coming and join Eloise's Fertility Squad free support app to connect with others, who get it **https://squad.fertilityhelphub.com/**

Dr Yvonne Frankfurth

Founder + Fertility Coach for Egg Donation abroad at **repro-travel.com**
Affiliate, ReproSoc / Reproduction SRI, University of Cambridge
Yvonne offers individual support to women and couples on their journey abroad for IVF and egg donation (**www.repro-travel.com**). Always up-to-date with the fertility landscape in Europe, she provides relevant information and personalised coaching tools to her clients, enabling them to make confident decisions for their fertility journey abroad. Her insights are based on 7+ years coaching and her own academic research. She is an affiliate at ReproSoc / Reproduction SRI at Cambridge, where she also teaches on family well-being, gender and reproduction.

CONTRIBUTORS

Becky Kearns

Becky is a patient advocate, founder of Defining-Mum and Paths to Parenthub offering support and connection for donor conception, as well as co-founder of Fertility Matters at work. With her own personal experience of early menopause, numerous cycles of IVF and egg donation, she acts as a patient voice, using her platform to raise awareness and supports others on a more difficult path to parenthood, particularly those needing to turn to donor conception. Working previously as a HR professional she and her co-founders Natalie and Claire at Fertility Matters at Work realised the need for better recognition and support within workplaces for those experiencing struggles to build their family. They are working to raise awareness and educate through their membership, training and policy programmes with the aim of guiding organisations towards becoming *Fertility Friendly*.
You can find Becky on Instagram @DefiningMum and her Paths to Parenthub support platform at **www.pathstoparenthub.com**. Fertility Matters at Work also have an active Instagram community, encouraging others to share their insights and experiences which they use to shape their training and awareness activities to represent a wide range of family building challenges and situations.

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/

Reham Salim

Mr Rehan Salim is a Consultant Gynaecologist and Subspecialist in Reproductive Medicine, and the Medical Director of Lister Fertility Clinic at The Portland Hospital. He graduated in medicine from St Andrew's University & King's College London, later completing subspecialty training in reproductive medicine at University College London Hospital. Following this, he was then appointed as consultant at UCLH where he led the Reproductive Medicine Unit, developing the NHS IVF service.
He has wide experience in IVF and provides a highly individualised approach to patients, tailor making protocols to achieve the highest pregnancy rates. An area of particular interest is patients who have had previous failed fertility treatment or who are considered poor responders to IVF treatment. Not only this, Mr Salim also has a special interest and extensive experience in reproductive surgery and is able to perform most surgical procedures via minimal access techniques (laparoscopy or hysteroscopy) including myomectomies and excision of endometriosis.

Barbara Scott

Barbara Scott is Chair of The Association of Reproductive Reflexologists, founder of Seren Natural Fertility and author of Reflexology for Fertility, published in 2016.
In 2017, she was awarded 'Complementary Therapist of the Year' by the Federation of Holistic Therapists and in 2019 she was awarded the Innovation in Reflexology Award by the Association of Reflexologists.
Barbara speaks and lectures globally on her patient-centred integrative approach to supporting both men and women having difficulties conceiving.
She is currently undertaking a PhD to explore the effects of reflexology in supporting those experiencing difficulties in conceiving.

CONTRIBUTORS

Venessa Smith

Venessa is an HCPC registered clinical scientist with more than 25 years' experience working in fertility. Her embryology career began under Professor Robert Winston at Hammersmith Hospital, before working at a number of different UK clinics. During her time at the London Women's Clinic as Embryology Laboratory and Sperm Bank Manager, she developed a specific interest in gamete donation and led the first known donation program in the UK. She later became the group's Quality Manager and is experienced in clinical governance, cross-border reproductive care and all aspects of fertility legislation. Venessa now works in the ACU at Guy's Hospital and sits on the HFEA's Licensed Centre's Panel and its Ethnic Diversity Working Group. Venessa has been a regular speaker at many patient-focussed events and conferences, working with the Donor Conception Network for over a decade. She has contributed to a number of books and journals.

Connie Stark RNC,C.P.C.

As a certified nurse in reproductive medicine/ infertility, I have had the honour to work in various fertility clinical settings. Consulting, collaborating and coaching with fertility start-ups has offered me amazing opportunities to help many aspiring parents on their journey to parenthood. Founding and operating A.R.T. of Wellness, a fertility coaching service promoting health and wellbeing for all people on the path to parenthood has been an awe-inspiring process and experience over the last 10 years. Creating and launching 1:1 coaching programmes, wellness groups, educational webinars, community education programs and publishing fertility journal articles all made a difference for the better, fulfilling my purpose. My journey continues as the Director and Lead Fertility coach for Robyn. Robyn is an innovative partner in the unique journey to parenthood, providing access to integrative maternal wellness tools, resources and providers while offering a community of support where you can share, learn, and grow.

connie@wearerobyn.co

Prof Alan Thornhill

Professor Alan Thornhill is a fertility expert with over 25 years of experience and more than 100 scientific publications in IVF. Specifically, he's a clinical scientist (specialising in embryology). Uniquely, he's worked in IVF and diagnostic laboratories, research, clinical and business management, and even with the UK's fertility regulator. Working in US and UK-based IVF clinics and consulting globally, he's been involved in the IVF journeys of thousands of couples (both professionally and personally). He's helped and advised patients, friends and strangers with issues including low sperm count, sperm and egg donation, genetic testing, surrogacy, treatment overseas and more.
He currently works in the biotech industry and his personal mission is to provide his unique brand of fertility coaching to people in need of help.

Dr Geetha Venkat MBBS, DGO, MD, FRCOG, Director

Dr Venkat has more than twenty years of experience in various fertility clinics around Harley Street. Her focus has been to tailor treatments to the needs of her patients while incorporating the latest developments in the discipline. Dr Venkat presents her work regularly in conferences and has published articles in many peer-reviewed journals. She has also contributed two chapters to the authoritative book on 'Donor Egg IVF', published in 2008. She offers advice to the community on fertility matters in television and radio programs.

Aleksander Wiecki

Aleksander advocates for transparency and truth about all aspects of IVF treatment. He is also a patients' experience manager. With strong expertise and knowledge of the IVF and infertility industry (including IVF clinics and genetic laboratories) Aleksander strongly believes that there is sometimes 'a gap' between IVF patients and clinics. This is a gap where patients may fall for the most common IVF treatment traps during their infertility journey. That's why Aleksander believes that patients need help and support which they don't necessarily get from IVF clinics. The support which comes from an objective, trustworthy and reliable source. Aleksander is a regular guest at ESHRE annual meetings, the Fertility Show in London, the Fertility Forum, the IMTJ - Medical Travel Summit, Fertility Exhibitions and conferences around the world.

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INSTITUTO BERNABEU

OVARIAN AGEING, ONE OF THE GREAT CHALLENGES OF REPRODUCTIVE MEDICINE

The Low Ovarian Reserve Unit of Instituto Bernabeu offers solutions such as regenerative medicine and the use of pharmacogenetics

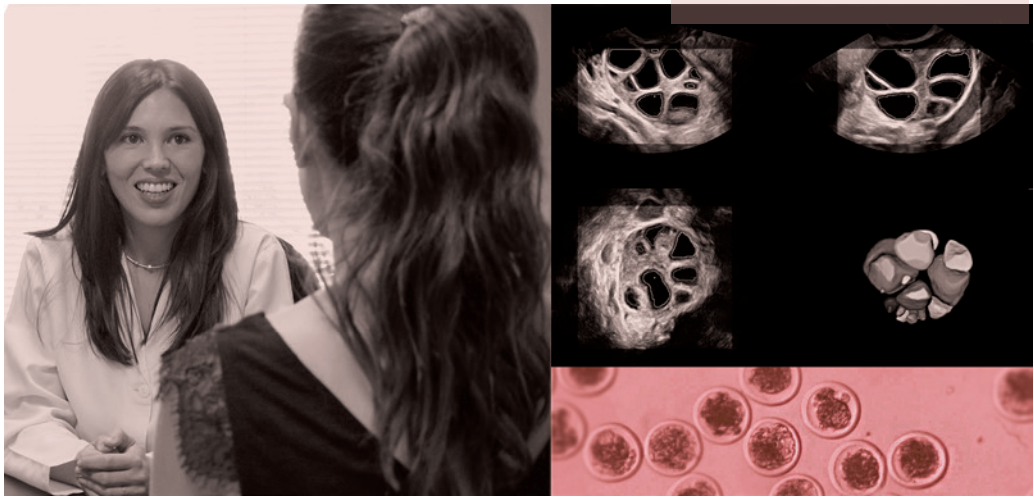
Can a woman with **early menopause** conceive with her own ovules when the ovary is no longer capable of doing so? After ovarian stimulation, is it possible to obtain more ovules in women who have had very few?

For years, for social, professional and personal reasons, among others, women have delayed the time of **becoming a mother.** The ideal is to have a child between 19 and 30 years of age; but the reality is different. The biological clock marks depletion, and also reduced quality of ovules from 35 years of age, on average.

The reproductive medicine applied by Instituto Bernabeu through its different specialised units at its clinics, among them those of **Madrid**, **Palma de Mallorca** and **Alicante**, offers solutions to young patients who suffer from early ovarian ageing, or who due to age are less likely to become mothers with their own ovules.

THE HIGHER THE AGE, THE LESS LIKELIHOOD OF PREGNANCY

"The **ovarian reserve** – that is, the total number of oocytes that a woman will have in her whole life – is established before her birth and will decrease over time," explains **Doctor Rafael Bernabeu**, Medical Director of Instituto Bernabeu. "From 36 years old, 2% of the possibility of **pregnancy** is lost per month, resulting in a 24% reduction per year. This reduction is increasingly accelerated at higher ages," the physician warns.



REGENERATIVE MEDICINE

Regenerative medicine has been a significant advance, helping patients to reactivate their ovarian activity to make use of their genetic material. A few years ago, numerous procedures were being evaluated to achieve the so-called "ovarian rejuvenation". Instituto Bernabeu Gynaecologist and Director of the Poor Ovarian Responders Treatment Unit, **Doctor Ana Fuentes**, explains that these technical practices have the objective of the **"activation" of ovules or follicles** which remain "dormant" in patients with a low ovarian reserve. These inactive ovules have even been found in women with early menopause. Doctor Fuentes indicates that "although we continue to make progress in researching these treatments, spontaneous and In Vitro Fertilisation (IVF) pregnancies are being achieved in patients whose only alternative was egg donation.

OVARIAN REJUVENATION TECHNIQUES

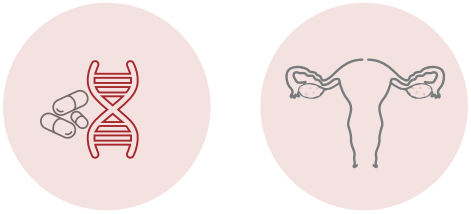
Currently, the most commonly used procedures are the administration of platelet-rich plasma (PRP) within the ovary and ovarian fragmentation for follicular activation (OFFA). Platelet-rich plasma is the administration, within the ovary, of a small portion of the patient's own blood, rich in growth factors. In turn, the OFFA technique consists of the extraction of part of the ovarian cortex, its fragmentation and subsequent reimplantation in areas near the ovary. Doctor Fuentes explains that this "mechanical damage", due to the use of tools, can activate **inactive follicles** in some patients.

"From 36 years old, 2% of the possibility of pregnancy is lost per month,"
warns Doctor Rafael Bernabeu

RESEARCH AND PERSONALISATION

However, this is one of the great challenges of reproductive medicine. Instituto Bernabeu is one of the main **European leaders** in fertility research, with over a decade focusing its RD&I projects on providing solutions.

From the Low Ovarian Reserve Unit, personalised treatments are designed in accordance with the specific needs of each patient. In 2014, the clinic developed a new test, IBgen IVF, which personalises the treatment, adapting the hormonal medication in accordance with the **genetic profile of the ovary of each woman**, to thereby obtain more oocytes after the stimulation of the ovaries with pharmaceuticals.



"IN THE MIDDLE OF **DIFFICULTY** LIES
OPPORTUNITY"
Albert Einstein

BACKGROUND

This Unit is a global point of reference, as is the Implantation Failure and Repeated Miscarriage Unit. In the last four decades, Instituto Bernabeu has been successful in the birth of over **20,000 children**, and has attended to over **125,000 patients** from **137 countries** at its **8 clinics** in **Alicante**, **Madrid**, **Palma de Mallorca**, **Albacete**, **Cartagena**, **Elche**, and **Benidorm** in Spain, and in **Venice** in Italy it works to maintain the **highest quality standards**, applying **personalised reproductive medicine treatments** where the patient is always the priority.

Follow us:

Embryo Transfer – How best to prepare for it

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

What to expect when it's time for your embryo transfer

You've come through the first three important stages of IVF – ovarian stimulation, egg recovery and insemination, and now it's time for the fourth and final stage – embryo transfer.

There are different types of transfer: fresh, frozen, cleavage (day two or three), blastocyst (day five or six), single, and multiple embryo transfer. Your IVF clinic will be able to advise you about the type of transfer that is most appropriate for you based on how many embryos develop, the health of those embryos and your IVF history.

How to prepare for your embryo transfer?

On the day of your embryo transfer, it's fine to shower as usual in the morning. Be sure to wear comfortable clothes that are easy to remove and don't wear any fragrances, or perfumed body lotions.

Assuming your transfer is going ahead without you being sedated (in some cases sedation is given, but it's worth bearing in mind that this usually attracts an additional charge by the clinic) you can eat and drink as normal beforehand: Try and drink a few glasses of water before you arrive to the centre as you will be asked to keep a moderately full bladder, as this allows good ultrasound visualisation of the catheter used to transfer the embryo(s), and position of the uterus.

If you are opting to be sedated, follow any advice your clinic gives you about when your last meal and drink should be before the procedure.

Take any medications that have been prescribed for you exactly as instructed, but you may be asked to refrain from taking anything that is inserted vaginally (such as a pessary) the morning of the transfer.

What will happen before your embryo transfer?

When you arrive at your clinic, you will be taken to the admission area where a nurse will issue paperwork for you to complete. If you have received the consent forms electronically before the day of transfer, ensure you have read and signed them – and of course have them with you.

In preparation for the transfer, your physician and the embryologist will discuss the number, grade and quality of embryo(s) to be transferred and you will be advised if there are supernumerary (spare) embryos which would be suitable for freezing on the same day as the transfer. Your physician will also advise if they believe any of these embryos need to be observed until the following day before a decision to freeze them is made.

Most clinics offer patients the option of freezing spare embryos, but not all embryos survive the procedure and implantation rates may be lower than with embryos which are transferred fresh.

What happens during your embryo transfer?

The embryo transfer itself is actually a simple procedure. Prior to the transfer, the physician and the embryologist will confirm your name and date-of-birth to make sure it matches the identifying information on the embryo(s).

Your physician will insert a speculum into your

vagina (similar to taking a smear test) to visualise the cervix, which will then be cleaned gently to remove any mucous and discharge.
They will then insert a long, thin catheter containing the embryo(s), along with a small amount of culture media, which are then passed through the cervix into the uterus, where the embryo(s) are released.
Your physician will perform a transabdominal ultrasound simultaneously as the transfer is performed to ensure optimal placement of the embryo(s) inside the uterus.
For most women, the procedure isn't painful, but it is entirely normal to feel minor to mild discomfort from the speculum, or from having a full bladder.
After your clinician has completed the embryo transfer you will be asked to lie on your back to rest for a short time.
If you need additional medications your fertility team may dispense them on the day of your transfer, or give you a prescription to get them from your local pharmacy.

Single or multiple embryo transfer?

In the past, it was usual for multiple embryos to be transferred to give IVF patients a better chance of at least one successful implantation. However, there is significantly greater risk from multiple pregnancies, so nowadays, unless there is a sound clinical reason for doing so, generally physicians only transfer single embryos.
If you have concerns about single embryo transfer, you should speak to your clinician who will be able to explain in detail what is being recommended for you and why.

Side effects you may experience after your embryo transfer

You can expect to experience some minor side effects after your procedure. These may include minimal vaginal spotting immediately after the transfer.
You may also experience minimal vaginal spotting a few days prior to the date of your pregnancy test, menstrual-like cramps and bloating, pelvic and/or lower back pain and some mild soreness in your vaginal area.

Once you are home and until the date of your pregnancy test

You'll be able to go home after your embryo transfer and you will be advised to take things easy and rest for the remainder of the day.
You should continue with your hormone medications as advised by your fertility team until the date of your pregnancy test; this is usually 10-12 days after your embryo transfer.
You can expect to resume your normal activities and work the day after your transfer. In the meantime, continue to take all medications as instructed by your fertility team. You may be offered progesterone pessaries, gels, or injections after your embryo transfer to support the lining of your womb.
If you are also taking any pain relief, or medication for a high temperature, nausea, or constipation, these may be allowed, but be sure to consult with your physician first.
Don't do any vigorous physical activity or go swimming and avoid sexual intercourse in the days between your transfer and pregnancy test. Also avoid any activity that raises your body temperature, such as having a sauna, massage, steam room, jacuzzi, hot yoga, or heat pads.
You should also avoid all alcohol, smoking and caffeine, prolonged sun exposure and late nights.
Take the time to relax and connect with your partner and friends in the waiting time between transfer and pregnancy test, and try to maintain a calm, positive outlook.

