At the clinic

WHEN AT LAST YOU GET TO THE CLINIC, THE CHOICE OF TREATMENTS ON OFFER CAN BE BEWILDERING. MOST PEOPLE HAVE HEARD OF IVF, BUT THERE ARE OTHER TREATMENTS TOO. THIS SECTION WILL TELL YOU MORE ABOUT THEM, WHAT THEY INVOLVE AND WHETHER THEY COULD BE FOR YOU

Many people tell us that they feel a bit swept along by the process when they go to a clinic. It's important to feel that you are getting the most out of your consultations, and feel comfortable asking questions, or taking time out to think things through. There can be a lot of difficult issues to consider, as this section will show: decisions such as what to do with embryos not used for your treatment, or how to tell your child that they were conceived using donated eggs or sperm. Do remember that the clinic staff are there to help you make the right choice for you.

Even with understanding family and friends, you can feel isolated while you are having fertility treatment. That's why, throughout this section, we've asked people to share their experience of treatment with you and to offer advice on what they learned.

As well as thinking about treatment and the surrounding issues, you'll also find there's quite a lot of paperwork involved. This is because the clinic needs to make sure that you understand, and agree to, all that is involved in having treatment (see opposite).

Every patient longs for the moment when a pregnancy is confirmed. But some people find they have been so focused on treatment that they don't feel prepared for the actual pregnancy. There's more information on what to expect in this section.

Sadly, although treatment is becoming more successful, this is not everyone's experience. This section also looks at what to do if your treatment has not worked.

Finally, whatever the outcome of your treatment, we hope that you feel that your clinic has looked after you well throughout, both physically and emotionally. But if you are unhappy with your clinic, this section will provide suggestions for how to make a complaint.

Giving your consent

As with most medical procedures, you and your partner, if you have one, will have to give your consent to treatment.

You may wonder why there can be so many forms to fill in before treatment can even start but this is necessary to protect you and any child you may have. Fertility treatment is still relatively new and there are many ethical issues to consider.

The HFEA provides clinics with consent forms for different treatment options and you and your partner will have to sign the ones relevant to your circumstances. For your consent to stand, it must be written and it must be current (ie. you have not subsequently withdrawn it).

It is important that you fully understand the implications of the treatment to which you are giving your consent. Your clinic will offer you the opportunity to have professional counselling, which many people find helpful. Your clinic must also provide information about the procedures and processes involved in your treatment. There is no hurry, so do ask questions and make sure you understand this and take your time to reflect on it before you sign anything.

There are three different types of consent:

1. CONSENT TO:
Your fertility treatment
Basically this is no different to the form you have to sign for many other medical treatments. For example, if you are having IVF you will have to consent to egg retrieval and the transfer of embryos into your womb. Similarly, you will have to give consent if your treatment involves donated eggs, sperm or embryo transfer (see 3).

2. CONSENT TO:
Disclosure of information
Your clinic is not allowed to tell your GP or anyone else about your treatment unless they have your consent to do so. It is up to you to decide what information you allow to be disclosed and to whom.

3. CONSENT TO:
The use and storage of eggs, sperm and /or any embryos produced from them
The use could be for your own treatment, for the treatment of others if you are donating sperm, eggs or embryos, or for research. Storage relates to the freezing of sperm, eggs or embryos for future use.

As long as your eggs, sperm or embryos have not already been used in treatment or research, you can change or withdraw your consent by getting in touch with the clinic where they are being stored. Your partner or, if a donor was used, then the donor, may also change or withdraw consent at any time until the eggs,

sperm or embryos have been used in treatment. If consent is withdrawn by either party or a donor, the eggs, sperm or embryos may not be kept in storage or used in treatment.

You must also state what you would like to happen to these eggs, sperm or embryos if you were to die or become mentally incapacitated and therefore incapable of changing or withdrawing your consent.

It is important to keep in touch with your clinic. They will contact you six months before any eggs, sperm or embryos reach the end of their storage period, so it is vital that you let them know if your contact details change. If your storage period limit is up, the clinic is obliged by law to allow any eggs, sperm or embryos to perish, even if they have not been able to trace you first. If they do not comply with this, they risk losing their HFEA licence.

For more information about embryo storage, see page 36 and **www.hfea.gov.uk/ForPatients**

YOU ASK...

Can a man be registered as the father of a child conceived after his death?

Although rare, there are situations when a woman may want to have a child with her husband or partner, which is conceived after his death. For example, he may have had sperm stored prior to cancer treatment. A man can be recorded as the father of a child resulting from fertility treatment carried out after his death, as long as his consent is there in writing.

Licence to...

Fertility treatment is strictly regulated by law to protect you and your family. Under the Human Fertilisation and Embryology Act 1990, any treatment which involves mixing sperm and eggs outside the body, or using donated eggs, sperm or embryos, has to have an HFEA licence. It is illegal to create an embryo (embryo includes an egg in the process of fertilisation) outside the body or to keep or use an embryo without an HFEA licence.

In practice, this means that clinics need an HFEA licence to provide:

- in vitro fertilisation (IVF)
- donor insemination (DI)
- intra-cytoplasmic sperm injection (ICSI)
- gamete intra-fallopian transfer (GIFT) using donor sperm or donor eggs
- any treatment using donated eggs, sperm or embryos
- sperm, egg and embryo freezing and storage
- pre-implantation genetic diagnosis (PGD)
- pre-implantation genetic screening for aneuploidy (PGS)

Clinics carrying out the above treatments are regularly inspected by the HFEA. At present, IUI and GIFT using the patient's own eggs and partner's sperm don't require an HFEA licence. To find out more about the HFEA, how we regulate fertility treatment in the UK, and how you can provide feedback on your experience of treatment, visit **www.hfea.gov.uk.**

Drugs and surgery

A COMBINATION OF FERTILITY DRUGS AND SURGERY ARE OFTEN USED TO KICK-START TREATMENT EITHER BEFORE OR DURING IVF

FOR WOMEN

If you aren't ovulating (producing and releasing an egg each month) at all, or only sometimes, fertility drugs - which trigger egg production in much the same way as your body's own hormones - can help. This is known as ovulation induction. You may get pregnant using fertility drugs alone, but they are more often used with other treatments such as intrauterine insemination (IUI) and in vitro fertilisation (IVF). Read on for what to expect.