Reasons for cancelling the embryo transfer

Sometimes your clinical team may decide to postpone or cancel your embryo transfer. There are several reasons why they may decide this is the right thing to do. These may include:

- You may not be medically well enough
- You may have symptoms of Ovarian Hyperstimulation Syndrome (OHSS). This only occurs in approximately two to three percent of IVF patients,

but it can have serious side effects resulting in vomiting, abdominal swelling, and shortness of breath. It usually occurs after the hCG (human chorionic gonadotrophin) injection given to help egg maturation.

- The embryos haven't progressed adequately to the stage of development suitable for transfer
- The procedure cannot be performed without sedation and the anaesthetist is not available on the day
- You have fluid or blood in your uterus revealed by the transabdominal ultrasound scan on the day of transfer
- You have started bleeding and the lining of your uterus (womb) is thinner than before
- You have forgotten to take your hormone medications as recommended by your fertility team
- You have decided, since egg collection, to have the embryo(s) genetically tested before transfer

According to Professor Luciano Nardo, Founder & CEO of **NOW-fertility.com**:

"Of course embryo transfer is an important step in IVF treatment, so it's entirely natural for patients to be nervous. I always go through all of the above points with my patients and try to put them at their ease ahead of embryo transfer. I also advise all patients to ensure a partner or friend is with them as much as possible during any procedure and there to support them both physically and emotionally between the time of the embryo transfer and subsequent pregnancy test."

"If you are concerned by, or do not understand, any element of the transfer process, don't hesitate to ask your clinician: in fact, write down any questions that come to mind so you don't forget to ask them. If you are not trying to remember questions, or worried about what to ask, this will help to reduce your stress in the days leading up to your embryo transfer and on the day itself."

Explanation of terms

Embryo: An embryo refers to the early developmental stage following the fertilisation of an egg (derived from a female) by sperm (derived from a male) as a method of sexual reproduction.
Embryologist: A scientist involved in reproductive research or fertility assessments.
Cleavage: In embryology, cleavage is the division of cells in the early development of the embryo, following fertilisation. This takes place at day two or three after fertilisation.
Blastocyst: A blastocyst forms when a fertilised egg is in its second phase of growth. This takes place from days five to nine after fertilisation
Uterus: The womb
Cervix: The narrow passage forming the lower end of the uterus.
Transabdominal ultrasound scan: A safe and non-invasive visualisation test used to take images of internal organs which does not use radiation but instead involves directing high-frequency sound waves to the uterus.

Embryo Transfer Do's and Don'ts

DO'S

- Make a list of any questions you and your partner have for your IVF clinic team
- Do talk through any concerns with your partner, friends, and family, and of course your physician in advance of your embryo transfer – this will help calm any nerves
- Do eat healthily and avoid alcohol and caffeine in the days leading up to and immediately after your embryo transfer
- Continue to take any medications prescribed by your clinic team
- Immediately report any nausea or abdominal pain either before or after your transfer
- On the day of your transfer, wear loose, comfortable clothing that's easy to get on and off
- Discuss with your clinic if you'd like any spare embryos to be frozen and the process for doing this
- Discuss with your physician what side effects, if any, you might expect immediately after your embryo transfer
- Rest immediately after your transfer, but so long as you feel well the next day, you should be fine to get back to your normal routine

DON'TS

- Don't forget to chat through any concerns with your physician
- Don't forget to take any signed paperwork and consent forms with you on the day of your transfer
- Don't wear perfume or scented body lotions on the day of your embryo transfer
- Don't worry about the procedure being painful – most women experience only mild discomfort. If you are concerned, don't be afraid to speak with your physician about sedation
- Don't have sex, stay out late, or undertake vigorous exercise in the first few days immediately after your transfer
- Don't do anything to raise your temperature in the days immediately after your transfer
- Don't be alarmed by mild vaginal spotting a few days before your pregnancy test – this is completely normal
- Don't stop taking any prescribed medicines unless your clinical team expressly tells you to do so

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we are family

Risks associated with multiple embryo transfer + HFEA guidelines explained

By **Julia Chain**, Chair, Human Fertilisation & Embryology Authority (HFEA)

There are over 75,000 cycles of fertility treatment each year in the UK, and everyone who embarks on treatment does so in the hope of one day having a healthy baby.

To realise that dream, there are many decisions that need to be made, and not all are easy. Even before they walk through a clinic's door, patients must consider what type of treatment they want and where they want to have it. For some, it can feel like information overload and that feeling can continue during the treatment process; there is so much to absorb.

One of areas that can be particularly challenging to navigate can come towards a milestone moment in treatment - at the time of embryo transfer. Usually, after prior discussion with their clinic, patients decide whether to transfer one or more embryos.

On the surface, a decision – like transferring multiple embryos - that could lead to having more than one baby appears uncomplicated and maybe even desirable, but when you look a little closer, these decisions can have huge consequences for the patient and the baby.

What is a multiple embryo transfer?

After a cycle of IVF, usually several eggs will be collected and once fertilised, the patient would hopefully be left with a number of good quality embryos. At this stage, the clinic will speak to the patient about how many of these embryos they'd like to transfer to the womb. The clinic will usually advise one embryo is transferred but, in some cases, where embryo quality is poor for example, they may transfer more.

The risks

Multiple pregnancies are the single greatest risk of fertility treatment for patients and their babies. They were at a record high in the early 1990s with the average UK multiple birth rate from IVF at around 28%. That means around a quarter of all IVF births during that time resulted in more than one baby being born.

Although having more than one baby can appeal to some, medical experts do not recommend it because of the serious health risks associated with multiple births.

A multiple pregnancy increases the risk of stillbirth, neonatal death and disability. Compared with carrying one baby, twins are four times more likely to die in pregnancy, seven times more likely to die shortly after birth, ten times more likely to be admitted to a neonatal special care unit and have six times the risk of cerebral palsy. For mum, risks also increase due to late miscarriage, high blood pressure, pre-eclampsia and haemorrhage.

Putting it simply, the more babies in a pregnancy, the more complex the care and greater the risk.

These facts are not designed to worry patients, but they must be equipped with this information so together with their clinical team, they can make fully informed decisions about their care.

What does a good embryo look like?

Embryos can differ in quality; those that are of the best quality are more likely to implant in the womb and lead to a pregnancy so a clinic will always use the best embryo available.

The number of cells present, the rate at which the cells divide, whether the cell division is even and

whether there are any fragments of cells present – meaning some cells have degenerated – are all taken into consideration when selecting which embryo to transfer.

Embryos can be transferred to the womb at two different stages of their development; the cleavage stage, where embryos are selected on day two or three of their development and blastocyst stage, where embryos are selected on day five of their development. Embryos that reach blastocyst are more likely to increase the chance of a successful outcome.

In the UK, roughly three quarters of women have a blastocyst transfer and a quarter have a cleavage stage transfer.

If after treatment, patients have embryos that they do not wish to use, they could consider donating them for training purposes to allow healthcare professionals to learn about, and practice, the techniques involved in fertility treatment. They could also consider donating them to others for use in their own treatment. Patients should speak to their clinic for more information about this.

Best practice

If patients have more than one good quality embryo available, it's now best practice for most women to have only one embryo transferred to the womb. The clinic would then freeze any remaining embryos – providing they were of good enough quality – so they can be used by the patient at a later date. Typically, it will be older women who are less likely to have two embryos successfully implant in the womb, which would mean they would qualify for a multiple embryo transfer. But this hasn't always been the case.

Until 2007, clinical practice often involved transferring more than one – often several – embryos to the womb. It was only when the HFEA commissioned a group of experts to report on the risks of multiple births from fertility treatment, that practice changed.

The HFEA's 'One at a time' campaign was launched in 2007 and encouraged clinics to transfer one embryo and freeze any remaining embryos for good prognosis IVF patients. The combination of these policies and concentrated efforts across the fertility sector led to fewer double embryo transfers, and fewer multiple births as a result. This in turn reduced the risk placed on patients, and the pressure placed on NHS services. The HFEA introduced a multiple birth target in 2009 which licensed clinics were expected to meet and the good news is that these safety improvements for patients have led to birth rates from IVF continuing to rise while the risks associated with multiple births have been minimised.

The reduction in multiple births from IVF has been a huge success with the 10% target reached nationally in 2017. This decreased further to 6% in 2019.

The HFEA recently published its '**Multiple Births in Fertility Treatment 2019**' report that looked at the progress made with reducing multiple births. It found:

- Single embryo transfers increased in use from 13% of IVF cycles in 1991 to 75% in 2019.
- The multiple birth rate has reduced most among patients under 35 (from 27% in 2007 to 6% in 2019) and patients over 44 (from 31% in 2007 to 5% in 2019).
- Highest multiple birth rate among patients aged 35 and under (above 30%) receiving double embryo transfers.
- When donor eggs were used, transferring multiple embryos carried a greater risk of multiple births (around 30% across all ages) from 2015-2019.
- Black patients typically had higher multiple birth rates at around 12% from 2015-2019, compared to 10% across all ethnic groups.
- About 60% of IVF twin births were preterm (under 37 weeks) compared to 9% of singleton births from 2015-2019.

Room for improvement

Clinics have worked incredibly hard to reduce multiple births and it is something to be celebrated. However, there is still work to be done as we know a very small number of fertility clinics are above the HFEA's 10% multiple birth target. In a recent survey, we also found that around 30% of patients weren't made aware of the risks associated with multiple births.

Our report identified a private and NHS divide with privately funded patients aged 37 and under having higher rates of multiple births from 2015-2019 in their first IVF cycle compared to NHS-funded patients.

Earlier this year, the HFEA published its National Patient Survey 2021, which gave an insight into practice today and it continued to show an NHS vs private care divide with 42% of self-funded patients having a multiple embryo transfer compared to 21% of NHS patients.

Of the 1,200 people surveyed at the end of 2021, three in ten patients (30%) had received a multiple embryo transfer during any of their treatments, with those doing so tending to be older; almost half (46%) were aged 38+ compared to 22% under 37. This suggests that guidance is being followed.

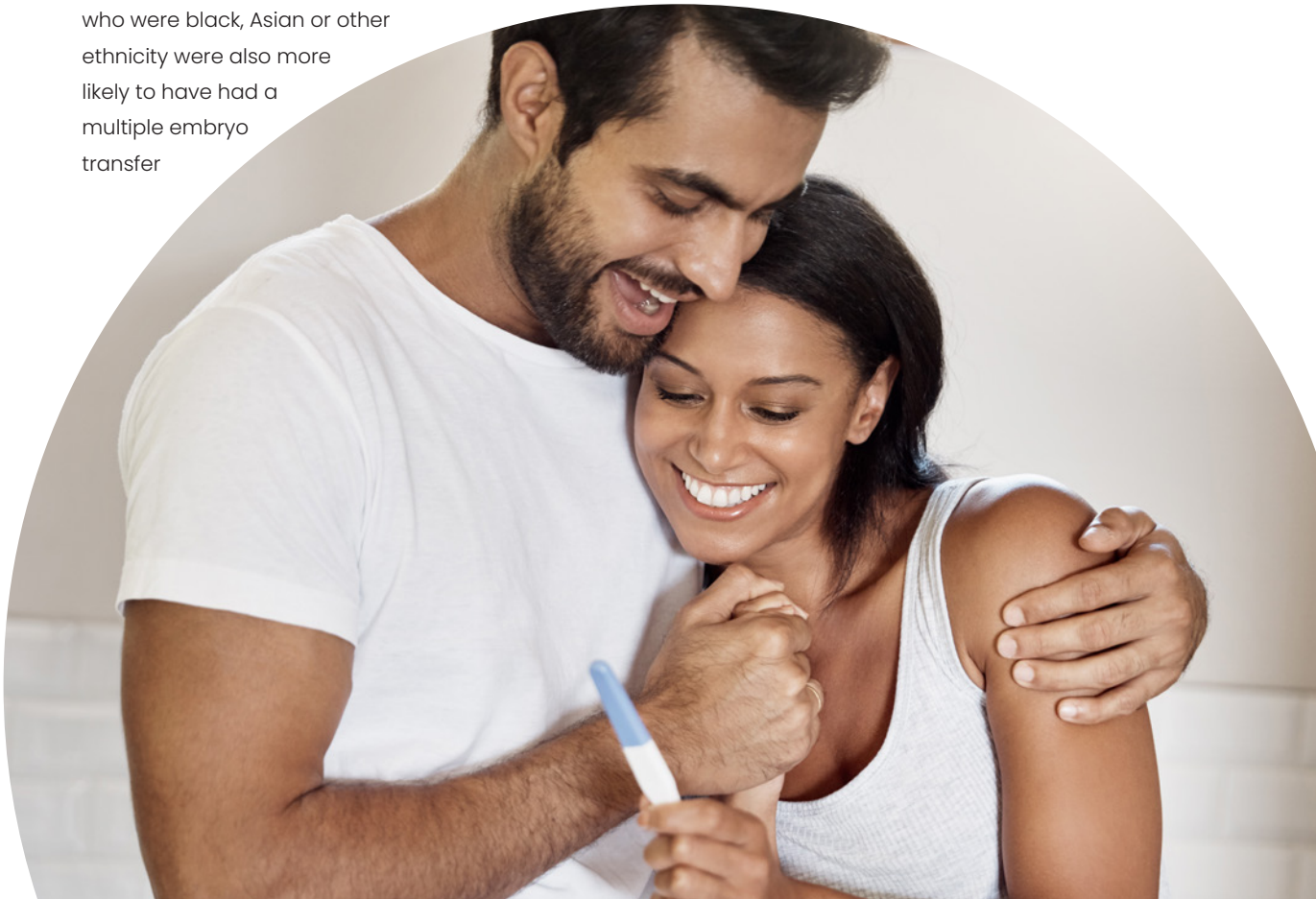
Respondents with a mixed ethnic background, who were black, Asian or other ethnicity were also more likely to have had a multiple embryo transfer than white patients (38% vs. 29%), similar to findings from our recent work on ethnic disparities in fertility treatment.

The survey confirmed that patients who had multiple embryo transfers did so on clinic advice, with half (51%) doing so because of age and/or previous unsuccessful cycles. A third (32%) did so because of low ovarian reserve or low-quality embryos, with those under 35 more likely to say this was the case (37%). But worryingly, a third (32%) asked for a multiple embryo transfer because they believed it would increase their chances of getting pregnant, and 6% asked for a multiple transfer as they wanted to have multiples.

This shows that despite the huge progress made in this area, it's clear that more needs to be done to raise awareness of the risks to some patients.

We want all fertility patients to achieve their dream of one day having a baby. The success of the *One at a time* campaign shows that this can be achieved in the safest possible way. We will continue to monitor multiple birth rates in our drive to improve the health of patients and their babies, and we will work with clinics to ensure patients have access to information to make choices that are right for them.

To find out more about what's involved in fertility treatment as well as other impartial advice and information, visit **www.hfea.gov.uk**.



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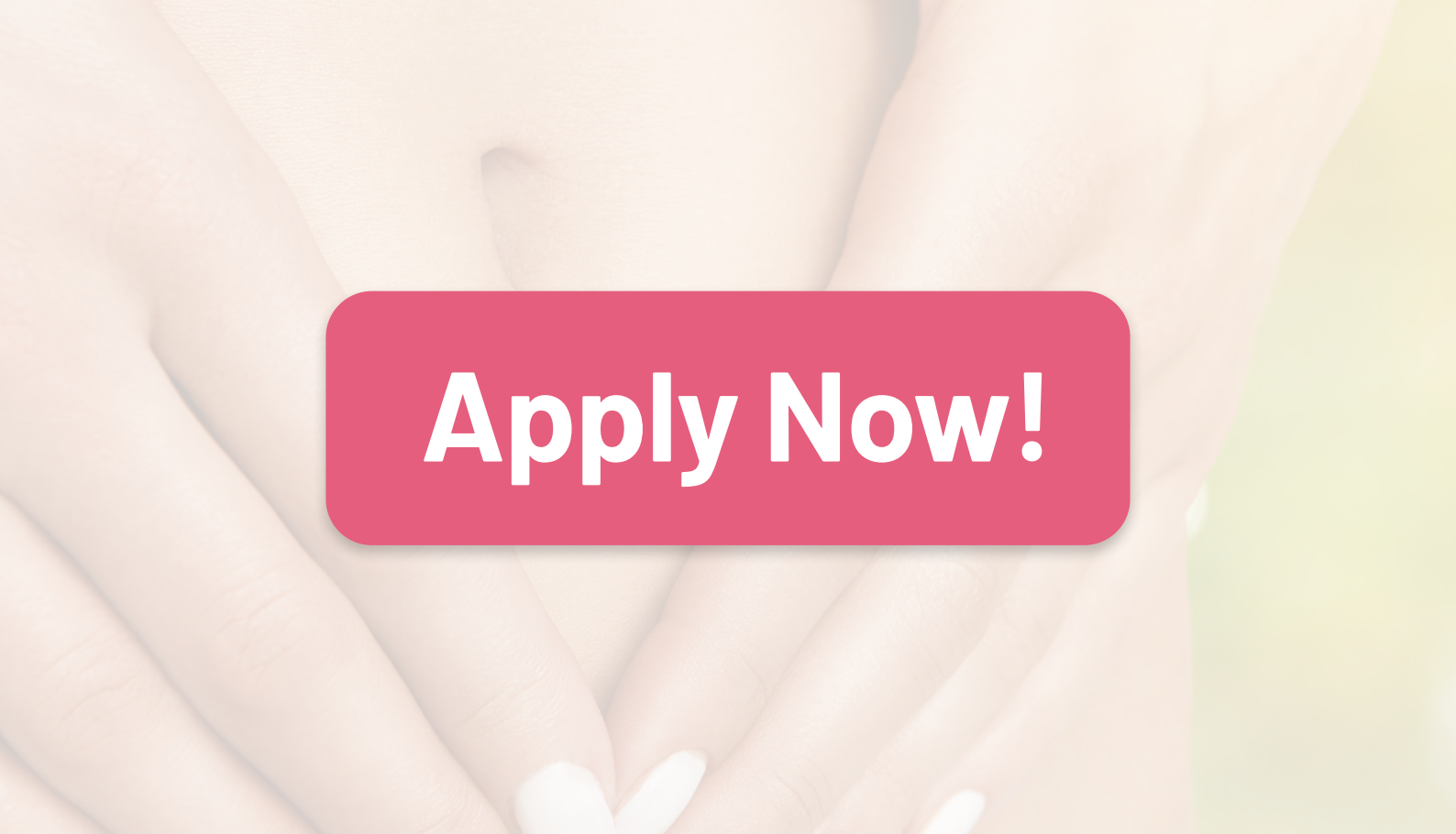

Apply Now!

A proactive focus to the Two Week Wait

By **Connie Stark**, Director of Fertility Coaching at Robyn, Chicago, USA

With my 30+ years of experience as a fertility nurse and coach, I'd like to share my top ten tips for thriving, not just surviving the 'two week wait'. Many readers will know that the 'two week wait' is the time between ovulation and a missed period. For those undertaking IVF, it's the time between embryo transfer and the pregnancy test.
In my experience, many couples undergoing fertility treatments including IVF end up 'dreading' the 'two week wait'. After a busy time of medical procedures involved in the IVF cycle it can feel like a long and frustrating time to wait for the outcome. I advise you to think about what you see and feel and change the lens from struggle and fear to focusing on your resilience and proactive steps towards parenthood. Remember your cycle was more than a 'medical procedure' - it was an emotional journey too so indulge in the calm and restore during this time.

Consider your mindset

My first and most essential tip is to change your lens from focussing on the 'dreaded' 'two week wait' to focussing on preparing for parenthood. Negative thoughts create the 'flight or fight' stress response, keeping fear in charge and stress hormones high and perhaps thinking and feeling "I'll never be a parent". Instead, consider changing the lens to focus on a positive vision/image of how parenthood looks for yourself. Allow yourself to visualize how you'll feel when you have your longed-for baby in your arms. Creating a colourful, hopeful image of parenthood activates endorphins - a healthy hormone response. Try to inhabit affirmative thoughts and feelings about impending parenthood. Encourage your partner to do the same. Repeat proactive thinking daily. Say to yourself, "I am on the path to parenthood."

Plan for your IVF treatment to work

This may sound obvious but through my 30+ years of experience as a fertility nurse and coach, I know that many individuals and couples go through an IVF cycle harbouring negative thoughts about whether the treatment will work. This is understandable as many people will have endured challenging fertility journeys with multiple losses and disappointments along the way. Even those new to IVF may find it hard to allow themselves to believe that it'll work the first time. However, I believe that it's fundamental to IVF success for patients to 'plan' for their treatment to work. By this I mean allow yourself to daydream about becoming a parent, walk those baby clothing isles in your favourite stores visualizing what you'll buy when you get a positive pregnancy result. Actively 'live' the feeling of becoming a parent.

Whilst waiting and preparing, try to find your purpose and be your best self

Think about what defined you prior to this current life stage of reproduction. Ignite your hobbies, talents, relationships and the activities you enjoy. Find the moments that made you laugh and create new moments to laugh even louder! Whilst looking after yourself physically (gentle exercise, not rigorous exercise), allow yourself two weeks of fun and new experiences. With your proactive mindset in charge, make this a fortnight of enjoyment.

Take time to feel thankful and grateful

Feeling thankful during a time of waiting can be tricky but I assure you, you'll feel better for it. Create a daily ritual to spend some time journaling what

you feel thankful for. It could simply be jotting down 3 things a day which you're thankful for. You could also create a 'Thankful Thoughts' jar where you write on a small piece of paper each day something that you feel thankful for. The jar becomes a positive symbol of your proactive mindset.

Resist searching the Internet

Beware of 'Dr Google'! If you have any questions about any physical symptoms during the 'two week wait' (preparation), ask your IVF medical team, do not go online searching for answers yourself. I understand that it's hard not to over-analyse every twinge in your body during this waiting time but if you have questions or concerns contact your medical team as they're best placed to advise and reassure you.

Remember, focus your thoughts to the present moment. Gently tell yourself that your body is preparing for parenthood.

Don't test too early

As tempting as it is to do your own pregnancy test at home, my advice is to follow the test schedule that your IVF clinic gives you. After an embryo implants into the uterine wall, it takes time before there's enough of the pregnancy hormone, human chorionic gonadotropin (hCG) to be detected by a blood test, let alone an at-home pregnancy test. Instead, treat yourself to buying fresh flowers, new body lotion or your favourite decaff tea. Choose something that nurtures YOU.

Communicate with your partner

Share your feelings with your partner (or your trusted family and friends if you don't have a partner). Allow yourselves to share in the excitement and hope of this time. Also share any worries you may have. Plan what you'll do together once you get the pregnancy result. Whether it's a positive or negative result, you and your partner matter. Plan something to look forward to, whatever the result.

Get support from people who understand

IVF is tough – both physically and emotionally, financially and socially. Connecting with others who 'get it' and understand what you're going through is vital. Remember this is about YOU and your unique journey. Try not to compare yourself to anyone else's experiences. You are your expert on YOUR path.

It's not about 'fake it til you make it'. It's healthy to cry and rid thoughts and emotions that blur your vision of parenthood. Be honest and real with yourself.

A proactive mindset is not always easy but just being aware of yourself with clarity is empowering, creating hopeful opportunities throughout your journey.

Explore the counselling options available either through your IVF clinic or via resources such as BICA (British Infertility Counselling Association) **www.bica.net**

There are also many online infertility forums. Fertility Network UK **www.fertilitynetworkuk.org** offer support groups either online or in-person.

Explore relaxation techniques which work for you

There are many ways to ease anxiety during this waiting time. From breathing exercises to acupuncture to meditation and movement, explore what feels right for you. Even simple, at-home activities such as mindful colouring, reading or just watching your favourite TV shows can be calming and soothing.

Eat healthily, stay hydrated, avoid caffeine, avoid alcohol and no smoking

A healthy lifestyle during this waiting (PREPARING) time will help you feel more 'in control' and in charge of choices you make to be your best self. Knowing that you're proactively eating well and looking after yourself will enhance your positive proactive mindset.

I wish you the very best during your 'two week wait' and beyond. Remember, whatever the outcome focus your proactive mindset on next step options throughout your journey and most importantly remember that YOU MATTER! Take very good care of YOU.

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Supporting IVF Cycles with Reflexology

By **Barbara Scott**, Chair of The Association of Reproductive Reflexologists, Author *'Reflexology for Fertility'* and PhD Research Student

Undertaking a cycle of IVF can be a daunting prospect and it doesn't matter whether this is a first cycle or another cycle in one of many. It also doesn't matter whether you are facing this prospect alone, as part of a couple or with lots of friends and family support, it can all still feel a little overwhelming. There are so many unknowns that can impact upon how you feel physically, emotionally and mentally that it can all seem like a bit of an emotional roller-coaster. So, making sure that you take care of yourself can get a bit lost in the process and yet it is one of the most important things you can do for yourself that can help to make it all just a little a bit easier.

Having a support plan can help you to feel that you have some control and an ability to improve how you feel whilst going through your cycle. Many people use a combination of different complementary therapies to help manage both physical symptoms and emotional well-being and they can be very therapeutic. Reflexology is just one of these and is increasingly used by both men and women when they are embarking upon their fertility journey.

You may have heard lots of anecdotal evidence about the effects of reflexology for natural and assisted conception but have no idea what it is, how it works or what you might expect if you decide to try it. Among other things reproductive reflexology can be a source of great support and nurturing whilst undertaking a cycle of IVF.

Most people now have some concept of what reflexology is as it has become so widely available. The basic principles are that every part of your body is represented in tiny reflex points on the feet, hands or ears, in a not dissimilar way to acupuncture. By working on these 'reflex points', it is believed that we can bring about changes that may be of benefit to the person receiving the reflexology treatment. There are so many theories about how or why this may happen, none as yet have enough research to prove how it works. What we do know is that whilst we can't always explain 'how' it works we can very effectively 'prove' that it does work. There are now many published papers on the beneficial effects of reflexology on a wide range of reproductive issues. *Hasani et al (2019)*.

Getting into really good shape before a cycle of IVF can be of great benefit mentally as well as physically, a bit like preparing to run a marathon. We find that the more preparation you do beforehand the less side effects and the better the outcomes.

What can reflexology do and how can it help?

Let's start with men as they are so commonly overlooked. One of the things that we know is that reflexology is useful at managing stress levels when used regularly. We also know that stress can be detrimental to the development and function of sperm and can cause sperm DNA fragmentation (damage to the DNA contained in the head of the sperm). Reducing stress levels to a more manageable level can help to improve sperm quality and having good quality sperm is just as important for IVF/ICSI as it is for trying to conceive naturally.

As sperm take approximately 12 weeks to develop from a single cell to a fully-fledged sperm available and ready for use, reproductive reflexologists use a tailored 12 week program to support this process. This means weekly treatment sessions for eight weeks followed by fortnightly sessions. It is useful to have had an up-to-date semen analysis prior to beginning treatment followed by a further analysis at the end of the programme to measure progress and outcomes.

When presenting yourself for treatment your

reproductive reflexologist will want to know as much as possible about your individual circumstances in order to devise a treatment protocol that will provide the best possible outcomes.
The reflexology itself is actually pleasant to receive and can be deeply relaxing, involving using techniques to work on precise reflex points on the feet, most particularly those related to the endocrine system and reproductive areas.
Just as for men, preparation is key for women who are going to be using IVF/ICSI as part of their journey to parenthood. Making sure that your reproductive health, general health, stress levels and mental/emotional health are in good order is simply common sense.
Before beginning treatment, it can be useful to ensure that your menstrual cycle is functioning well. This may sound a bit strange as you will be taking powerful drugs that are going to completely disrupt your cycle, but it can help you to feel well before beginning treatment, particularly if your cycle is not at its best. Reflexology can be an excellent way of gently regulating your cycle, ensuring that each component part is working at an optimum.
Once you have begun a cycle of IVF/ICSI reflexology can be used in a number of differing ways.
Most people recognise that it can be a stressful and intrusive process and finding ways of offsetting this can be useful. There is much conflicting research on whether stress impacts upon IVF outcomes or otherwise, but one thing is certain, if you are able to manage stress levels you will feel better whatever the result and be in a better place to make decisions about the way forward. The one thing we can safely say about reflexology is that it is excellent for managing stress when used regularly.
Reproductive reflexologists are practitioners who have a depth of knowledge about reproductive health, fertility and assisted conception. What this means is that they will have a good level of understanding of the kinds of treatment that you will be undertaking and the effects that any underlying reproductive health condition may have. It also means that they should be able to respond accordingly using reflexology protocols that are designed to support you at every stage of your cycle and are safe to use. These protocols are usually used on a weekly basis throughout your IVF cycle.

What can you expect from a reflexology treatment session?

- Your first session (or initial consultation) provides an opportunity to share as much information as possible with your practitioner. This helps them to build up a picture of where you are and discuss your treatment plan.
- Your practitioner may also like to see you both together for your initial consultation.
- During this session your practitioner might use a short reflexology diagnostic tool that allows them to gain some insight into what protocols might be most appropriate to use.
- It might be suggested that you have some reflexology prior to beginning IVF to ensure that you are in the best possible place before you begin.
- You will then usually receive treatment sessions on a weekly basis throughout your cycle of IVF.
- For men most of the treatment sessions occur prior to the cycle of IVF so that sperm are in the best possible condition prior to sample collection.

- Reflexology can also be supportive after a failed cycle to help with symptoms and getting your menstrual cycle back on track.
- It can also help in the early stages of pregnancy supporting progesterone levels, nausea and discomfort and managing stress and anxiety.
- The majority of people find reflexology a deeply relaxing form of therapy. Taking an hour to sit in a comfortable recliner chair or lying on a couch having your feet touched can induce a sense of deep relaxation and well-being.

As discussed previously there is now a wealth of research that supports reflexology as an effective modality for reproductive health *(Mahboubeh V, Babaei E et al, (2010)*. As yet, there is not so much research into the outcomes of combining reflexology with IVF. However, as an organisation we have undertaken some data collection of our own, looking at how effective reflexology can be at supporting both men and women with reproductive health conditions who are trying to conceive. In our small sample it did appear to show that there was some benefit. This study of 183 patients was carried out as a data collection by the Association of Reproductive Reflexologists in 2013, some of the results are available via our website. For comparison if we looked at a group of women in the age range 23 – 46 (this was the age range we were working with) and looked at success rates for IVF, we would expect it to be approximately 25-30%. In our sample study, the success rate was 52%, a good beginning but with more work to be done in the future..

Finally, it is important to find someone that you can trust, feel comfortable with and who is well trained. I usually suggest ringing three practitioners, speak to each of them on the phone first of all before making a decision about who feels best to work with. Trust your intuition.

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Egg freezing - what is involved and who is it best suited to?

By **Mr Rehan Salim**, Consultant Gynaecologist & Subspecialist in Reproductive Medicine
Medical Director at Lister Fertility Clinic
at The Portland Hospital

Background

Women are born with all their eggs. Throughout their lives, they will use up these eggs until there are none left; this stage is called the menopause. Although women are born with millions of eggs, the number seems to fall rapidly so that by the time they reach puberty they probably have around 600,000 of the original and by the age of 30 this number is probably around 180,000. Compounding this problem is the fact that no two women are born with the same number of eggs and that no two women seem to lose their eggs at the same rate. This means that although most women will have an average number of eggs for their age, some will have more and some will have less.

The other important issue, beyond the number of eggs, is the fact that as women grow older the egg quality also seems to decline. This is seen in the pregnancy rates for women over the age of 35 where the chances of pregnancy start to fall and by the age of 38 there is an acceleration in this fall. Equally, the risk of miscarriage and the risk of having a chromosomally abnormal pregnancy rises beyond the age of 35 and rapidly increases beyond the age of 38. These problems are all predominantly linked to the egg having the wrong amount of genetic material within it so that any embryo that results will also be abnormal and so less likely to implant and more likely to miscarry if it does.

Therefore, as age is linked to not only egg quantity but also egg quality, there is a logic in trying to preserve eggs at a younger age so that they can be used in later life when a woman's own eggs will be less in quantity and quality. In effect preserving fertility potential of their younger self.

What is egg freezing?

Egg freezing is a process whereby a woman's eggs are collected and frozen for later use. Usually, this is done at an age when a woman's own fertility is optimal. It is done for a variety of reasons but in essence it allows delaying pregnancy from a present time to one at a later date. The reasons for this are complex and include not being in the right relationship, career considerations or simply wanting reassurance.

The eggs can then be thawed at a later date and used with either a partner or donor sperm to create embryos in an IVF laboratory. These are then used to hopefully create a pregnancy.

Preparing for egg freezing

The process of egg freezing is in essence the first half of an IVF cycle - we will discuss this later. Preparing for this treatment may help your chances of success. In general, a healthy lifestyle, not smoking and keeping alcohol to a minimum are sensible. There is good evidence to show that cigarette smoking and excessive alcohol consumption are detrimental to a woman's fertility and a significant part of this is related to the direct effects of alcohol and smoking. A healthy diet that has all the important nutritional components, that includes fats, protein and carbohydrates, is important. There is some evidence to show that a "Mediterranean type" diet may be beneficial to women's fertility and this is encouraged in women who are trying for a baby and therefore probably would benefit women who want to freeze eggs. Having said that, many women across the world, with wide varying diets are perfectly fertile and it is important to maintain a perspective.

Supplements may be helpful. However, the evidence base behind most of these is lacking. They probably will do no harm and so often they give a sense of control in what can seem like an uncontrollable situation. Most evidence and studies around supplementation are of poor quality and tend to reinforce one view or another. A good fertility specialist will be able to talk through supplements and give a balanced view.

As with all medical treatments, investigations help in planning treatment. The mainstay of fertility tests is the test of ovarian reserve. Of these, the Anti-Mullerian Hormone (AMH) and Antral Follicle Count (AFC) are probably the most important. AMH measures a blood test for a hormone that is made by the cells that surround each egg and so reflects the total number of eggs. The AFC is an ultrasound test where the number of small scans containing eggs is counted during an ultrasound scan. Both these tests reflect egg quantity only. They tell us nothing about egg quality and they tell us nothing about the rate of decline in egg reserve. These tests were originally developed to help guide planning for IVF cycle; they have found current use as a variety of attempts to predict chances of pregnancy and future fertility. It should be very clear that they cannot do either of the latter.

What happens during an egg freezing cycle?

In order to understand the process of egg freezing, it may be helpful to consider what happens in a normal menstrual cycle first. For women who have a regular predictable menstrual cycle, there are two main events ongoing – egg recruitment and then ovulation. At the start of the period, the ovaries present the body with several eggs. The number that are presented is linked to egg reserve – the higher the egg reserve, the more that are presented. The brain then makes a hormone, Follicle Stimulating Hormone (FSH), to stimulate the follicles so that one develops. Usually, the most sensitive and responsive, and therefore also, maybe, the healthiest egg will start to develop. The remainder will die away by a process known as atresia. As the follicle starts to grow, it will make oestrogen, and this oestrogen has negative feed-back onto the brain which then, as a result of the rising oestrogen levels, reduces that mount of FSH made and this in turn means that no other follicles will develop. In this way, only one egg is allowed to develop each month in a natural cycle.