Ovulation-inducing drugs

Clomiphene citrate, usually known simply as Clomid, is the oldest and probably the most widely used fertility drug. Taken as a pill, it tells your brain that you are not producing enough oestrogen, which indirectly stimulates your ovaries into producing eggs.

What for Straightforward ovulation failure in women under 40.

Possible side effects Hot flushes, mood swings, nausea, breast tenderness, insomnia, increased urination, heavy periods, spot breakouts, weight gain. Some experts think your risk of ovarian cancer may increase slightly if you take it for more than a year.

Pituitary stimulators

Pulsed gonadotrophin-releasing hormone (GnRH), such as Gonadorelin, kick-starts the pituitary gland into action. A small battery-operated pump usually worn on your upper arm injects pulses of the drug directly into your bloodstream (hence the term 'pulsed'). This triggers egg production by mimicking your body's production of a hormone produced by the pituitary.

What for Ovulation failure resulting from a lack of the hormone GnRH.

Possible side effects Stomach pains, sickness and nausea, heavy periods and headaches.

Ovary-stimulating hormones

Drugs containing follicle-stimulating hormone (FSH) and/or luteinising hormone (LH) stimulate the ovaries to produce eggs. These include Gonal-f, Puregon, Menogon, Menopur and Merional. They are injected into a muscle or under the skin by your doctor at the clinic, your GP or practice nurse. Alternatively, you may be shown how to inject yourself at home. When the eggs are mature, you are given a single injection of the hormone human chorionic gonadotrophin (hCG) to trigger the release of an egg.

What for To stimulate ovulation before treatment cycles, or if you have polycystic ovary syndrome (PCOS) and your ovaries are not responding to Clomid. They are also used for infertility caused by failure of the pituitary gland and in some cases of male infertility.

Possible side effects Over-stimulation of the ovaries, known as ovarian hyper-stimulation syndrome (OHSS, see page 24); increased risk of multiple pregnancy (twins, triplets or more) when used for ovulation induction, allergic reactions and skin reactions.

During treatment, your doctor will usually prescribe other drugs for you to take at various times to give them more control over your treatment cycle. These may include:

Cycle-suppressing drugs

Drugs such as Goserelin and Burserelin copy the action of natural hormones that block the release of the two hormones controlling ovulation: FSH and LH. These are known as gonadotrophin-releasing hormone (GnRH) analogues. You take them as a nasal spray or as a daily or monthly injection before, or at the same time as, fertility drugs.

What for To stop the menstrual cycle.

Possible side effects Hot flushes, night sweats, headaches, vaginal dryness, mood swings, changes in breast size, breakouts of spots, acne and sore muscles.

Drugs that maintain pregnancy
Progesterone, for example Cyclogest, Gestone, Crinone or Progynova, can be taken after the injection of the pregnancy hormone, hCG, or on the day embryos are returned to the womb. You take them as a vaginal suppository, a pill, gel or by injection into the buttock.

What for To thicken the lining of the womb in preparation for nurturing a possible embryo.

Possible side effects Nausea, vomiting, swollen breasts.

FOR MEN

Drugs are not so important in the treatment of male infertility as they are in female treatment. However they may occasionally be prescribed in certain situations. These may include:

- Antibiotics to treat infection or inflammation
- Vitamins C and E to improve sperm movement, although there is no convincing evidence that this improves the chance of pregnancy
- Gonadotrophin injections or pump administration for certain rare conditions in which no sperm is produced
- Drugs that close the bladder neck when sperm are being ejaculated into the bladder instead of the penis (retrograde ejaculation)

Surgical options

FOR WOMEN

My tubes are blocked because of chlamydia. I have heard that an operation might help.

Surgery used to be popular when IVF and ICSI treatments were less advanced and available, but an operation can still help in some cases. Blocked tubes, caused by inflammation and scarring as a result of infections such as chlamydia, for example. Others include fibroids, endometriosis and other conditions affecting the womb or tubes.

These days, keyhole surgery is most often used. Your doctor at the fertility clinic will be able to advise on whether surgery is the best route for you and also if it is available on the NHS.

I was sterilised two years ago as I thought I didn't want more children. But now I have a new partner and we want to try for a baby. Can my tubes be repaired?

You can have an operation to rejoin the ends of the fallopian tubes. Success rates are higher if you were sterilised quite recently and if the tubes were clipped rather than tied. Keyhole sterilisation reversal (laparoscopic anastomosis) can also be done but is generally less successful than open surgery. Instead of the 10cm bikini line cut involved in traditional sterilisation reversal surgery, the surgeon makes a 1cm cut near your belly button through which a laparoscope (small telescope with camera attached) is inserted to allow the surgeon to rejoin the tubes.

FOR MEN

I have had a vasectomy but my partner and I now realise we would like to have another baby. Is it too late?

If you can't produce any sperm, for example, you may have had a vasectomy or a failed reversal, a small operation known as surgical sperm retrieval can be carried out to remove the sperm from the epididymis (where sperm are made) or the testicles.

PESA (percutaneous epididymal sperm aspiration) involves guiding a small needle through the skin into the epididymis to draw out a small amount of fluid containing sperm. TESE (testicular sperm extraction) uses the same method to remove a small amount of tissue from the testes. MESA (microsurgical sperm aspiration) uses a small needle to extract relatively mature sperm from the epididymis. The collected sperm can be used to fertilise the eggs by means of ICSI (see page 26).

Is treatment for varicocele a possible cure for male infertility?

Probably not. Until recently, it was thought that treating a varicocele (varicose vein of the testicles) in an infertile man would increase the chance of becoming fertile again. Studies have shown that after treatment, the sperm count and quality often improve. This was assumed to increase the chance of fertility. However, a recent large analysis of studies looking at this issue found that there was no good evidence to say that fertility is increased by treatment. If you are infertile, your specialist will be able to advise on current research.

YOU ASK...

Is the chance of having twins or triplets higher if you are taking fertility drugs?

The injected drugs used to stimulate ovulation do increase your chances of a multiple pregnancy and birth: twins, triplets or more. If you are taking fertility drugs with IUI, many doctors will cancel a cycle in which you produce a large number of follicles (egg sacs) as this increases your chances even more.

If you have IVF, the risk of a multiple pregnancy is limited by replacing one or two embryos.

IUI: Intrauterine Insemination

THIS IS A RELATIVELY SIMPLE FERTILITY TREATMENT WITH A PROVEN TRACK RECORD OF SUCCESS

Intrauterine insemination (IUI) involves inserting sperm into the womb to coincide with ovulation (when an ovary releases an egg) to increase the chances of conception. This treatment can be used where there is unexplained infertility, or if ovulation problems are identified. So what actually happens?

Is it for you?

The clinic may recommend IUI if:

- your sperm count is low or your sperm are poor movers (often referred to as having poor motility)
- your sperm are not surviving the journey through the cervical mucus (sometimes it can be too thick for the sperm to pass through) or because there are antibodies present that attack your sperm
- you are experiencing impotence or premature ejaculation.

YOU ASK...

Does IUI hurt?
This treatment is usually fairly painless although you may experience mild cramps similar to period pains. Very occasionally it may be difficult to get the catheter through your cervix, which can be uncomfortable, but your doctor should offer you painkillers to ease any pain.

How are sperm prepared?
Sperm are washed to remove the fluid in which they swim (seminal fluid) and prepared to select the healthiest specimens that are likely to be the most fertile. The sperm are then placed in the small tube or catheter to be inserted into the womb.

What to expect

FOR WOMEN

- If you are not using fertility drugs (known as an unstimulated cycle), IUI is done between day 12 and day 15 of your monthly cycle - with day one being the first day of your period. You are given blood or urine tests to identify when you are ovulating, or you can use an ovulation predictor kit.
- You may, however, need fertility drugs to stimulate ovulation (a stimulated cycle), which, if prescribed by your doctor, usually come as an injection and nasal spray (see page 18). Your eggs are tracked by vaginal ultrasound scans as they develop. As soon as an egg is mature, you are given a hormone injection to stimulate the egg's release.
- The sperm is inserted 36 to 40 hours later. The doctor inserts a speculum (a special instrument that keeps your vaginal walls apart) into your vagina through which they then thread a small catheter (a soft, flexible tube) into your womb via your cervix. Sperm, which have been previously prepared to select the healthiest ones, are then inserted through the catheter. The whole process takes just a few minutes. You may wish to rest for a short time before going home - ask your clinic what they recommend.

FOR MEN

- You will be asked to produce a sperm sample on the day the treatment takes place.

Donor insemination: Fresh or frozen sperm?

Donor insemination is the name given when donor sperm is used to fertilise your eggs. This can either be done at home using a home insemination kit, or in a clinic, using IUI.

If your treatment takes place in a clinic, the donor sperm will have been properly screened for infections such as hepatitis and HIV. This means freezing the sperm for several months.

If you are considering using fresh donor sperm for home insemination, it won't have been quarantined and so cannot be guaranteed to be free from infection.

If you are concerned about this, it is worth discussing it with your GP or a counsellor.

You may also wish to consult a solicitor because, where fresh sperm is used (outside a licensed clinic), the donor is considered by law to be the child's legal father, with all the responsibilities and rights that that involves.

For more information about using donated sperm, including the ending of anonymity for donors, see pages 29 to 33.

The expert says...

'IUI is one of the simple methods of helping couples with fertility problems. For unexplained infertility, IUI is usually the first line of treatment. This can be followed by IVF if unsuccessful.'

Success rating

The success rates for IUI using fertility drugs are around 15 per cent per cycle of treatment, provided that the man's sperm and the woman's tubes are both healthy. As with other treatments, IUI tends to be more successful if the woman is younger and, therefore, more fertile.

After the treatment you will be booked in by the clinic for a pregnancy test to see if the treatment has been successful. If it fails after several attempts, it suggests that there may be some underlying reason for your infertility and, depending on your age, your doctor may suggest you go on to try another treatment such as IVF. All things being equal, it would be reasonable to try three to six IUI treatments.

Our story: **Learn what you can about treatment**

Seeta, 33, and her husband Tahir, 40, had been trying for a baby for a year without success. Initial tests suggested PCOS, which later proved not to be the case. After treatment the couple, who live in Kilbarchan, Scotland, had their daughter, Hema. Seeta tells their story:

Treatment time

'I was initially diagnosed with polycystic ovary syndrome (PCOS) and then with unexplained infertility. We tried Clomid, which didn't work, and then were referred for IUI. After three failed cycles on the NHS, I conceived our daughter, Hema. The nurses were really good, friendly and kind and responsive to our needs. But there were a lot of frustrating silly little things which would wind me up, such as long waiting times at the clinic, meaning I got back to work late.'