In an egg freezing cycle, women will take the hormone FSH, via daily injections, from the start of their period to try and cause around 10-15 follicles, at least, to start developing. The number that develops is based on their ovarian reserve tests and age. This means that, in contrast to what happens normally, no one follicle is selected over the others and rather than one developing, many will develop. As these follicles develop, they will make oestrogen, this oestrogen would normally feedback to the brain and reduce FSH production. However, as the FSH is being given by daily injections, there is no negative feedback and all the follicles will continue to develop. The development of the follicles is monitored by ultrasound scans and blood tests over the next two weeks approximately. At the end of this time, when the follicles have had enough time to develop, the eggs are ready to be collected. The final injection given is called a trigger shot – this is a hormone that causes the developing eggs in the follicles to proceed onto the next stage of their development and become mature. There are two types of trigger available and the choice of which one to use is important.

The egg collection itself is done under an anaesthetic and no pain should be felt at all through the procedure. An internal scan is done whilst the woman is asleep, and a needle is guided into each follicle and the fluid aspirated. Within the fluid should be an egg. The egg collection itself is a quick procedure and for most women will last no more than fifteen minutes.

Once the eggs are collected, they are then assessed for maturity and frozen. Egg freezing is done by a process called vitrification. The advent of vitrification is what has enabled us to freeze eggs with such high success rates. Eggs, like any other cell in our body, are made up of water predominantly. When frozen, this water in cells forms ice crystals which damage the delicate structures within the cells. This damage is what caused previous forms of egg freezing to yield poor results. Vitrification, however, changed this as it involves dehydrating the egg before freezing – in essence protecting the egg from ice crystals.

What are the risks of egg freezing?

Like all medical procedures, egg freezing carries risks. Overall, these risks are low and the procedure is done commonly now with the vast majority of women having no complications.

The risks include

- Not responding to stimulation (5%): this is related to age and egg reserve and the clinic should have had a clear and honest conversation around individual circumstances and chances.
- No eggs being collected (<5%): very rarely no eggs are collected. This can be due to low egg reserve or age but equally can be due to a suboptimal response to injections of follicles being empty.
- Infection and bleeding at egg collection (<1%): the risk of inserting a needle into the ovaries is low but occasionally can result in either bleeding or an infection which would require further immediate treatment.
- Over response (<1%) : young women and women with high ovarian reserve are at risk of over responding to medications and developing ovarian hyperstimulation syndrome (OHSS). This requires careful monitoring and judicious use of alternative medications to minimise risks. This complication is very rare in good clinics.
- No mature eggs (<1%): occasionally eggs can be collected but none are at a stage where they can be frozen. This can be related to protocol selection and monitoring and needs a careful evaluation to see if any changes would result in a better outcome in future cycles.
- Failure to thaw and fertilise: one of the longer term risks, even if a good number of eggs are frozen, is the chance that a lower than expected number of eggs would survive the thaw and fertilise (see below for further discussion).

What is my chance of having a baby if I store my eggs?

There is very limited data about the outcomes for women who are storing eggs for their own later use. The data we have about the outcomes for donor eggs may not apply to women storing eggs for their own use, as those donating eggs have been selected for their fertility potential and therefore may have a better outcome. We can consider different scenarios to help us understand this better:

Table 1 is simply a guide to the chance of a live birth at different ages and is there as an overall guide. It assumes that the fertility potential of a woman storing eggs or embryos for her own future use is the same as that of a women having IVF because of a conception delay: this may not be true and it could be better or worse. It also only applies when there is at least one embryo available to transfer. Some women who have eggs collected for storage of either eggs or embryos sadly will not have an embryo to transfer if none of the eggs/embryos survive the storage process, or, in the case of stored eggs, none of those that survive result in an embryo. The estimates do not differentiate between cycles where more than one embryo was transferred at a time.

Table 1: estimated live birth rates for one embryo transfer cycle using fresh embryos, stored embryos and embryos created from stored eggs

age group	under 35y	35-37y	38-39y	40-42y	43-44y	>44y
Fresh embryo(s)*	34%	29%	22%	14%	5%	1%
estimate for stored embryo(s)**	34%	29%	22%	14%	5%	1%
estimate for embryo(s) from stored eggs***	28%	24%	18%	11%	4%	0.8%

HFEA data: live births per treatment cycle with IVF & ICSI in 2017.
***Based on HFEA data for fresh cycles: outcomes with fresh and stored embryos are approximately the same and I have presented estimated live birth rates by age at which the embryos were created, not the age of the woman when she used them .*
****Assumes live birth rate with stored eggs is 19% lower than with fresh eggs.*
+May over-estimate live birth rates in women over 36 years old as fewer eggs may survive the storage process.

The estimates in **Table 1** are for the outcome of one embryo transfer cycle, which may be of more than one embryo at a time. For some women storing eggs/embryos there may only be one embryo, but for others there may be several embryos and therefore more than one chance to become pregnant, i.e. she may be able to have more than one attempt per batch of eggs collected. The chance of a live birth at any particular age depends on the number of eggs collected and the number of embryos that result from that batch of eggs.

Table 2 illustrates the average number of eggs collected in one cycle at different ages.

Table 2: average number eggs collected by age

age group	under 35y	35-37y	38-39y	40-42y	43-44y	>44y
number of eggs collected	12	10	9	8	6	4

HFEA Supplement to the 'Egg freezing in fertility treatment' report 2010-16

Not every egg collected is suitable to be stored (see above). So, although eggs are not tested before storage (there is no currently available way to test eggs and still leave them capable of being fertilised), they are examined under the microscope by the embryologist to ensure that they are mature and are not showing signs of degenerating. On average, 80% of the eggs collected are stored. This percentage is approximately the same as the proportion of fresh eggs that are suitable for fertilisation if embryos are to be created and stored.

As mentioned previously, not every stored egg will survive the process but approximately 70-80% will. The ability of eggs to survive the storage process depends on their quality, which is age dependent, plus the technical ability of the laboratory storing the eggs. Eggs from younger women are of better quality and have a higher chance of surviving. Eggs from women over 35 years of age have a lower chance. Although many clinics will do a reasonable number of egg storage cycles, they may not have used enough of these stored eggs yet to be able to demonstrate their results.

How many eggs do I need to have a baby?

Several different research groups have used mathematical modelling to try to answer this question: it is therefore important to see these numbers simply as a guide to decision-making, as with the estimates discussed before.

Table 3: chance of having a baby from stored eggs if 10 eggs were collected

age group	35 years or under	36 years or over
estimated live birth rate	60-70%	30%

These estimates are based on using all the embryos that result from the hypothetical 10 eggs that were collected, if needed. To put it another way, the estimates are for the chance of having a baby from the batch of eggs collected: some women will only have one embryo transfer cycle and others may have several. The live birth rate for women under 35 years of age does not vary very much within that age group. So for example, the chance of having a baby for a 30 year old is not that different from that for a 35 year old. In contrast, the variation in live birth rates for women in the 36 years and over group varies considerably by age, those

40 years old and above having a much lower chance of having a baby than those at the lower end of this age group. It is likely that women 36 to 39 years of age will have a live birth rate around 40-50% with 10 eggs collected.

The chance of having a baby depends on the number of eggs available, which depends on the number that were collected. **Table 4** illustrates the estimates if 20 eggs were collected. It also includes the average number of eggs collected in one cycle for each age group.

Table 4: chance of having a baby from stored eggs if 20 eggs were collected

age group	35 years or under	38 years	42 years
estimated live birth rate	80-90%	60-70%	30-40%
average number of eggs collected per cycle	12 eggs	9 eggs	7 eggs
number of cycles needed to have 20 eggs collected	1 cycle	2 or 3 cycles	3 cycles

Table 4 illustrates that the average woman under 35 years will need to do 2 egg storage cycles to have a 90% chance of a live birth. A 38 year old woman will need to do 2 or 3 cycles to have a 60-70% chance and a 42 year old will need to do 3 cycles for a 30-40% chance.

How long can eggs be stored for?

Current law in the UK allows for eggs to be stored for up to 55 years. Consent is initially taken from 10 years and then can be extended in 10-year renewals. It is therefore very important to remain in contact with your clinic to ensure that storage consent is always valid.

What is the cost of egg freezing?

This will vary from clinic to clinic. However, in general, the estimate would be around 4000-5000 pounds inclusive of tests and treatment. Medication costs will vary depending on individual circumstances but can range from £800-£2000.

Summary

Egg freezing has provided women with an opportunity to preserve their own eggs at a time when their own fertility is optimal for use later when their own natural fertility chances may have depleted. Whilst it is a good treatment, with good chances of success, these chances depend on age and ovarian reserve. Like all medical treatments, it carries risks and discussion of these risks should form a key part of consultations.

Varicocele and Azoospermia

What are these male fertility conditions and how can they be managed to improve chances of IVF success?

By **Dr Geetha Venkat**, Director of Harley Street Fertility Clinic

In my article, we will examine azoospermia and varicocele, and how they can be managed to best improve chances for positive outcome.

If you and your partner have been trying to have a baby for 6+ months, then it might be time to consider having a fertility health check-up completed. Often, the emphasis is placed on a women's fertility health, but assessing the man's health is just as important. Your partner could be facing infertility because of a few conditions, including azoospermia and varicocele. These two words may sound daunting and unfamiliar to many, but they are simply common terms used by medical professionals, such as myself, to describe when there is no sperm in a man's ejaculate (azoospermia) or an enlargement of a vein next to the testes (varicocele). In fact, either of these conditions may be causing male infertility.

To truly understand what these terms mean and how they could be affecting your fertility, let's look at them in more detail.

Azoospermia

Azoospermia is defined as the lack of sperm in ejaculate. Inevitably, this is a huge contributing factor towards male infertility. According to the **National Library of Medicine**, azoospermia can be found in 1% of all males and 10-15% of men who test for infertility, which is a significant population in the field of infertility.

There are two types of azoospermia:
- obstructive (OA), where a blockage in a tube is preventing the sperm from entering the ejaculate or,
- non obstructive (NOA), where the testes are not producing enough sperm.

When a man opts to have a vasectomy, he is essentially opting to have an obstructive azoospermia, where we would purposely cut or block the tube, stopping sperm from entering the ejaculate.

Azoospermia can be diagnosed quickly and easily, by semen analysis, in which a sperm sample is analysed within a clinical laboratory. Your doctor might also find it useful to know more about your family history. Asking questions surrounding illness, fever, medication use, fertility history and so on, will help your doctor to build a comprehensive over-view of your fertility.

The doctor will advise you to have a blood test and an ultrasound scan of the testes to diagnose whether you have obstructive or non-obstructive azoospermia.

The treatment will involve retrieving sperm directly from the testicles; it can be done by a simple procedure called PESA/TESA, if it is the obstructive type. In non-obstructive cases, micro-TESE will be the procedure carried out to retrieve sperm.

In case no sperm is retrieved by the micro-TESE procedure in non-obstructive azoospermia, the next option might be to consider donor sperm.

Varicocele

A varicocele is a medical term used to describe an enlarged vein near the testicle. Because of their twisted and swollen appearance, a varicocele can look similar to varicose veins which are commonly found in the leg. Such enlargement of the veins nearer to the testis causes heaviness and pain and, due to the increased temperature locally, can cause infertility issues. Varicoceles are more common than people think, around 1 in 7 men will have these next to their scrotum, bur for many, they don't cause an issue or any pain.

Varicoceles are found to affect fertility because they can decrease the motility of the sperm as well as cause more deformed sperm. It is widely accepted that varicoceles can increase the temperature in the scrotum, which in turn, decreases sperm production.

Although medical professionals can't be certain as to what causes varicoceles in some males and not others, many believe it is do with a faulty valve within a vein next to the scrotum. Varicoceles are usually formed after puberty, on the left side.

Fortunately, varicoceles can be treated when detected. If you are in pain, over the counter medicines should relieve your discomfort. When looking to treat varicocele for fertility purposes, an embolism or ligation can be offered, whereby the vein is briefly blocked.

There is controversy regarding the role of varicocele in male infertility. Sometimes, treating these conditions can improve the sperm parameters; however, sometimes it might not have any effect.

At Harley Street Fertility Clinic we have an urologist (Mr Asif Muneer) who sees patients with male infertility and advises accordingly. He is also able to carry out appropriate procedures for both azoospermia and varicocele.

For a male fertility check-up, please visit our website. https://hsfc.org.uk/treatments/male-checkup/

To find out more about male fertility, please watch our recorded webinar: **https://hsfc.org.uk/webinar/male-fertility-webinar/**

To book a male fertility check-up, please **contact us** today.

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Spotlight on HFEA – the UK Independent Regulator's top 5 priorities

Clare Goulty, Editor-in-Chief of Fertility Road talks with **Julia Chain**, newly appointed Chair of HFEA about her role and what's ahead for the UK's governing regulator

Clare: Welcome Julia. For the benefit of our readers who may be new to hearing about the Human Fertilisation and Embryology Authority, please outline the current role of the HFEA.

Julia: The HFEA is the UK's independent regulator of fertility treatment and research using human embryos - the group of cells that can lead to the creation of a baby.

We are responsible for ensuring that everyone who enters a fertility clinic receives high-quality care. Licensing, monitoring and inspecting fertility clinics enables us to do this, as well as via the free, clear and impartial information we provide to patients. You can visit our website – www.hfea.gov.uk – for information on fertility treatment and detailed reports on all UK fertility clinics.

The HFEA has a unique role in the UK healthcare landscape: the regulation of the creation of life. The HFEA was the first such regulatory body in the world and is held up as an example of excellence overseas for its innovative regulatory work.

We collect data on all treatments that take place in the licensed centres across the UK that we regulate. This information is invaluable in many ways as it can lead to developments in science and research and support service planning and delivery. And for patients who use donor eggs, sperm or embryos, the organisation provides information to any children conceived to help them learn more about their genetic origins.

Clare: As Chair of HFEA, what's your main objective over the next 12 months?

Julia: To ensure the HFEA continues to look ahead to how our law should change to best reflect changes in society, medicine, scientific developments and modern patient care.

Clare: How does your main objective translate into the top 5 priorities for HFEA?

Julia: Firstly, we need to continue to make sure that clinics are able to offer safe fertility treatment during the ongoing Covid-19 pandemic. Fertility treatment was the first 'non-essential' treatment to re-start after the first lockdown and we are really grateful for clinic staff working so hard to continue to offer safe treatment to patients since then.

A new law has just come into force that both increases the length of time for which sperm, eggs and embryos can be stored and also makes some changes to the process that patients and donors storing their eggs, sperm and embryos must follow in order to do so. This is good news for patients, but we are working hard with clinics to make sure the new law is understood. This is especially important for those who might have stored their eggs or sperm many years ago before undergoing chemotherapy as the new law now requires them to get in touch with their clinic every 10 years.

Another big moment will take place in 2023 when the first donor-conceived children born since the rules changed in 2005 will be able to access identifying information about their donor from the HFEA. This will have huge implications for many families, and we want to ensure we can manage these big changes.

The HFEA wants to ensure that fertility issues, including for example, a better understanding of why black and some ethnic minority groups can have poorer outcomes when accessing fertility treatments, remains high on our agenda. Providing impartial patient advice and information will also be a priority.

Lastly, we are working with fertility laws that are mostly over 30 years old. So much has changed since then and it is a key priority of mine to make recommendations to the Government on how this law could change to better improve patient care and our ability to regulate effectively.

Clare: How do those key priorities directly affect patients undergoing fertility treatment?

Julia: Each patient going into a clinic should know that they are being offered safe and effective treatment. We have a robust inspection system and look at a wide range of issues from the safety of the clinic to the information it provides patients. The priorities I have outlined will ensure this is continued and enhanced by the changes we would like to see.

Clare: Given that the Human Fertilisation and Embryology Act has recently reached its 30-year milestone, is it time to modernise it? If so, which areas of the Act do you wish to focus on?

Julia: Much of the fertility law has stood the test of time remarkably well and we can, and do, regulate effectively with the tools we have. However, we need to update and future-proof the law so we can continue to act in the best interest of patients for many more years to come.

Looking ahead, the HFEA has begun work to identify where the law needs to be modernised further, making it better suited for the issues of today and tomorrow.

There are three core areas we want to prioritise and these are: patient protection, scientific developments and consent, data sharing and anonymity. However, it is important to note that the decision to change the law is for Government and ultimately Parliament to decide and not the HFEA.

We will be running a consultation later this year and it is really important we hear the views of professional and patient bodies in addition to interested patients. The consultation will inform the recommendations that the HFEA will submit to the Department of Health and Social Care around the end of the year.

Potential UK Government changes and recommendations to Employers' fertility policies

By **Becky Kearns**, Co-founder of Fertility Matters at Work

In the previous issue of Fertility Road magazine, Claire Ingle and Helen Burgess talked about entitlements, more specifically the lack of entitlements, when it comes to dealing with fertility treatment whilst in the workplace. To help change this, we at Fertility Matters at Work, amongst others, are working with MP Nickie Aiken in the UK to ampaign for statutory time off for people who have to attend appointments for assisted reproductive treatment. This would effectively mean that fertility appointments would be treated in the same way as antenatal appointments, with our hope being that over time fertility appointments would also become expected, accepted and acknowledged as a statutory right by organisations.

Under the recent Private Members Bill (PMB), proposed and submitted to parliament by MP Nickie Aiken, all companies in the UK would have to give both employees and their partners time off for fertility treatment. We've spoken with Nickie on one of her recent podcast episodes **https://anchor.fm/nickie-aiken/episodes/Improving-IVF-support-in-the-workplace-e1gj9qa** to help provide an understanding of the real-life challenges that people face. She's now working hard to raise awareness of this issue and in recent interviews with national media has shared how she understands that "undergoing treatment while juggling a career is very tough. Many people feel they cannot tell their employer for fear of being overlooked for a promotion or being made redundant."

What would it mean to you to have the statutory right to take time off to attend appointments for fertility treatment?

This law could be a potential game changer mainly because it effectively gives employees the confidence and validation to talk to their employer about going through treatment (if they choose to) rather than feeling like they have to hide it. I'm sure your feelings about what it would mean to you mirror many of those within our Fertility Matters at Work Instagram community who shared:

"I wouldn't have to feel guilty for taking time off, which eventually led me to leave my job."

"It would give me the headspace to deal with the emotional rollercoaster without having to take sick days."

"It would mean I could focus on treatment and not have the extra stress of sneaking around."

"It would mean everything. Validation that infertility is a real thing."

"It would mean gaining a little control in this unpredictable world that is infertility".

"I wouldn't have to delay treatment until I can take holiday".

"Relief that I could still have a holiday rather than having no holiday left."

"More relaxed and not having to use annual leave."

"I wouldn't feel like an inconvenience to the business."

Giving security to openly take authorised time off

It's hoped that this proposed change will help those who may currently be going through multiple rounds of tough IVF treatments in secret. Many people go through treatment in silence due to a fear of impact to their career and professional reputation, resulting in them feeling they have no other choice but to take sick leave and generally feeling unsupported when often there is no policy, guidance or support within their workplace.

At Fertility Matters at Work, we know from our research that 61.1% did not feel confident talking to their employer about trying for a baby via this route and that many fear that there would be an impact to their career in asking for time off to attend appointments. A law in place to give a statutory right will help them to know that this needs to be recognised and allowed by their employer with little chance of challenge.

Planning fertility treatment around work can be hugely difficult, as it often depends on how your body responds to treatment and when your period starts as to when treatment can begin. The appointments can be up to every other day and sometimes at late notice depending on blood test and scan results. This can make the stress of 'hiding' appointments even more difficult to bear and even more difficult to attend. Being able to have authorised time off to attend appointments, even just for an hour in a morning, is one of the most common areas of support people tell us they need. If this law were to pass, it would give them the right to take this time.

Changing mindset and misconceptions

Within our recent FMAW survey we received comments highlighting the misconceptions and challenges that come alongside a lack of legislation relating to this life-event. We asked respondents what would help them feel more supported:

"Being allowed a couple of days off for treatment. Not having HR tell me that I can't have any time off because treatment is 'my choice' rather than a necessity."

"Clear policies that allow for time off. A more open conversation so it doesn't feel like wanting a baby means I don't want a great career too."

Given that IVF is often seen simplistically as a 'lifestyle choice' rather than a treatment for a medical condition, despite the World Health Organisation describing infertility as a "disease of the reproductive system", this proposed law could drastically change this misconception. It would support in dispelling the myth that fertility *isn't* a workplace issue or something to be talked about at work, opening the door for people to take something that is a right, not just a hopeful request.

What if I don't want to share information about my fertility treatment with my employer?

Some people have asked, would I have to tell my employer that I'm going through fertility treatment with this law in place? It's important to note that, despite the huge shift that this could potentially bring in awareness and understanding, there will still be people who won't feel comfortable

in disclosing. Even with a law in place, changing mindsets and culture around this topic won't happen overnight. Assisted reproduction is a hugely personal experience, one that still has stigma and shame attached to it. What we hope is that this will provide greater security to those going through fertility treatment, giving them the opportunity to choose whether or not to disclose, rather than being forced to hide it. So, the simple answer is no, you wouldn't have to disclose, but being mindful that if your employer doesn't know, it's more difficult for them to support you.

How can YOU help make a difference?

The first reading of the "Fertility Treatment: Employment Rights" bill took place in June 2022, with the second reading taking place in UK parliament on 25th November 2022. In the meantime, there's still work to be done – and **YOU** can help!

In UK parliament the more momentum and support there is behind a bill, the more chance it has of being debated and passed through. It's by no means an easy process, but every single one of you can help make a difference by contacting your local MP to share why this is so important to you (or your loved one if you're not personally affected) and that you expect them to be supporting Nickie Aiken with the "Fertility Treatment – Employment Rights" bill.

We've made it really easy for you to do this, head to our website **www.fertilitymattersatwork.com/campaign**, simply enter your postcode and this will automatically populate an email with your local MP's email address.

Over the next few weeks, we want to flood the inboxes of MP's all over the country to get them to take notice! Sharing your personal stories with them can really help bring to life the challenge of fertility treatment on everyday working lives, helping to drive momentum, supporting Nickie to push this legislation through parliament.

Politics has been rather polarising and divisive in recent years in the UK, but it's important to note that this is a bipartisan issue that will hopefully gain cross party support. Therefore, even if you didn't personally vote for your local MP, they still represent you in parliament and can help push this forward.

We're really excited about where this campaign might take us and hope to make the experiences of those going through fertility treatment in the future a little less stressful when it comes to the workplace. To follow the progress of this campaign on our socials head to Instagram: @fertilitymattersatwork, LinkedIn: Fertility Matters at Work, Twitter: @fertmattersatwork.

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Donor Conception is different

– Part 2 – Pregnancy and the early years

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

Sharing your story

In the first part of this three-part series, we explored decision making around donor conception at the treatment stage, looking at how it's different and what that can bring up. This second article looks at the differences that can come up once you're pregnant or have a young child via donor conception.

It's finally happened!

So, you made the decision to move forward with trying for a baby, you crossed all the fingers and toes you could find and, amazingly, it actually happened. You're finally pregnant, or you have a young child.

Congratulations!

Maybe this is your first child, and you're experiencing the excitement (and perhaps the overwhelm) of your new role as a parent. Or maybe you've used donor conception for a second child, in which case this may feel like familiar ground. Either way, you have a much-wanted baby and are hopefully enjoying family life.

Telling and Talking

The main difference for families using donor conception is the issue of sharing information about your child's conception. It's interesting how quickly you may find yourself in situations where you'll have to make decisions about how much of your story to share with people. You may be asked questions, often sooner than you think, that require a certain level of honesty about how you conceived. It's really helpful to be prepared for that, so you don't get caught off-guard.

Some people are incredibly open. They're happy to share the most intimate details of their lives with anyone who will listen. If you're that sort of person you may not worry about who needs to know; let's shout it from the rooftops! Possibly, you'll need some ideas on timing and vocabulary and a community around you and your family. But for the most part you're not troubled by talking about this subject.

Not everyone is quite so comfortable. You may have decided to keep sharing to a minimum during treatment, only letting a very small number of close friends or family know you're using donor conception. You may not have talked about it at all, which is really understandable. It's a private matter and managing other people's feelings and expectations may have felt like adding even more of a burden during stressful fertility treatment. But now you're pregnant or have a child you're likely to find yourself in situations where you need to decide just how far to go with answering questions and you'll have to decide when and how to start talking with your child.

Who needs to know and who is going to ask?

The first time potentially awkward questions can come up is at the midwife appointments during pregnancy when you may be asked about medical history. Obviously, providing accurate medical information is really important for good healthcare for pregnant mums as well as the baby/child. But it can feel uncomfortable having to explain your situation and most likely being unable to provide the information on the donor's side, particularly if you're caught unawares.

Apart from medical situations, for heterosexual couples, the general assumption will probably be that you used your own eggs and sperm so you're unlikely to be asked questions. If you're part of a same-sex couple or are single, and people aren't

aware of that, some of the questions may mean having to clarify your personal circumstances, as well as the fact you've used a donor. Lesbian couples and single women (and gay and single men) can find it frustrating to have to first keep explaining that they don't have a male (or female) partner to strangers and acquaintances who ask about their pregnancy or child.

"Who's the lucky man?"

Work and other situations may throw up conversations as soon as you're pregnant. As a solo mum, for example, you might wonder how to respond when your colleague says "Congratulations! Who's the lucky man, then?". Same-sex couples may be greeted with a similar "I've just heard you're expecting. Congratulations! How's your wife feeling?". You then find you need to explain that actually your partner is male and you're using a surrogate and an egg donor. It can feel like a lot of detail to share in one go.

Mostly, people are just curious and interested, but the conversation can quickly veer into very personal topics. You might feel like answering honestly, or you might not, and you need to be prepared.

Set your boundaries

Sharing personal information with trusted friends and colleagues is one thing. But there will, of course, be people who you aren't close to, and may not even like very much, who may want to know more details than you want to provide. Boundaries can be hard to manage in off-the-cuff conversations and we would recommend finding some default sentences to rebuff anyone you don't want to share too much with.

Remember that you don't have to answer all (or indeed any) questions. It's fine to respond with something ambiguous, or to omit certain bits of information, while you decide whether or not you want to explain further with this person. There can be a pressure to be totally honest, particularly if you've decided you want to be open. But openness can still have boundaries, in the same way that you probably wouldn't share the same amount of detail with someone you hardly know as with a very close friend. There is time to reveal more information, if you decide to, later on.

"Where does her curly hair come from?"

Who looks like whom and who shares traits or interests or talents is a really common topic in families. Those conversations often start as soon as a baby is born and continue for a lifetime. For some parents, these kinds of comments about a child's appearance and traits can be a challenging reminder that they aren't genetically related, or that they may have got those traits from someone outside the family.

It's helpful to remember that people rarely mean to be hurtful and may not even appreciate that you find these comments or questions hurtful. The secret is to build resilience and try to embrace the donor and their essential contribution in making your child into your family story. Maybe your daughter gets her curly hair from the donor's side. Well, how wonderful! It might take time to genuinely feel that level of confidence, to acknowledge the donor in this way. Hearing from others, further along that family journey, is often really helpful just to know that it is possible and can be so positive.

Thoughtless comments may come your way

If you decide to share part or all of your story with other people you may be anxious about their reaction. In our experience at the Donor Conception Network, people are mostly open and positive when they hear the news. It may not be a choice they think they would make for themselves, and they are entitled to that opinion. We are all different, of course. However, they can sometimes say insensitive or hurtful things. People may be overly curious, or nosy, and they may express themselves clumsily or thoughtlessly. Very rarely are they actually being deliberately mean.

Remember, they have probably had about 5 minutes to consider what you're telling them, and they certainly won't be clued up on language and the more subtle nuances of donor conception. For you,

on the other hand, this is most likely a topic you've spent weeks, months, possibly years thinking about. They are playing a catch-up game to get to understanding things to the depth that you do, and may need time (and a bit of patience!) while they do that.

Do I have to tell my child and how will they respond?

It's important that donor conceived people know the truth about their conception, but we know that many people find the prospect a challenge. We generally recommend starting the conversation when children are young so that they can integrate the information into their sense of who they are. Telling young children is also easier for parents. A baby won't notice as you experiment with different language or ways of telling the story. They won't notice if you get upset when remembering your fertility journey, which may bring up all sorts of emotions.

When you first tell them, young children are unlikely to be very interested or ask questions. They'll probably find the subject utterly dull and uninteresting. The important thing for them is that they feel loved and cared for. As they get a little older, they may need language to explain things to other children, when necessary, particularly if they are in solo parent or same-sex couple families. Other children may well be curious and, as part of trying to understand the world around them, may quiz your child about how it's possible not to have a dad or a mum. You can empower your child with simple and clear ways to respond and explain things when needed. As they grow up, the story and the language they use may evolve as they make sense of it and take ownership. I'll cover more of that in the next article in this series.

It's not a secret but can I keep this private?

The balance between privacy and secrecy can be tricky. The truth is that once you've been open with someone, your child or another adult, it's very difficult to keep control of the information. It's possible that people you hadn't wanted to know will find out. It's why we emphasise building parental confidence and resilience, with support, so that if difficult situations do arise, you're able to deal with them. You might also be surprised by how many other people have had their own similar struggles and find your openness a source of inspiration.

Exactly how you tell your story depends very much on you. Some people need time to build confidence in talking about it and for others it comes more easily. Your personal situation will probably also determine how much you want to share and when. Children's story books can really help, providing a structure and narrative, but the precise how and when is something that is very individual.

What if I'm not sure about some of the decisions I've made?

Now that a baby is here, any doubts or anxieties that weren't addressed earlier may resurface which can be disconcerting, particularly whilst you're trying to enjoy family life. You may feel you rushed headlong into treatment and felt blindsided by the decisions you had to make, often under time-constraints and emotional pressure. It can be hard to separate out the normal ups and downs of adjusting to life with a baby from more serious worries or issues. If you do have complicated feelings get in touch with us at DCN and, of course, get any professional support you think might help.

I'm not feeling super confident

That's really common and we can help.

DC Network was founded to help support people with all things donor conception related, and particularly around 'telling and talking'. The charity publishes books and runs workshops to help people with being open and finding the words to explain to children in a simple, positive and age-appropriate way. Our range of books for young children *'Our Story: How we became a family'* has variations for pretty much all family situations, including surrogacy and twin versions.

The *'Telling and Talking'* series of booklets for parents cover the topic at the different child developmental stages. And the DCN *Telling and Talking* workshops provide a confidential, facilitated and supportive space to explore hopes and fears and plans with other parents at a similar stage. Our Network is great for those who would like to connect with other parents, or enable their children to meet others made 'just like them'.

Our community is incredibly diverse and super supportive. Join us!

The donor conception element of your family story is important, but small. There is so much more to being a family and family life. Things will work out gradually. Make sure you enjoy this precious time.

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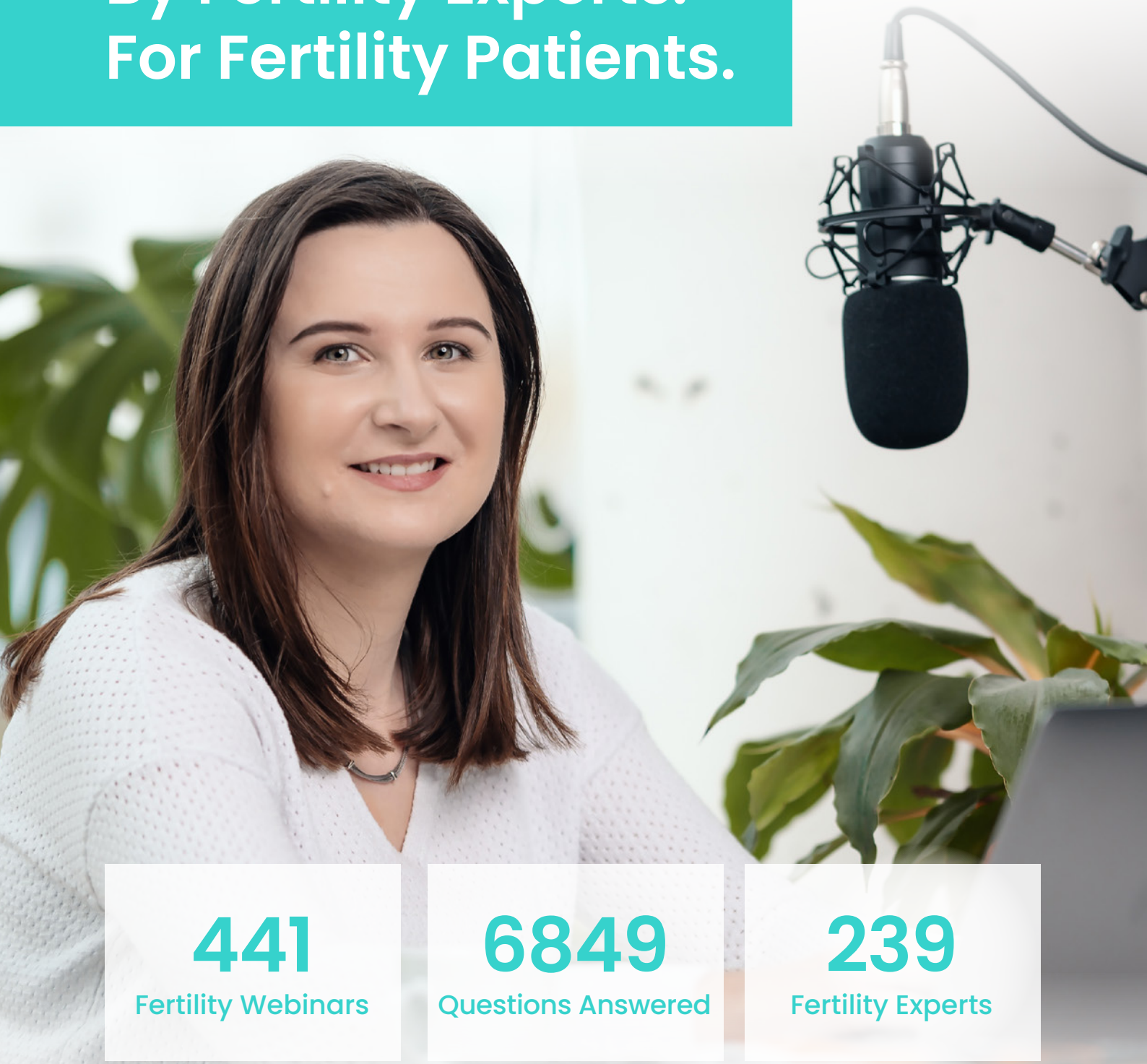

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Taking the Egg Donor route – will the baby look like me?

By **Professor Alan Thornhill**, Clinical Scientist specialising in embryology

I know this is important to egg donor recipients – otherwise I wouldn't be writing about it. And I don't want to mislead you into reading an entire article only to frustrate you in the final sentence. So here it is: Spoiler alert #1. Maybe the baby will look like you, or maybe they won't! It's really that simple.