Feelings

'We felt out of control because we were being told what to do and had no say in what we were offered. At first I thought that the drugs would work and then I hoped that IUI would work first time. When it didn't I got upset and found it difficult. Even though I had a fantastic pregnancy and sailed through it and the birth, I never let myself think any further ahead than I was at the time. As a result when Hema was born at 37 weeks we had bought very few clothes and equipment.'

'Coming from an Asian background, infertility is something that is not discussed openly although we ourselves didn't feel that there was a stigma. We told a few people outside our immediate family and friends and I distanced myself from some people who I felt were not supportive for a while.'

'We felt it was quite personal and didn't want everyone knowing. We didn't want to keep telling everyone if cycles failed at a time when we were still trying to get our own heads around it.'

'People think that because they got pregnant easily it's easy for everyone and they can come out with hurtful comments. Although unintentional, you are very vulnerable when you are going through treatment.'

Our relationship

'It was hard at times because both of us were in different places at different times. Talking through things brought us together and I would say it has made us stronger as a couple.'

Our tips

- Remember you are not alone. Once you tell people they often say, "I know someone who has been through that".
- Learn what you can about treatment. We knew very little when we first embarked upon it but as time went on we learnt a lot more. There's plenty of information about the technicalities, but nothing about how you are going to feel during or after treatment, or about complementary treatments. After the third attempt at IUI, I went to see a Chinese medical practitioner and had acupuncture and Chinese herbs. I also did yoga and we joined the west of Scotland support group, Cradle. This gave me some control back, which was great.

IVF: In Vitro Fertilisation

IN THE UK ALONE, APPROXIMATELY ONE BABY IN EVERY 80 IS BORN AS A RESULT OF IVF TREATMENT. IT HAS BECOME ONE OF THE MOST POPULAR TREATMENTS, BRINGING HOPE TO THOUSANDS OF COUPLES

IVF literally means 'fertilisation in glass', hence the familiar name of 'test tube baby'. Eggs are removed from the ovaries and fertilised with sperm in a laboratory dish before being placed in the woman's womb.

Is it for you?

The clinic may recommend IVF if:

- you are an older woman
- you have been diagnosed with unexplained infertility
- your tubes are blocked
- you have been unsuccessful with other techniques such as ovulation induction or IUI.

What to expect

FOR WOMEN

IVF involves several complex steps. Techniques differ from clinic to clinic but a typical pattern of treatment might go like this:

1 Boosting egg supply
At the start of your treatment your doctor gives you drugs to block the hormones your pituitary gland usually produces during your monthly cycle. This allows them better control over when your eggs are produced. You then take different drugs to make your ovaries produce more than one egg (see page 18).

2 Checking on development
Vaginal ultrasound scans are carried out to monitor your developing eggs. The clinic will also do blood tests to chart the rising levels of oestrogen produced by the eggs.

As soon as the tests show that the time is right, you will have another injection of a different hormone to help your eggs mature. Timing is crucial, as you must have this injection 34-38 hours before your eggs are collected - this may mean you having it last thing at night.

3 Collecting eggs
Eggs are collected by ultrasound guidance or, occasionally, by laparoscopy.

- **Ultrasound guidance** takes around 30 minutes and you are either given a drug to make you drowsy or a general anaesthetic. Using vaginal ultrasound to produce pictures on a screen, your doctor inserts a thin needle through your vagina into each ovary. They then guide the needle into each egg sac in turn, sucking the egg into it.

- **Laparoscopy** is done under a general anaesthetic. Your doctor inserts a laparoscope (small telescope with a light attached) through a small cut in your stomach followed by a fine needle to remove the eggs as before. Nowadays, it is rare for laparoscopy to be used.

4 Collecting sperm
Around the time your partner's eggs are collected, you produce a fresh sample of sperm. This will be stored for a short time before the sperm are washed and spun at a high speed, so that the healthiest and most active can be selected. If you are using donated sperm, the sample is taken from the freezer and prepared in the same way.

5 Fertilising the eggs
Your eggs are mixed with your partner's sperm and left in a laboratory dish for 16-20 hours before they are checked to see if any have fertilised. Any that haven't, or any that have fertilised abnormally, are discarded. The remaining embryos are then left for another 24-48 hours before being checked again.

6 Preparing for pregnancy
Two days after your eggs have been collected, you are given progesterone via pessaries, injection or gel to help prepare the lining of your womb.

7 Transferring the embryos
Two to five days after fertilisation, one or two healthy embryos are usually chosen and put back into your womb through your cervix via a catheter (a fine, thin tube). The decision about how many embryos are transferred is important because it affects not just your chance of conceiving but also your chance of having a multiple birth (see page 24). Remaining embryos may be frozen for future IVF attempts, if they are suitable (see page 36).

Success rating

It is often thought that IVF has a high failure rate, but the overall success rate for conception is about the same as in nature and sometimes better. The chances of you having a baby, though, are slightly lower as women may miscarry early on, just as in natural conception.

Female fertility diminishes with age, so if you are using your own eggs, the younger you are, the higher your chances of success. One in four women under 30 have babies after IVF, but only one in ten by the age of 40.

The expert says...

Although hugely popular, IVF is not the answer to all fertility problems and is only recommended where there is a genuine reason and/or because simpler methods have failed. For women over 40, IVF cannot overcome the decline in the number and quality of eggs that is part of the natural ageing process.

Further options

Blastocyst transfer

If you have good quality embryos but they fail to implant in the womb, your doctor may suggest you try blastocyst transfer. This allows your embryos to develop to what is known as the blastocyst stage before they are put back in the womb. A blastocyst is an embryo that has developed for five to six days after fertilisation by which time it has two different cell types and a central cavity. Allowing your embryo to develop for longer can increase your chances of a successful pregnancy.

Assisted hatching

Before an embryo can attach to the wall of the womb (known as implanting), it has to break out or 'hatch' from a gel-like shell called the zona pellucida. Some embryos have a tougher shell than others, which makes it more difficult for them to do this. Making a hole in or thinning this shell (using acid, laser or mechanical methods) may help embryos to 'hatch'. Some clinicians believe that the use of assisted hatching results in better pregnancy rates, while others feel there is still too little information to support its use. If your clinic suggests this treatment, do talk it through with them, asking why they are recommending it and what the perceived benefits will be in your case.

Our story: **We felt left out, not having a baby**

Kate, 37, a self-employed advisory teacher and her husband Rupert, 40, programme manager at a college of further education, live in Twickenham. They had their son, Louis, aged 18 months, after three attempts at IVF. Kate tells their story:

Treatment time

'After an initial diagnosis of unexplained infertility, we discovered that my problem might be PCOS-related. When our first attempt at IVF using ICSI, funded by the NHS, failed we decided to go to a private clinic where we had two more attempts.This time we were offered both ICSI and assisted hatching to help things along and I conceived Louis on the second attempt.'

Feelings

'Initially I experienced a deep sense of emotional disappointment as if I had been let down by my own body. Over the next nine years my emotions veered between defeat to determination, anger and resignation. Although we didn't feel there was any stigma attached to being childless we felt left out because we didn't have a baby.'

'We did not want to add to the taboo of infertility by not telling anybody. On the whole people were overwhelmingly supportive although there were a few who said foolish or hurtful things. We lost a few friends but collected a lot of godchildren! Although we love them, what we really wanted was our own children. My mum found it hard to know how to support me, but she found a helpline for relatives of people with infertility that was great.'

Our relationship

'Although it brought us closer together it put a strain on our daily lives. When it was clear that we would need IVF, we agreed I'd become a part time advisory teacher. Rupert didn't have such an option. If there is a plus point, it's the fact that we had learnt how to live with each other before we had children.'

Our tips

- Find emotional support. Fertility clinics are places of science and medicine rather than emotions. Find someone outside your relationship to offer you TLC.

  Make time to talk through all the stages of your treatment with your partner. Attend appointments together and go for coffee afterwards to talk. Listen to each other without judgement and be loving.

- You may not instantly bond with your baby. I was anxious during my pregnancy and didn't enjoy it. It took a couple of weeks to recover and fall in love with Louis.

IVF: In Vitro Fertilisation

YOU ASK...

I'm 35. Can I have IVF on the NHS?

As long as you are between the ages of 23 and 39, you should be able to have at least one cycle of treatment funded by the NHS. There are various criteria to qualify for funding, including if you or your partner have been diagnosed with a fertility problem or if you have been trying to conceive for at least three years, and do not already have children (see pages 10-11).

Our doctor is sending us to an IVF clinic that's miles away from where we live. Can I have treatment closer to home?

You may be able to have 'satellite' IVF which means that most of the early stages of treatment can take place at your local clinic or hospital. Only the actual placing of the embryos in your body is done at the IVF clinic.

The big advantage of satellite IVF is that it's less disruptive so you might not need to take time off work. You will also save the time, cost and energy of travelling backwards and forwards to the IVF clinic. Sometimes eggs can also be retrieved at the local unit and then taken to the IVF clinic in a portable incubator. This is known as 'transport IVF'.

You can find HFEA-licensed clinics with satellite or transport centres on the 'find a clinic section' at www.hfea.gov.uk.

What is natural cycle IVF?

Natural cycle IVF involves collecting and fertilising the one egg that you release during your normal monthly cycle. This avoids the side effects of fertility drugs (see opposite) and you are also less likely to have twins or triplets. And because your ovaries aren't being artificially stimulated, they don't need to rest after IVF. So should your treatment be unsuccessful, you can try again sooner if you wish.

Pregnancy rates are more or less the same as with conventional IVF over three to four attempts. It may be worth trying if your periods are fairly regular and you are ovulating normally, but you have blocked tubes or unexplained infertility. Not all clinics offer this treatment.

How many embryos should I have transferred during IVF?

Research shows that, for many women, limiting the number of embryos transferred during treatment to two reduces the number of multiple pregnancies, without causing a significant decrease in the pregnancy rate. This is why the HFEA guidelines say that clinics should transfer a maximum of two embryos to women under 40, while women who are 40 or over can have a maximum of three transferred.

Where donor eggs are used, the maximum number of embryos that can be transferred is two, regardless of the age of the woman having IVF. This is because the egg donors are fertile women who have to be under the age of 36.

Some clinics now offer the transfer of one embryo to certain women, normally those under 35 with a good chance of success, particularly if they are having blastocyst transfer (see page 23)

Why would I want to avoid a multiple pregnancy?

Although having twins may have some appeal because two children are an instant family, you need to bear in mind the increased risks and pressures associated with multiple births. If you are carrying more than one baby, the pregnancy and birth are more likely to have complications, both for you and for your babies. For more information, visit www.hfea.gov.uk/ForPatients.

Did you know?

Scientists and doctors took over ten years to develop IVF treatment. Louise Brown, who was born in July 1978 to a blaze of publicity, was the first ever 'test tube' baby.

Treatment reactions

Like all medical treatments, IVF has risks as well as benefits. These can include reactions to drugs and certain pregnancy problems.

Drug reaction

What it is: A mild reaction to fertility drugs.

Symptoms: Hot flushes, feeling down or irritable, headaches and restlessness.

What to do: Nothing. If symptoms don't get worse they usually disappear.