In fact, that's not so different from the answer I'd give if you were using your own eggs. However, since it is a common, interesting and important question, let's spend some time unpicking it.

We've all heard people say: 'He got his mum's eyes', 'She really looks like her dad', or something similar. As a young embryologist in my first week of training, I vividly recall meeting new parents visiting the IVF clinic with their baby. 'Aw, he looks just like his Dad', I said (thinking this was the right thing to say). I later learned the couple had used donor sperm. I'm not sure the baby looked especially like the father, and I have no idea what the sperm donor looked like. There was, I suppose, enough similarity between the baby and the father for me not to do a double take.

When someone asks: 'Will the baby look like me?', they might mean any or all of the following:

- Will the baby look like I did as a baby?
- Will the baby grow into a child resembling me as a child?
- Will the child grow into an adult that looks like me now?
- Will this child age in the same way as me?

Spoiler alert # 2: We cannot really know how you will look in the future, and does this really matter anyway?

The reason I make these distinctions is twofold: it is self-evident that babies look different from children and children look different from adults. Also, a lot can happen between baby and adulthood – most of which is down to our environment, how we live our lives and how we choose to change our appearance. For example, skin damage due to smoking or sun exposure can dramatically change your appearance.

However, maybe you're really wondering whether the baby will grow up to look like it could have originated from your eggs.

If you are dreading a lot of complicated genetics, don't worry - I'll keep it simple.

Physical characteristics are inherited from DNA provided by the egg and sperm provider. Two important things happen during reproduction.

First, during sperm and egg development, the chromosomes (packages of DNA containing the genes) recombine. This is akin to shuffling a deck of cards – the same cards but in a different order. This means that each child can get a different hand of cards despite having the same parents – if this shuffling didn't happen, all siblings would be like identical twins! Second, and this one is more obvious, each child is made up of a 50/50 mixture of genes from the egg and sperm. Put this way, an egg donor only has a 50% chance to influence appearance and, depending on the particular genes and their versions, this is not always an even split. Considering just these two factors means that the physical characteristics of the child may favour one parent, both parents or neither parent – everyone has seen a child that looks nothing like his/her parents. In the case of egg donation, the DNA again comes from the eggs and sperm but there is no genetic contribution from the intended mother. That means the baby may not resemble its birth mother.

However, if her partner's sperm was used, the baby may well look more like its father anyway, because he and the baby share 50% of his genes.

Let's consider the genetics behind physical appearance, focussing on visible traits known to have a strong genetic component (for example height and hair colour). Many other physical traits are influenced by genetics, but these ones are common and easily recognised (high heels and hair dye aside).

Given that each baby receives half its genetic make-up from the egg and half from the sperm, you might assume that physical characteristics can be simply averaged. However, a taller-than-average man and a shorter-than-average woman won't necessarily have a child who grows to an average of their combined heights.

You may recall biology lessons in which you learned that brown hair colour (more of the pigment melanin) is dominant to blonde (less pigment) - the idea being that the gene responsible for making melanin comes in different versions (the highly active version making more melanin, resulting in brown hair). This story holds to a degree, but it really isn't that simple. I wouldn't guarantee anyone's hair colour based on the parents. Spoiler alert #3: Blonde parents can have children with brown hair and hair colour can change over time. If you want to read more about this, I recommend this article. **https://www.familyeducation.com/pregnancy/what-color-hair-will-my-baby-have**

The story is not the same for eye colour and other characteristics, but you get the message that things are not quite as simple as we were told in school.

To complicate matters further, another factor influencing gene activity is known as epigenetics. This is another opportunity for the environment to influence things. The environment in this sense can include exposure to stress, chemicals and the uterus; that unique environment that houses your developing baby throughout pregnancy. Rather than change hair or eye colour, the environment during your pregnancy is likely to influence other things such as later susceptibility to diseases including diabetes. It pays to look after yourself during pregnancy.

If you really want a child with blonde hair (like yours), then you should probably select a blonde egg donor and the 'father' will most likely also need to have blonde hair. At least, that will skew things towards having a blonde child.

At the risk of stating the obvious, the biological sex of your child will also influence their physical appearance. Not least because of the different sex hormones present. Young children in the same family, whether biologically male or female at birth, can often look remarkably similar. However, once they reach puberty, secondary sexual characteristics develop with a dramatic impact on appearance: The broad shoulders and facial hair in males, broader hips and breast development in females are triggered by different levels of circulating hormones (including testosterone and oestrogen). Different levels of circulating hormones in females at puberty and beyond can significantly alter their appearance (more prominent curves, fuller lips and so on). Some of these hormonal levels are genetically determined, but environment, once again, has a huge role to play.

Can I influence the appearance of the baby (make it look more like me)?

Yes, you can influence the baby's appearance by selecting an egg donor with a similar natural physical appearance to you (in terms of height, hair colour, skin tone, ethnicity, eye colour and so on). However, and I cannot stress it enough, this will only skew things in favour of a particular set of physical traits. It is not a guarantee.

Most egg banks or egg donation programmes I know try to match the egg donor to the intended mother as far as possible - if that is requested. The availability and diversity of egg donors is better in some countries than others. For example, Black and Asian donors are scarcer in the UK compared with

White donors, potentially impacting your chance of finding a close match. One provider uses algorithms to digitally analyse the recipient's physical features (like using facial recognition software) to facilitate an extremely close match to a potential egg donor. This is interesting and might well influence the chance of a child looking more like you. However, this assumes a similarity between the appearance of the intended mother and egg donor, which has not been altered by surgery, disease, or other significant environmental factors. Also, this matching process cannot change any limitations of donor availability or a potentially dominant genetic contribution from the sperm.

Why are so many people concerned about the child's appearance?

I've heard many distinct reasons and they all have validity:

- Some people are simply curious.
- Some choices are aspirational – "I want eggs from an Angelina Jolie look-alike" (yes, such websites do exist).
- Perhaps the fertility journey has been exceptionally painful – if the child doesn't resemble you, this could be a constant reminder of why you needed egg donation.
- Maybe you just want to get on with the job of raising your child without family, friends or strangers constantly asking questions.
- If your plan is not to tell your child about their genetic origins – the more they resemble you, the less they will suspect.

Whatever your motivations for asking the question about appearance, these and other concerns can and should be properly discussed during 'implications counselling'. This is mandatory in many IVF clinics. Rather than seeing it as an obstacle to your treatment or simply a tick-box exercise – please consider its potential value for sorting through issues you may or may not have considered.

A word of warning about Dr Google

In my research for this article, I wanted to better understand what was currently being claimed on the internet. Please treat Dr Google's advice with caution. There is a lot of information but much of it is misleading, unverified, or not properly referenced. There's no clear relationship between how highly a site ranks (how quickly you will find it) and the accuracy of the content. In addition, the small excerpt or teaser you see before clicking through to a site can be downright misleading. For example, I found a site asking: 'Egg donation: will my baby look like me?' The teaser said: 'A resounding 'yes'. I was astounded – was this a new area of genetics of which I was unaware? When I clicked the link, the question was actually: 'Can I influence the baby's health in the uterus?' The answer to that question is indeed a resounding yes. However, influencing the baby's health and its appearance are not the same thing at all.

I completely agree that you should do anything possible to improve the baby's health and development while pregnant. I'd encourage all prospective mothers (including those using an egg donor) to consider carrier screening – a genetic test for those people providing the egg and sperm. Available in many donor programmes and clinics, carrier screening can significantly help reduce the incidence of serious genetic diseases (like cystic fibrosis, sickle cell anaemia, thalassemia and hundreds of others) in children born from donation. Sadly, not all donation programmes see this as a priority over other features such as physical appearance. But I'd be willing to bet that most prospective parents would choose genetic health over physical appearance every time.

In the end, there is no way to determine exactly what your child will look like. But there are many ways you can increase the chances that your baby will be healthy and have the best start in life.

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Double Donation – How does it work?

By **Venessa Smith**, HCPC Registered Clinical Scientist and ACU Quality Manager

The use of donor sperm in conception has been reported anecdotally for hundreds of years. In comparison, double donation, the use of donor eggs and donor sperm, is a relatively new treatment.

What does Double Donation mean?

Double donation should not be confused with embryo donation, when a previously created embryo is donated to a recipient. These embryos are usually donated by patients that have already completed their family and do not wish their surplus embryos to be discarded or donated to research. Whereas with double donation, donor eggs and donor sperm, are chosen by the recipient to create their own unique embryos for use in their treatment.

Since 1991, UK clinics have had a legal obligation to report all treatment cycles undertaken to the Human Fertilisation and Embryology Authority (HFEA). This data has since been published and has shown that during the last 30 years there has been a 40 fold increase in cycles when both donor eggs and donor sperm are used. During the period 1991-2019, the birth of 3000 children has been recorded.

Why is Double Donation on the increase?

There are a number of reasons for the increase in use of double donation. Firstly, couples who have had repeated failed cycles using their own gametes, may decide that it will increase their chance of pregnancy. The UK has always struggled to find donated embryos and despite attempts by a number of charities to create a 'surplus embryo' register, this has never got off the ground. Patients are generally reluctant to donate their surplus embryos to other couples, perhaps in part due to the perceived complexity of their own children having a full genetic sibling outside the family unit.

Moreover, single women who require donor sperm, tend to start their fertility journey at a later age when the use of an egg donor, instead of their own eggs, provides a significantly higher chance of success. The increasing availability of donor gametes internationally has led to a wider choice and the general increased acceptance of different modes of conception has also opened the door for more individuals embarking on double donation treatment.

How does Double Donation work?

The pathway to double donation involves a number of steps:

1. Finding your egg donor:

Finding an egg donor can be a time-consuming process. The demand in the UK far outstrips the supply, particularly if you require a donor from an ethnic minority group. This often leads to patients accepting a donor from another ethnicity or opting to travel abroad for their egg donation cycles. Cross border reproductive care is often a successful route but introduces its own challenges and should be carefully researched if this is your pathway of choice.

There are two types of egg donor: fresh and frozen. Historically, fresh donors were used, which involved the synching of the donor and recipient, with a fresh transfer planned for both. However, more

recently, the use of frozen donor eggs is more common. This has a number of advantages: it not only gives flexibility for the timing of embryo transfer (ET), it also ensures that there are fewer cancelled treatments since availability of embryos is confirmed prior to ET scheduling. The recorded cycle success rates using frozen eggs and fresh eggs is very similar despite fewer frozen eggs being allocated per cycle. It should also be remembered that with frozen eggs, Intracytoplasmic Sperm Injection (ICSI) is always required, to compensate for the impact of the freezing process on the outer shell of the egg.

Due to the challenges of finding an egg donor, recipients may need to be flexible with treatment venue. There are some egg banks in the UK that are closely affiliated to a particular clinic and therefore patients must register with them prior to selecting an egg donor. International egg donors are available for import in some cases.

2. Selecting your sperm donor

In comparison, the process of sperm donor selection has been established for many years. If a suitable donor is not available locally, it's fairly easy to import samples from overseas and the costs are comparable. Once a donor has been selected, the sperm quality needs to be considered. Since an egg donor is being used it is not necessary to purchase 'washed' samples. The washing process, to remove the cryoprotectant, is a standard part of the thawing and preparation process in your treatment centre. So paying for this step is not required. Also, if you are using frozen donor eggs, a lower quality sample (count and motility) can be chosen. You will be having ICSI fertilisation, where only one sperm is needed per egg received. Higher quality samples are needed if you are not intending to have ICSI as part of your treatment.

3. Selecting your egg and sperm donors

Egg and sperm donor selection can be a complex process. Often initial requirements seem very clear but through viewing different donor profiles, recipients' likes and dislikes may change. Historically, it was common for a racial match to be the first consideration, but now family units are much more ethnically diverse and therefore things are not so 'black and white'.

Generally a recipient would firstly consider which physical characteristics would work for their family unit. When double donation is involved, it is more common for couples to decide that they wish to match themselves. However, with the increasing number of single women choosing double donation, priorities have changed. Although one of the donors may be chosen as a match to themselves or to their wider family group, the second donor may be chosen purely on personality traits, hobbies or academic success. This opens the door for much more diversity in the donor pool, where previously only those donors that were deemed attractive enough were selected.

Historically, matching the donor's CMV (Cytomegalovirus) status with your own would be a consideration. CMV if contracted during pregnancy, can have a detrimental impact on your foetus's development. However, it is now standard practise to screen all donors (egg and sperm) to ensure the active virus is not present.

Blood group matching was also once considered a crucial part of donor selection. This was not always for medical reasons. Some families wanted to ensure that if they chose to keep their use of donation a secret, it would not be accidentally discovered in a medical emergency, by having a child whose blood group was not a match for a parent.

Removing both of these exclusion criteria, has

greatly increased patient choice and should be discussed with your treating clinician if you are concerned.

4. Donor half siblings

In the UK, any donor can legally contribute to the creation of 10 family groups. This does not mean 10 children, but 10 families who may decide to have more than one child. Therefore, with double donation, if both donors reach their maximum family quota, there is a chance that your resulting child may be linked to up to 20 different families with multiple offspring. However, although it is usual for a sperm donor to contribute to his full family quota, the nature of the egg donation process is self-limiting with most egg donors contributing to less than 5 families.

If you decide to opt for a donor that is not recruited in the UK, you may wish to consider the number of half sibling families you would feel comfortable with. Although imported donors do have to meet the 10 UK family limit, they may have been used internationally where the family limits are higher or not so closely regulated.

5. The treatment

Once your donors have been chosen and if frozen, are safely stored at your chosen clinic, it is time to start considering when you wish to have treatment. If you are using fresh donor eggs, this may depend on the donor's availability. If using a donor as part of an egg sharing arrangement, timing will be when your donor intends to have her own treatment. As mentioned previously, a fresh embryo transfer (ET) can only be accomplished if you are able to synchronise your cycle with the egg collection date. For many, this proves tricky and the decision to freeze any resulting embryos is the better option with a frozen embryo transfer (FET) planned for a later date.

In comparison, when using frozen eggs and frozen sperm, treatment can be planned to either match your normal menstrual cycle (a natural FET) or programmed in a medicated cycle. Either way, the creation of the embryos can be organised to aim for a blastocyst ET on Day 5 post egg and sperm thaw, which is known to give you the best chance of pregnancy. Again, the created embryos can be frozen and used in a FET if preferred.

6. The outcome

With all treatment cycles, the outcome is dependent on many factors. However, when using donor eggs and donor sperm, negative contributing factors are greatly reduced. All donors go through an exhaustive number of tests and assessments and approximately 95% are rejected from the donation program for reasons ranging from medical history to motivation to donate.

The best example of the success of this strict recruitment is the removal of the impact of age on egg quality. As we all know, egg quality declines with age. All egg donors, recruited in the UK must be below the age of 36. This is clearly demonstrated by the published HFEA data for birth rate per cycle in double donation, for female patients between the age of 45-50 years (1991 - 2019) which is listed as 32% (fresh ET). In comparison the same age group, using partner sperm and patient eggs is documented as 2% birth rate/cycle (fresh ET).

If you're considering Double Donation, useful sources of information can be found at: The Donor Conception Network (DCN) **www.dcnetwork.org** and the Human Fertilisation and Embryology Authority (HFEA) **www.hfea.gov.uk**

EggDonation Friends.com

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Find Egg Donation Clinic Abroad

The real-life story

My experience of becoming a mother with the help of sperm donation

My experience of becoming a mother with the help of sperm donation

Eloise Edington, Founder of Fertility Help Hub shares her experience of taking the sperm donor route to create her much longed-for family. Eloise talks with our Editor-in-Chief **Clare Goulty** about what she learnt along the way.

Clare: Here at Fertility Road, we understand how complex and multi-layered the decision to take the donor route can be. Often, people have already travelled a fertility journey which led up to and influenced their decision to take the donor route. Eloise, what was your fertility journey before considering sperm donation?

Eloise: My husband and I were trying to conceive for six months naturally and when it didn't happen, we decided to have a fertility check done at a clinic. To our disbelief, my husband's sperm analysis came back showing zero sperm. My husband received a Klinefelter Syndrome infertility diagnosis which meant that for us to have children IVF was needed. The experience completely shifted our outlook, and purpose. After being told that we would need to have IVF, my husband underwent a Micro-TESE sperm retrieval operation in the United States. Sadly, it was unsuccessful, so donor sperm was our only route to having a baby with my eggs.

Clare: On reaching your decision to take the sperm donor route, how did you feel? And how did your husband feel?

Eloise: It all happened incredibly fast! We chose our sperm donor before my husband's operation; in case they couldn't find sperm in his testes. We got the news that the operation was unsuccessful the day before my egg retrieval, so we only had one night to digest that we would be moving forward with fertilizing my eggs with donor sperm, fresh, the very next day. It was a difficult time.

Clare: Did those feelings evolve over time? What changed your feelings?

Eloise: When we came back from that first cycle with donor sperm IVF, it didn't work. We got the results back in the UK and we were devastated. I think my husband was relieved however to have a bit more time to digest the news and recover from his painful operation. When we went back to the United States a few months later to try again with two frozen embryos, we were both in a much better place emotionally and physically.

Clare: How did you approach selecting a sperm donor?

Eloise: We both had different 'favourite' choices, however we started the search with looks and personality traits (to best match my husband). Everyone is unique, so you can't replicate someone, but for us, being Caucasian, having blue eyes, being 6ft 3" tall and having a humorous personality, was key. We also took into consideration advanced medical history and academic results. It also helped that our chosen donor had the same favourite food and animal as my husband!