Ovarian hyper-stimulation syndrome (OHSS).

What it is: A potentially dangerous over-reaction to fertility drugs used to stimulate egg production. Cysts develop on your ovaries and fluid collects in your stomach. In severe cases (about 1-2 per cent) your ovaries become very swollen and fluid may fill the stomach and chest cavities. A fall in the concentration of red blood cells can lead to blood clots and blood flow to the kidneys may also be reduced.

Symptoms: Swollen stomach and stomach pains. In severe cases nausea and vomiting, severe stomach pains and swelling, shortness of breath, faintness and reduced urine.

What to do: OHSS is potentially very serious, so if you start to experience any of the above symptoms you must contact your clinic immediately. They may decide to stop treatment. If you are badly affected you may have to go to hospital as an emergency. For more information, visit www.hfea.gov.uk/ForPatients

Ectopic pregnancy

What it is: When an embryo develops in your fallopian tube rather than your womb. The chances of an ectopic pregnancy seem to be higher in women having IVF especially if they already have problems affecting their tubes.

Symptoms: Vaginal bleeding, low pregnancy hormone levels and, if pregnancy continues, miscarriage and a risk of the tube bursting.

What to do: You should have a pregnancy blood test to check for the pregnancy hormone, hCG. If you are pregnant you should also have a scan at six weeks to check for the baby's heartbeat and to make sure it is growing properly in the womb. Report any vaginal bleeding or stomach pain to the doctor.

Genetic testing

Several centres in the UK are currently licensed to carry out tests on embryos to detect certain inherited diseases and problems to ensure that only unaffected embryos are selected before being placed back in the womb.

Conventional tests for genetic diseases cannot be carried out until the 12th week of pregnancy so testing embryos before they are implanted could help you and your partner to avoid having to make the difficult decision of whether to have a termination (abortion) if either of you is the carrier of a genetic disease and the embryo is affected.

The tests are high-tech and therefore expensive.

Pre-implantation genetic diagnosis (PGD)

If you have had several terminations because your baby had a genetic disease or you already have a child with a genetic disease and are at high risk of having another, you might want to consider PGD.

It involves checking the genes of three-day-old embryos conceived by IVF for genetic diseases such as haemophilia and cystic fibrosis. There are currently ten UK clinics who offer this treatment.

How is it done?
In the laboratory, one or two cells are extracted from the embryo and are examined to see if they are carrying the culprit genes. Some genetic diseases, such as Duchenne muscular dystrophy, only affect males. In this case the cell is examined to find out the embryo's sex and only female embryos are replaced. This procedure is not allowed simply to ensure you have a baby boy or girl to balance your family.

Some serious or life-threatening genetic diseases may be treated using stem cells from a family member whose tissue is a genetic match for the affected person. Not all family members have the same tissue type.

In extremely rare cases, where no suitable donor can be found, parents of a child affected by a serious genetic disease may try to have a new baby in the hope that the blood from its umbilical cord, which is rich in stem cells, may be used to treat the existing, affected child. Their chances of having a baby whose cord blood may be used in this way can be increased by using PGD to identify embryos with a tissue type which matches that of the affected child.

This is a very complex and demanding procedure and may be used only where the condition of the affected child is serious or life threatening. The procedure must be authorised by the HFEA on a case-by-case basis.

For more information, visit www.hfea.gov.uk/ForPatients

Pre-implantation genetic screening (PGS)

If you are over 35, with a high risk of having a baby with a chromosome problem such as Down's syndrome, or have a family history of chromosome problems, you may want to consider PGS. It may also be offered if you have a history of recurrent miscarriage or have had several unsuccessful IVF treatments.

PGS involves testing embryos produced by IVF to make sure they have the right number of chromosomes. It is also called aneuploidy screening. Aneuploidy is where the embryo has the wrong number of chromosomes - for example, Down's syndrome, where there are three number 21 chromosomes instead of the usual two.

How is it done?
As for PGD, except that chromosomes are examined to see how many there are and if they are normal. There are currently eight UK clinics who offer this treatment (visit 'find a clinic' on the HFEA website for details).

Chromosome counts

Chromosomes are tiny structures found in the centre of each cell in the body. Each chromosome carries thousands of genes, which instruct your body how to work. Chromosomes are made up of two chains of genetic material called DNA. There are 23 pairs of chromosomes (46 altogether) in each of our cells, except for eggs and sperm, which each have 23 chromosomes. When these fuse together they create a single human being with the usual 46 chromosomes.

FURTHER INFORMATION
Visit www.hfea.gov.uk/ForPatients

ICSI: Intra-Cytoplasmic Sperm Injection

INJECTING AN EGG WITH SPERM CAN BE A SUCCESSFUL ANSWER TO MALE INFERTILITY ISSUES

Intra-cytoplasmic sperm injection (ICSI), which involves injecting a single sperm into the cytoplasm or centre of an egg, is the biggest advance in infertility treatment since IVF. It was introduced in 1992 and the next year the first UK baby from ICSI treatment was born. Over 4,500 babies were born in the UK during 2003/04 as a result of this revolutionary treatment for male infertility. So what actually happens?

Is it for you?

The embryologist will examine your sperm under a microscope and decide whether ICSI could increase your and your partner's chances of having a baby. It may be performed if:

FOR MEN

- your sperm count is very low
- your sperm cannot move properly or are abnormally shaped
- there are high levels of anti-sperm antibodies in your semen
- you and your partner have tried previous IVF treatment but few or no eggs have fertilised
- your partner has responded poorly to ovarian stimulation, producing few eggs of which few have been able to be fertilised
- Sperm has been retrieved directly from the epididymis (PESA or MESA) or the testicles (TESE) or, rarely, by electroejaculation.