Clare: How long does the whole selection process take?

Eloise: We chose and bought sperm in about six weeks, because we had a planned date for our IVF cycle to begin and my husband's operation abroad was scheduled.

Clare: In your opinion, what is your 'must know' advice for others considering taking the sperm donor route?

Eloise: Read up about anonymous vs open and think about the child's best interests. There is no right or wrong, but when the child is here, it soon shifts from your fertility story to the child's story. Find a solid support network. We have an amazing free Fertility Squad with thousands of people also considering donor conception, which you're welcome to **join here**.

Clare: Is there anything you wish you'd known before taking the sperm donor route?

Eloise: There will be emotional bumps in the road, but it's the most amazing gift and we love our children to pieces.

Clare: How are you planning on telling your children about their origins? In your experience, what's the best age to do this?

Eloise: We have already started! There are some amazing books out there to help tell the story to your donor conceived child – some of which you can personalise. We have book discounts on www.fertilityhelphub.com, if you'd like to use them. We started speaking about it from before our children could talk, more to make us feel comfortable with telling the story. Our children love reading their personalised books with us! We don't talk about it every day but as and when it feels natural, we do.

Clare: How has your experience of becoming a mother with the help of sperm donation affected other aspects of your life?

Eloise: When our twins were six months old, I decided to leave my job in advertising and set up a community-led platform (**Fertility Help Hub**), which offers people around the globe all the resources, community, and expert support I wish we'd had access to at the time. It's grown hugely over the past three years and it's wonderful when readers and followers message us saying how grateful they are for the expertise and support. **Subscribe to our weekly newsletter here** to see what it's all about.

Clare: What were/are your most useful sources of support? Family, friends, donor-related groups or organisations?

Eloise: Sadly, I couldn't find a like-minded community or support groups when we went through our struggles six years ago (hence starting my own community), however some friends and close family were everything to us. I love being connected to other parents of donor conceived children through the work I do now. I am always happy to talk to anyone considering using a donor or having treatment with donor conception – **follow us on Instagram here** and drop me a DM anytime.

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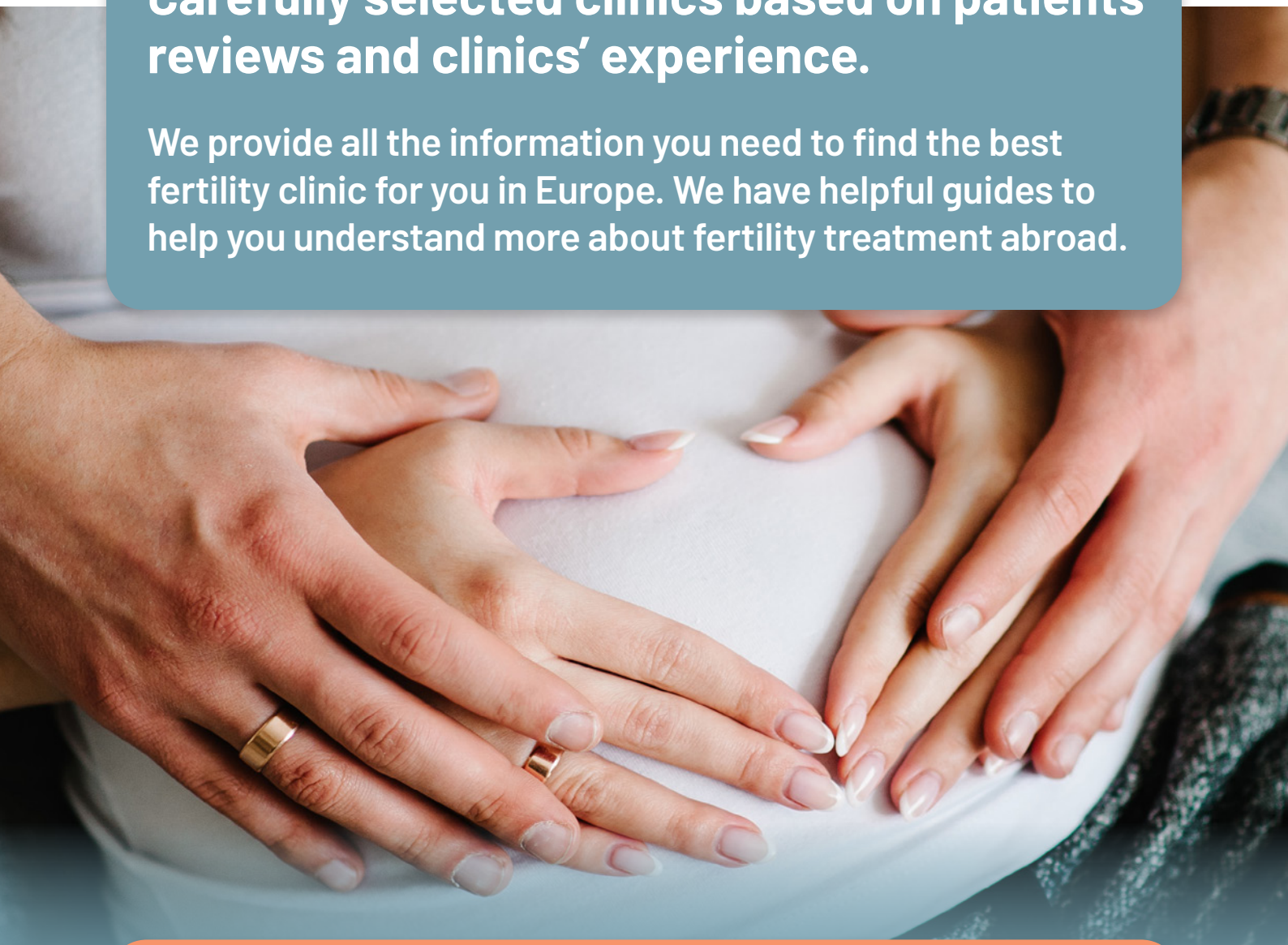

Find IVF Clinic Abroad

Donor races availability throughout Spain

- what donor races are available in Spain?

By **Luis José Arenaz Villalba**,
CEO Fenomatch, S.L.

The search for egg donors according to their ethnicity is always one of the first steps that any fertility clinic has to face, along with medical requirements, compatible blood type, and genetic compatibility.

It is important to understand the availability of races/ethnicities from the point of view of relative classifications. Each country, and each clinic within a country, classifies donors differently according to their ethnicity/race. We could talk about a very basic classification, for example: Caucasian, Asian and African donors. Another more extensive classification would be Nordic, Mediterranean, African, Indian, Asian, Mulatto. Thus, we could make a wide range of classifications that depend on different recognizable physical features of the person such as skin colour, eye colour or facial structure.

In Spain, all ethnic groups are available, although Caucasian donors are the most prominent because Caucasian is the main ethnic group in Spain. However, saying "Caucasian" is a very broad classification, since a Caucasian donor can have a Mediterranean profile or a more Nordic profile. It is at this point where many Spanish clinics have put themselves at the forefront of technology with the Fenomatch tool, which allows them to fine-tune the ethnic profile of each donor, with objective criteria based on Artificial Intelligence algorithms. It has been a breakthrough that has allowed them to make a selection much more in line with the patient's profile. In Spain, there is already an expression to "Fenomatch a patient" when looking for a donor.

Unfortunately, Asian donor profiles are not widely available, neither in Spain nor in Europe. Socio-cultural characteristics and the percentage of the Asian population make it much more difficult to find Asian-Japanese or Asian-Chinese donors in Europe in general.

Are there certain Spanish regions where some of the egg donor races are more available than in other regions?

In Spain, the characteristics of the donors follow a pattern that is very similar to European, mostly Caucasian, although with a different predominance in terms of eye colour, skin tone or hair colour than a Nordic-type donor may have.

There are regions such as Madrid, Barcelona, Valencia or Alicante that have seen a great increase in the demand of international assisted reproduction treatments with egg donation in which there is a significant challenge in finding a variety of Asian, Black or Native American donors. This situation, together with the recruitment of Caucasian donors with different traits and blood types, has forced clinics to create specific recruitment and information programs for potential donors, always without focusing on financial compensation and calling for solidarity between women.

Within this specificity, the recommendation is to look for clinics that have a good donor recruitment program, a good gamete database or bank, and advanced selection tools for the classification and organization of donors. In this sense, clinics with Fenomatch can securely share this information to not only have better technology but to have access to more donors, and therefore be able to make a better selection.

Where do the egg donors come from?

We have to take into account that Spain is a country with a long tradition of donation, with blood and organ donation rates well above the average for European countries. This trend holds for egg donation, despite there being little financial compensation: approximately 60% of women who donate eggs state that their main motivation is to help other women.

More than 70% of Spanish donors have studied or are studying at University, and they are between 22 and 27 years old.

The most common profile of the Spanish egg donor is a university-educated woman between 22 and 25 years old. However, the profile can vary considerably between different cities and centers that have different strategies in terms of their donor recruitment programs.

In Spain, due to the anonymity of the donors and because it is the patient's medical team that has to choose the donor while maintaining their anonymity, it is not possible for a friend or sister to be the specific donor for the patient.

With regards to the origin of the donors, 84% of the donors are Spanish by nationality and reside in Spain.

How are donors in Spain qualified according to the law? What is the qualification process and what tests are involved?

Law 14/2006, of May 26th, on assisted human reproduction techniques establishes that the donation must be made anonymously, be voluntary, be informed and be unpaid. The donation of gametes in Spain implies that the confidentiality of all data related to the health of the donor provided to authorized personnel must be guaranteed, as must be the results and traceability of their donations.

The donor, despite being unpaid, receives compensation for physical discomfort, travel, and labour expenses derived from the donation process, provided that the amount does not imply an economic incentive. The average compensation to donors is €1,100.

Anonymity in Spain implies that the recipient and the donor cannot know each other either in the present or in the future. The donor selection in Spain, by law, is run exclusively by the recipient patient's medical team; the recipient patient is unable to see photographs or discover identifying data of the donor. Spanish law establishes that the medical team has the obligation to find the donor with the closest phenotype to the patient within the available donors. Of course, children born by egg donation can request information from the donor as long as it is not likely to reveal the identity of the donor. Furthermore, there are exceptions contemplated in the regulations by which it would be possible to disclose information about the donor in the event that this information is relevant to the health of the resulting born child(ren).

During the egg donation process, clear and exhaustive checks are carried out, including an evaluation of the general health condition of the donor, a gynecological examination and a psychological evaluation that must guarantee the emotional health of the donor. Once the suitability

of the donor is approved, serology tests (hepatitis, syphilis, HIV, rubella...), karyotype to rule out chromosomal abnormalities, and a carrier test are performed. The carrier test is a process that is performed by all fertility clinics in Spain with the aim of matching between patient and donor to reduce the probability of contracting genetically inherited diseases. Currently, the carrier tests carried out cover the 7 genes recommended by the Spanish medical associations, which are the most basic aimed at discarding donors, to the analysis of the complete exome.

Furthermore, egg donors must be between 18 and 35 years old, although the most common profile is that of a woman between 22 and 27 years old, and the maximum number of children born from the same egg donor is 6.

Is it possible to buy or get oocytes from an external egg bank outside of the EU and transport to Spain? Are there any legal aspects to be considered?

Nowadays, there is the possibility of freezing eggs, with success rates of the treatment very close to those of fresh cycles. This opens up the range of opportunities to be able to carry out donor treatments to create an egg bank that allows them to be transported and therefore improves efficiency in the search for the ideal donor.

These eggs must meet legal and quality requirements in each country, and if these requirements are compatible, we can talk about obtaining or importing eggs.

That being said, it must be considered that the transport of gametes is a very delicate activity, the different legislations of the countries are involved in the process to guarantee the safety of transport and strict compliance with the law, including the purpose to which that egg it is going to be dedicated or the origin in terms of the rights of the donor.

An example of this is the export of gametes from Spain to other countries. Any clinic must guarantee that it cannot be used for a surrogacy process, a process currently prohibited in Spain. The same happens in reverse, depending on the country from which it is imported, the competent authorities of each country must be guaranteed strict compliance with both the documentation for transport and the justification of the purpose of the gametes. Although being within the EU can make the process relatively easier, it is not easy at all and each case must be studied country by country.

Additionally, the requirements of each country must be taken into account within the reproduction process itself. For example, in Spain it is common to carry out carrier genetic testing on all donors, and the Spanish reproductive societies recommend a number of genes that should be reviewed. If such tests are not performed in another country, it will hardly make sense to import gametes from that country. This idea is repeated with a multitude of tests, assurance of quality of the gametes, etc...

Spanish law establishes that eggs can be brought from other countries as long as the following requirements are met:

- There is an authorization for the transfer by the competent health authorities in both countries.
- The receiving center of the samples must be a center authorized by the Spanish health authorities.
- Those responsible for the gametes have to authorize the transfer of personal information.
- The center of origin of the biological samples must adopt the necessary measures so that the personal information is protected during the transfer if it is carried out by third parties.
- A complete traceability of the process must be fulfilled by both centers, and the receiving center must identify itself and issue an acknowledgment of receipt of the sample.
- The transport must be carried out by a company specialized and certified in the transport of biological material.

Answering the question "can you bring eggs from other countries outside the EU?": Yes, but it is a very complicated process and there are many laws to consider depending on the country 'we are considering.'

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ROPA in Spain – a legal IVF option for same-sex female couples

By **Dr Yvonne Frankfurth**
Founder + Fertility Coach for Egg Donation abroad at repro-travel.com
Affiliate, ReproSoc/Reproduction SRI, University of Cambridge

New reproductive technologies have opened doors to alternative family models. One such technology is the so-called ROPA method which stands for "Reception of Oocytes from the Partner". This fertility treatment allows same-sex female couples to share motherhood right from the beginning of conception. Using ROPA, one woman provides the egg, which subsequently becomes fertilised with donor sperm; the other woman in the partnership becomes pregnant with the fertilised egg and gives birth to the child. The method is therefore often described as enabling lesbian couples to experience biologically shared motherhood.

Whilst prohibited in several countries, Spanish clinics have been using ROPA as a method of conception since 2007. According to Spanish law, women should be able to benefit from reproductive technologies regardless of their sexual orientation. Women in a same-sex relationship must be married or in a civil partnership to access ROPA treatment. In Spain they will both be considered the legal mothers of the child.

"Who donates the egg, who gets pregnant?"

A medical check-up of both partners is performed prior to ROPA treatment. Thus, the egg reserve, the quality of the eggs and the condition of the respective uterus are examined in both women. Based on this, the fertility doctor will recommend which of the two women is best suited as an egg donor and which is best suited as a recipient of the fertilised egg. Age often plays a role here; if a woman is much younger or under 35, she is usually preferred as the egg donor. Of course, however, the preference of the couple themselves is also factored into the decision of who will provide the egg and who will experience the pregnancy.

If both women have the prerequisites for egg donation and pregnancy, they can make the decision amongst themselves: Who should be the genetic mother (by means of egg donation) and who should be the biological one (by means of pregnancy)? Various aspects play a role in this decision-making process: age, individual preferences as well as practical considerations.

Here is an example of how a couple who travelled to Spain for ROPA made this decision. Tina, a 36-year-old woman living in London with her 33-year-old partner Laura, explains that due to a medical diagnosis it was clear right away who would provide the eggs and who would become pregnant: "I have had Turner syndrome since birth, which means that I have no eggs that can be used. However, when taking the right medication, I can still become pregnant and give birth to a child. That's why it was immediately clear that Laura would be the one providing the eggs. I am now pregnant with one of her eggs and it feels great. We are so grateful we can both become parents this way!" In this case, it was clear that Tina would not be able to provide the eggs. Other couples find it more difficult deciding who provides the eggs, and who becomes pregnant. For these couples, reciprocal ROPA might be a solution.

What is the "reciprocal ROPA cycle"?

If both women are healthy and thought to be

eligible for egg retrieval and pregnancy, what is called a "reciprocal cycle" can also be performed. In other words, it is possible to switch roles in ROPA. Thus, each woman can be pregnant once, and donate her eggs once. There are several Spanish fertility clinics that offer women the opportunity to do this at the same time. Each woman would then be pregnant with a child that is genetically related to their partner. However, sometimes there are medical reasons why a woman's eggs may not be viable, or where a pregnancy would not be advisable. In this case, reciprocal ROPA would not be possible.

Step by step: What is the treatment procedure for the ROPA method in Spain?

1. Health examination: The first step is to contact a Spanish fertility clinic that offers the ROPA method to lesbian couples. There you will have an initial consultation. Both women are usually tested for their suitability to donate eggs or become pregnant. This phase can take several weeks, depending on the tests which are performed. In Spain the karyotype analysis for genetic abnormalities is performed as a standard for egg donors. The results for this are usually available after a few weeks.

2. Search for a sperm donor: As soon as the doctor gives the "green light" from a medical point of view, the search for a suitable sperm donor can officially start. In Spain, sperm donors must remain anonymous. In this case, the future child will not be able to know the identity of the donor through the clinic. It is worth mentioning here that sometimes there are anonymous donors who register on online platforms, such as Ancestry and 23AndMe, so that possible donor-conceived children can find them on there.

3. Synchronisation of the cycles: For a fresh transfer, the cycles of both women get synchronised. It is however also possible to do ROPA without synchronising the cycles if the embryos are frozen before they get transferred to the woman intending to carry the child to term.

4. Hormonal stimulation and egg retrieval: One woman starts with the hormonal stimulation of the ovaries from day 1 of her cycle. During this time, several follicles mature, which contain the eggs. Then, after about 12 days, several eggs are retrieved, which are then fertilised with donor sperm. **Preparing the uterus:** The other woman, the intended gestational mother, is getting ready for the embryo transfer. To this end, she is given oestrogen so that the uterine lining builds up. Once her partner's eggs have been retrieved, the recipient normally also takes progesterone, which completes the preparation of the uterus for the embryo transfer and increases the likelihood for implantation.

5. Embryo transfer: Depending on

the number of eggs retrieved from the partner, the resulting embryos develop in a petri dish in the laboratory for 3 to 5 days. Finally, on day 3, 4 or 5, the clinician will transfer one of the embryos to the recipient (gestational mother). The success rate may be up to about 50% per transfer, but ultimately depends on a number of factors, amongst others, the quality of the egg.

6. Pregnancy test and ultrasound: It is recommended not to take a pregnancy test until 12 days after the transfer to exclude possible chemical pregnancies. If the test is positive, a blood test is usually done to confirm the pregnancy.

7. Shared motherhood: If everything goes according to plan, both women will become parents and each one of them will share a biological connection with the child, either through genes or gestation.

To conclude...

ROPA allows same-sex female couples to share biological and genetic motherhood. Many countries still prohibit lesbian couples to access fertility treatment; Spain in contrast has been offering treatments like ROPA to married same-sex female couples since 2007. When opting for ROPA you may therefore want to choose a fertility clinic in Spain, as these usually have many years of experience with this technology.

Furthermore, it can be helpful to book an independent coaching or counselling session before the treatment. Here you can reflect together with an expert on what having a family with shared motherhood and donor sperm means for you and for the child. Furthermore, you can think about how you want to tell others about the child's method of conception, and how and when you want to communicate this to the child in the future. Finally, as the family sociologist Susan Golombok (2021) summarised succinctly; more than the method of conception, it is above all love and honesty, which are most important for the parent-child relationship and the child's well-being (Golombok, 2021)

Sources:
Golombok, Susan. "Love and Truth: What really matters for children born through third-party assisted reproduction". 4 May 2021, Child Development Perspectives. ***https://srcd.onlinelibrary.wiley.com/doi/full/10.1111/cdep.12406***

"Which country, which clinic... and how long is the waiting time?", are questions that come up often. Dr Yvonne Frankfurth provides guidance for couples that consider travelling abroad for IVF to a European fertility clinic (www.repro-travel.com). With expertise and empathy, she provides up-to-date relevant information and personalised recommendations for intended parents seeking a clinic that best fits their individual circumstances.

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IVF in Spain – Pros, Cons, Costs & Availability

By **By Aleksander Wiecki**, CMO of IVF Media and Vice Chairman of The European Fertility Society

Patients from many countries for various reasons are looking for a location where they can be treated by means of assisted reproductive methods (ART). Spain is one of the most frequently chosen destinations for IVF treatment and is selected not only by patients from Europe, but also from the United States, Canada, and Australia.

What makes Spain the country of choice for IVF treatment?

1. Very experienced medical staff
2. Liberal IVF law and law referring to IVF with donor oocytes
3. Anonymous egg donation
4. A very large base of egg donors and sperm donors of various ethnicities
5. A large number of good, private clinics in the most popular cities
6. An extensive database of research centres - at universities - that educate doctors, geneticists, embryologists and other specialists in the field of IVF
7. Great location - allows you to combine your holidays with IVF treatment

The most popular cities chosen by patients for IVF treatment are Madrid, Barcelona, Alicante, and Valencia.

Availability of IVF treatment in Spain

IVF clinics in Spain

According to the report "Registro Nacional de Actividad - 2019-Registro SEF" published by SEF (Spanish Fertility Association), there are about 240 IVF clinics in Spain. Based on the information we receive from clinics and patients as part of cooperation on fertilityclinicsabroad.com and ferilityroad.com, approx 30-40 clinics specialize in treating patients from abroad. This means that the clinic staff speak different languages and the clinic is experienced and prepared to treat patients who come from abroad. The treatment of "remote" patients is different from the treatment of local patients - who can easily come to the clinic.

The age of the patient

In Spain, patients up to 50 years of age can be treated - in some cases it is possible to treat women up to 52 years of age. In the case of a male partner, there are no age restrictions in Spain.

Relationship with a partner

Spain offers treatment to married patients, single women and same-sex (female) couples. In the case of same-sex couples, the ROPA procedure is offered, which consists of collecting eggs from one of the patients, the so-called "known donor", fertilizing them with sperm from the sperm bank and transferring the embryos to the other female partner.

IVF treatment available

In Spain, most clinics offer all types of IVF treatment, including IVF with own eggs, IVF with donor eggs, ROPA, sperm donation, and embryo donation. Clinics also offer the possibility of collecting, freezing and storing oocytes. Most clinics offer advanced laboratory and diagnostic techniques.

IVF with donor eggs in Spain

Spain has become one of the most popular countries for IVF treatment with donor eggs. Clinics and doctors in Spain have extensive experience in

organizing this type of treatment. Spain is well known for its high availability of egg donors. A large number of egg donors in Spain affects the availability of treatment for patients - and thus reduces waiting times for finding a donor. Spain is also one of the few European countries that offers egg donors of various races and ethnicities. For example, in the Czech Republic - which is also very popular - the availability of donors is limited mainly to Caucasian women.

Anonymous egg donors

One of the reasons why the number of donors in Spain remains very high is their anonymity. According to the law, the donor remains anonymous and the patient who receives oocytes from the donor has no right to know her identity and appearance. In Spain, in accordance with the guidelines and recommendations of international infertility societies, e.g. ESHRE, ASRM, donors are selected for recipients - so as to ensure the greatest possible similarity - the so-called phenotype matching. This increases the likelihood that the child born from the donor eggs will be as similar in appearance to their birth mother as possible.
Anonymous egg donation is also the reason why many patients travel to Spain from places where donation is not anonymous - e.g. from Great Britain.

Are there any circumstances in which the donor identity can be revealed to the recipient couple or the donor-conceived child?

Yes, in case of severe genetically transmissible illness in which an analysis of the donor would be advisable, the geneticist can request the donor identity to be revealed.

IVF treatment costs in Spain

The costs of IVF treatment in Spain are among the highest in Europe, yet the popularity of this country is indisputable. In addition to cost, there are many other parameters that are important when choosing a country/clinic.

IVF with own eggs

The costs of IVF with own oocytes are on average around € 3,600 - € 6,700. Also, take into account preparation, visits, basic scans, egg retrieval and general anesthesia for the procedure, ICSI, blastocyst culture and embryo transfer.

IVF with donor eggs

The cost of an IVF program with donor oocytes is approximately € 5,900 - € 8,500 and includes preparation, visits, basic scans, donor eggs and donor compensation, ICSI, blastocyst culture, and embryo transfer.

Embryo donation

The costs of the donor embryo program are on average around € 3,000 - € 5,000 and include 1-2 embryos - usually at blastocyst stage and the embryo transfer.

Egg freezing

Women considering freezing their eggs face an average cost of between € 3,500 - € 4,700. This includes preparation, visits, basic scans, egg retrieval and general anesthesia for the procedure, oocytes vitrification and one year storage.

ROPA – Reciprocal IVF

For same-sex female couples, the average ROPA cost is € 5,000 - € 7,000 and it includes preparation, visits, basic scans, egg retrieval, ICSI, blastocyst culture, and embryo transfer.
The example costs above are given as average values showing the range of costs including basic services, techniques, procedures that allow one IVF cycle to be completed. Depending on the region and other factors, patients may find clinics in Spain that are cheaper and more expensive. Using the cheapest clinic is not always the optimal solution. Patients should rather look for clinics with average treatment costs - rather than the cheapest ones.
The above information on treatment costs is based on IVF ABROAD - PATIENT'S GUIDE, fertilityclinicsabroad.com.

IVF Success Rates in Spain

The effectiveness of IVF treatment in Spain in recognized clinics is similar to the European average. Indeed, in many Spanish clinics, the effectiveness of treatment is above average. Clinics in Spain report their success rates to the SEF (Spanish Fertility

Association), which also makes the data available to patients. Interestingly, Spain is one of the few countries in Europe where patients receive access to reports from individual clinics, and not only the collective reports.
Here you will find data on clinics in Spain published by SEF: https://www.registrosef.com/index.aspx?ReturnUrl=%2f#Publico19

IVF in Spain - Pros and Cons

PROS	CONS
Liberal IVF law	One of the highest cost of IVF treatment among popular countries in Europe.
High availability of egg donors of various ethnicities	Anonymous egg donation
Treatment options for female same-sex couples (ROPA)	Anonymous sperm donation
Experienced, professional medical staff	Few clinics display treatment costs on their websites
Recognized clinics in very good locations	
Broad experience in preimplantation diagnostics of embryos - PGT-A, PGM and others	
Possibility to combine vacation with treatment	

IVF treatment in Spain for patients from the UK

Most clinics in Spain that specialize in treating patients from abroad communicate in English - this applies to non-medical and medical personnel - including doctors and embryologists. Clinics are experienced and can advise on specific aspects of treatment that may prove problematic when the patient returns home - to the UK. These issues include purchasing hormone stimulation drugs, running hormone tests, and other services directly in the UK that are necessary for the next stages of treatment. Clinics are also knowledgeable about the naming and availability of prescription drugs - which may differ between Spain and the UK.
Not without significance is also the very good availability of flights from Great Britain to Spain - in particular to Madrid, Barcelona and Alicante.
Many clinics in Spain cooperate either with doctors or with clinics in the UK. As a result, they offer patients a smooth organization of treatment and save costs and time. Part of the treatment may be carried out in the UK, e.g. preparation for the IVF program and hormonal stimulation.

What are the differences in IVF treatment in Spain vs treatment in the UK?

- costs in Spain are lower than in the UK
- much better availability of egg donors
- ICSI is part of almost every IVF program in Spain (95%). In the UK, ICSI is only used when there is male factor infertility involved. In Spain, ICSI is not listed in the price lists as a separate item because this technique is considered standard in most IVF programs.
- excellent availability of IVF add-ons - and very extensive clinical experience in their use for individual patient groups.
- the costs of IVF add-ons in Spain are lower than in the UK.

Examples of costs of IVF treatment and additional procedures in Spain:

- Medical consultation: € 150 - € 250
- Sperm freezing: € 150 - € 350
- Embryo monitoring (all embryos within a cycle): € 300 - € 600
- Blastocyst culture: € 400 - € 600 included in basic packages in most of the IVF clinics
- Vitrification of (remaining) embryos and storage for 1 year: € 400 - € 900
- Frozen embryo transfer (surplus embryos): € 1,400 - € 2,500.

IVF in Spain - Final Thoughts

Spain is a very popular destination for patients who travel abroad for IVF, especially from the UK, France, Italy and Germany. Patients can choose from a wide selection of clinics. As a comparison, in the Czech Republic, which is also a popular IVF destination, there are about 10 clinics that specialize in treating international patients and in Spain there are approx 40. In many clinics in Spain the international patients account for as much as 60-80% of all treated patients - thanks to this, the quality of patient service is top-notch. Patient satisfaction is the clinics' priority.
There are a lot of resources where you can find information about clinics in Spain. You can read patient reviews in many places online but these should be treated with caution.
Information on clinics in Spain can be found, among others, on online forums, Facebook groups, and websites that help patients learn about treatment abroad.


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What should I avoid before embryo transfer?

Access full version online >

Here we share some of our fertility experts' answers.

Answer from:

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

In my opinion, there's nothing in particular that should be avoided before the embryo transfer. Of course, if you have been through an IVF cycle and your ovaries have been stimulated, plus you've gone through an egg collection, your ovaries could be bigger and more tender than usual. There could be a low risk of bleeding if you are too active, or you do an intense activity.

My advice is to get yourself in your best condition prior to (hopefully) pregnancy. Eat healthily, stay hydrated and don't do things that can reduce chances of success (for example: smoking, excessively exercising or taking recreational drugs).

Once you have started the stimulation stage of IVF until the embryo transfer, the recommendation is to avoid the risk of having complications such as bleeding, pain and bloating. In terms of increasing the efficiency of an embryo transfer, there is nothing special you can do.

Answer from:

Rami Wakim, MD FRCOG FACOG FICS
Gynaecologist, Consultant in Reproductive Medicine
Phoenix Hospital Group

One of the main things to avoid before the embryo transfer is stress. How best to avoid stress? Explore alternative therapies – meditation, hypnotherapy, acupuncture and other relaxation techniques. Find the best stress reducing activity for you.

Please also avoid having too much abdominal distension. Keep your diet light and no heavy meals. Eat small meals regularly.

Answer from:

Alpesh Doshi
Consultant Embryologist and Co-founder at IVF London

Usually there's no particular restriction on food. Of course, we always tell our patients that even during conception try and follow guidelines such as there are some amazing NHS websites about what you can eat and what you can't eat in pregnancy, so try and adapt that diet even during conception. In terms of Do's and Don'ts, we advise our patients not to have any hot baths after the embryo transfer. Do not wear any strong perfume or deodorant because embryos are very sensitive to such strong smells. The most important parameters are that after the egg collection, the patient needs to keep on taking their medications regularly, daily, on time but apart from that, there is absolutely no restriction whether that's from a food perspective or a lifestyle perspective. We do tell our patients do not engage with any heavy exercise – certainly post egg collection. Some gentle exercises are absolutely fine. On the day of embryo transfer, we say please take it easy. Again, no running the marathon! A nice walk, a gentle stroll and that's absolutely fine.

Answer from:

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

Before embryo transfer, there are two things

What should I avoid before embryo transfer?

women should take care of. First of all, it is very important to have a full bladder. Again, it is very important that the bladder is not completely full. What we usually advise our patients before the embryo transfer is to empty the bladder in the morning and then drink about 4 glasses of water. If the bladder is very full, this sometimes can cause problems during the embryo transfer and passing of the catheter.

Secondly, it is important to avoid sexual intercourse in the morning and the night before as orgasm can increase the contractions of the uterus. Regarding vaginal medication, at our unit, we do not have a problem with that, a patient can use it in the morning.

Generally, it is important to make sure that the patient is not stressed. Have a good night's sleep the night before. Avoid wearing perfume, especially alcohol-based perfume, because this can cause problems to the embryo during the procedure.

Answer from:

Marcel Štelcl, MUDr, PhD
Gynaecologist, Chief Physician
ReproGenesis

In my opinion, it's important to avoid stress prior to embryo transfer. Many patients are stressed because they expect some pain, etc. But in the majority of cases, it is not painful, and it is like a gynaecological examination. We sometimes need a full bladder for better performance of embryo transfer so I recommend not going to the toilet before embryo transfer.

Answer from:

Ali Enver Kurt, MD
Gynaecologist, Specialist in Obstetrics & Gynaecology Vita Altera IVF Centre

As far as we know, before the embryo transfer, there is only one contraindication and that's sexual intercourse, especially in the previous 24 to 48 hours. It is not allowed because in the semen there are some materials that can cause contractions in the uterus so we don't want that. So, in the 24 to 48 hours prior to embryo transfer, you must avoid sexual intercourse. The second and most important thing is to use the medications correctly.This is essential.

Regarding alcohol – one glass of wine won't hurt but don't finish the bottle! Try to relax and find stress-reducing activities that work for you. Avoid excessive exercise.

Answer from:

Arianna D'Angelo, MD
Gynaecologist, Consultant

In my view, there is no right and wrong answer to this question. People have to feel comfortable and have no regrets in the future. There is nothing that is actually extremely dangerous although you should avoid extreme exercise. It very much depends on whether this is a fresh embryo transfer or a frozen one. With the fresh embryo transfer, the ovaries are still swollen. Remember, you've just been through a procedure to retrieve your eggs. Therefore, it's best to avoid any strenuous exercise or anything that can put your ovaries at risk of rupture or torsion. Enjoy a gentle lifestyle during this period of time.

With the frozen transfer, there is not much to avoid. The ovaries should be perfectly fine, and there are no major risks. Because we do tend to do the embryo transfer with a full bladder, avoid going to the toilet just before coming for an embryo transfer. But other than that, there are no right and wrong things, it's what you feel comfortable with.

Answer from:

Carleen Heath, Clinical Embryologist, Dip. RC Path
Embryologist, Laboratory Manager
GENNET City Fertility

On the day of embryo transfer, avoid wearing strong body creams and perfumes as the scent of these can have negative effects on embryos within the lab. Also avoid skipping meals on the day. You may be required to drink an amount of water to fill your bladder for the procedure, so ensure you have something to eat as well.

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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:
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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/

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

Ovobank ID

Ovobank ID makes it possible to optimize egg donation treatments to the maximum thanks to its extensive donor database and its Ovotracker waiting list-free program, an advanced and rigorous system of transport, storage and traceability of samples.
Ovobank ID led by Enrique Criado and a team of professionals with more than 20 years of experience in human assisted reproduction techniques. Highly qualified embryologists and doctors who have developed their professional careers in laboratories in Spain, Italy and the United States.
Thanks to our success and experience in egg vitrification techniques made us become the first egg bank in Europe in 2013. Today, our high success rates have led us to create the Ovobank ID brand of donors with an open identity.

https://ovobankid.com

info@ovobankid.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

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/

Ferticentro

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

Dunya IVF Clinic

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

Pelargos IVF

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

EUGIN

Country: Spain
City: Barcelona

IREMA

Country: Spain
City: Valencia
https://www.irema.org/en/

UR Vistahermosa

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

FERTILITYROAD

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Northwood Crescent
Northwood, Santry, Dublin 9, D09C6X8
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https://fertilityroad.com/contact-us/