What to expect

FOR WOMEN

You take fertility drugs to stimulate your ovaries to produce more eggs, which are collected on a certain day as for IVF (see page 22). These are then fertilised with your partner's sperm (see below) and replaced in your womb in exactly the same way as for conventional IVF. Any suitable embryos not used at this stage can be frozen for future use. After the treatment, your clinic will arrange a future date with you for your pregnancy test.

FOR MEN

You produce a fresh sperm sample on the same day as your partner's eggs are collected. Your sperm are then used to fertilise her eggs by injection before they are returned to the womb.

YOU ASK...

I've heard that ICSI can cause birth defects. Is this true?

As ICSI is still relatively new, there have been some concerns that injecting the sperm into an egg could damage it and lead to birth defects.

However, the first results from an ongoing study led by London paediatrician Dr Alistair Sutcliffe, published in July 2003, were encouraging.

The study compares 541 children conceived by ICSI and 440 by IVF with 542 who were conceived naturally. It showed that at the age of five, the ICSI and IVF children were doing just as well as the ones who were conceived naturally.

Another concern is that infertile men could pass on their infertility to their sons born through ICSI through their genes. There is no definitive answer to this yet.

As with all risks, it is worth discussing this with your clinic. You might also like to consider talking through your concerns and options with a counsellor or with other couples who have used ICSI.

For more information, see www.hfea.gov.uk/ForPatients.

The expert says...

'ICSI has helped many thousands of couples to have a baby, especially in instances of a man having a low sperm count or poor quality sperm. But as the reasons for a low sperm count can lie in the genes, which may be passed through the male line, a man should always have a check-up blood test before going ahead with ICSI.'

Success rating

ICSI can hugely boost your chances of conception as the sperm don't have to travel to the egg or penetrate it. Success depends a lot on the skill and experience of the clinic, but as the technique becomes more widespread, success rates continue to improve.
As with IVF, the younger the woman, the higher the success rate.
Age is less important for men as sperm are freshly made and only healthy sperm will be used for ICSI. The quality of sperm, however, does decrease as men age.

Our story: **Give yourself time**

Annette, 35, a civil servant and Alan, 39, a chartered surveyor from Rhondda in South Wales, had been trying for a baby without success for two years. Tests revealed that poor sperm motility could be the reason. Annette tells their story:

Treatment time
'We didn't really have any treatment choices because of Alan's problems with his sperm, so IVF with ICSI was our only chance of having a baby. After two unsuccessful treatment cycles we changed clinics and after a third cycle our twins Ffion and Lowri, who are now 14 months old, were conceived.'

Feelings
'The whole experience is emotionally and physically battering. I remember sitting at my desk feeling utterly drained and thinking "will I ever get over this?". I didn't realise it was going to be as difficult as it was. But it was all worth it in the end. We have two lovely little girls and despite all the ups and downs I'm now over the moon.'

'At first we didn't tell anyone except my mother and work colleagues who knew because I had to have time off work for the first couple of rounds of treatment. But when we were asked at a family party yet again, "when are you going to start a family?", we decided to be honest. Most of our family and friends were supportive. But there were some who said irritating things like "all you need is a weekend and a bottle of wine and you'll be fine."

Our relationship
'Going through treatment brought us closer together. When things were bleak we would think at least we've got each other. That's the main thing.'

Our tips

- Give yourself time to recover between treatments. I had the second treatment straight after the first and in retrospect, I wish I had given myself more time to recover.
- Stay positive. Our worst fear was that it was going to fail.
- Be aware how difficult you may find pregnancy. When I did conceive it was almost: "Okay it worked. Now what?" I didn't enjoy pregnancy and because the twins were born early I found it hard to get close to them. I suppose it was self-preservation - I didn't want to get too attached in case it all went wrong.
- Get some support. I wish I'd had more support when we first started out. We did get support from family and friends but unless you have been through it yourself you have no real idea how it affects people.

GIFT: Gamete Intra-Fallopian Transfer

GIFT IS ONE OF THE EARLIEST FERTILITY TREATMENTS AND IS STILL GOING STRONG TODAY

Gamete intra-fallopian transfer (GIFT) starts off with gametes (your eggs and sperm) being collected in exactly the same way as for IVF. The healthiest are chosen, mixed together and placed in one of the fallopian tubes (the tubes down which eggs pass from the ovaries to the womb). Fertilisation takes place inside the body, just as it could have done had you not had medical intervention. So what actually happens?

Is it for you?

FOR WOMEN

- GIFT can help in many cases of unexplained infertility, for example, when your fallopian tubes aren't blocked or damaged.

FOR MEN

- GIFT can help if you have a low sperm count or sperm with poor movement (low motility).
- Your doctor may suggest you try IVF to make sure your sperm can fertilise your partner's eggs. If successful, GIFT may be used in the next treatment cycle or cycles instead of repeating IVF.

Success rating

This varies across clinics, but around 25-30 per cent of women usually get pregnant in any one treatment cycle. Like most fertility treatments, GIFT is most successful in younger women.

YOU ASK...

Is GIFT licensed by the HFEA?

This treatment only requires a licence when donor eggs or sperm are used (see page 29).

What to expect

FOR WOMEN

Before proceeding with GIFT, you may be given a hysterosalpingogram (uterine dye test) and a laparoscopy to check your fallopian tubes are healthy and clear. Up to the point of egg collection, GIFT is exactly the same as for IVF (see page 22).

Your doctor will make a small 5mm cut in your tummy (under anaesthetic) so that they can insert a laparoscope (small telescope with a light attached) to view your womb and fallopian tubes. The healthiest one or two eggs are then mixed with the prepared sperm in a catheter (a fine, flexible tube). The doctor inserts the catheter to deposit the eggs at the end of one or both fallopian tubes, nearest the womb. You need a short rest before going home and will be given some progesterone, via injections, pessaries or gel, to build up the lining of your womb to provide a good environment for any fertilised eggs.

FOR MEN

You are asked to provide a sperm sample on the same day that the eggs are collected. If donor sperm are being used, they are carefully thawed before being mixed with the collected eggs.

Using Donated Sperm, Eggs or Embryos

NEARLY 2,000 CHILDREN ARE BORN EVERY YEAR IN THE UK USING DONATED SPERM, EGGS OR EMBRYOS. THERE ARE A NUMBER OF SITUATIONS WHERE THIS CAN BE APPROPRIATE AND CREATING A FAMILY IN THIS WAY CAN BE VERY FULFILLING

The decision to go down this route, however, is not a straightforward one. It is strongly recommended that you and your partner, if you have one, talk to an experienced counsellor and to other people who have chosen this treatment option before making any decisions to go ahead.

Before you begin

It is tough going through fertility treatment, but the decision to use donated sperm, eggs or embryos will have a far-reaching impact on you, your partner and your relationship with your respective families.

You will need to be sensitive to your own and your partner's feelings and to give yourselves time to think everything through. Don't rush into treatment - only go ahead when you feel ready.

Don't go it alone. Most clinics run local patient support groups. The Donor Conception Network is a national support network for people considering treatment using donor eggs, sperm or embryos, and for those who already have children conceived in this way (see page 44).

Pause for thought

- You may be considering using donated sperm, eggs or embryos because other fertility treatment has been, or is likely to be, unsuccessful. Coming to terms with this can be like coping with a bereavement. Give yourself time to adjust.
- If you have a partner, you probably wanted to have their baby, not that of another man and/or woman, so it's not surprising if you feel a sense of loss at losing that genetic connection.
- If you are single, you may be letting go of the hope of being a two-parent family, and having a partner with whom to share the parenting.
- You may feel guilty that your sperm and/or eggs cannot be used and feel that the fact you are now considering donation is somehow your 'fault'. You may also worry that your partner blames you for the situation.
- You may feel disappointed, sad, angry and/or afraid - and so may your partner. It can be difficult to see them struggling to come to terms with their feelings at the same time as dealing with your own. However, it can often help if you are able to talk things through as you each work through your feelings.
- Sometimes discussing things with each other only gets you so far. You will cope in different ways. Can you get support from friends or family? Or an experienced counsellor can often help.
- Remember: genetic connection isn't what makes for a loving family as many men and women who have had a child or children using donated eggs, sperm or embryos have proved. Many say that the joy of becoming parents is even greater because of everything they have been through together.

YOU ASK...

Will my baby look like me and/or my partner?

Your clinic can provide details about the physical characteristics of donors available. They will attempt to match donor and patient characteristics. But just as with naturally conceived children, there is no guarantee that your baby will closely resemble the donor. Some ethnic groups are under-represented in the available donated gametes or embryos. If you are from such a group, you may wish to consider finding your own donor.

Can the donor change their mind?

Both you as the person being treated and the donor must give written, 'effective' consent. Donors have the right to change their mind at any time in the process until their sperm, eggs or embryos are actually used in treatment.

Using donated sperm

Using donated sperm in your treatment is an option in some circumstances when using your partner's sperm would be unlikely to be successful, or if you do not have a male partner.

Is it for you?

This may be an option if:

FOR WOMEN

- you are single or in a same sex relationship

FOR MEN

- you are producing little or no sperm
- your sperm is unlikely to be able to fertilise an egg
- you have a high risk of passing on an inherited disease
- you have had a vasectomy

What to expect

The clinic may do a pre-pregnancy check, including: details of your and your family medical history; a physical examination; ultrasound scan and blood tests; blood sugar and blood pressure check. They may also run some tests to make sure that you are producing eggs and that your fallopian tubes are healthy.

Treatment takes place at the time you ovulate (when an egg is released from an ovary). Some clinics recommend fertility drugs to help maximise your chances.

Using Donated Sperm, Eggs or Embryos

An end to donor anonymity

Until April 2005, if you conceived using donated sperm, eggs or embryos, the donor could remain anonymous. However, the overwhelming view of donor-conceived adults these days is that children born as a result of donation should be able to find out about their genetic origins.

As a result, the law was changed and children born from sperm, eggs and embryos donated after April 2005 will be entitled to information about the identity of their donor once they are 18 years old. Except in certain limited circumstances, sperm, eggs and embryos from anonymous donors can no longer be used.

Once donor-conceived people reach the age of 18, they are entitled to apply to the HFEA to find out the following non-identifying information about their donor from the HFEA's register:

- physical description (height, weight, eye and hair colour, skin colour)
- year and country of birth
- ethnic group, and their parents' ethnic group(s)
- whether they were adopted
- marital status
- how many children they already have (if applicable) and the gender of those children
- details of donor screening tests and medical history
- any other details the donor may have provided, such as information about their occupation, religion, interests and skills, reasons for donating, and a goodwill message.

(If a donor-conceived person is planning to marry or start a family, they can contact the HFEA to find out if they are related to their potential partner.)

If the donor registered (or re-registered) after 1 April 2005, the donor-conceived person can apply for the following identifying information about the donor:

- name, and name at birth if different
- date and place of birth
- latest known address
- physical appearance
- the donor's ID number at the centre

For more information about the HFEA Register, and what information can be given to a donor-conceived person, their parents, and to the donor, visit www.hfea.gov.uk/ForDonors

Pause for thought

- How do you feel about using eggs, sperm or embryos from someone you don't know? It can help to find out as much as you can about the donor.
- How will you feel if your child decides to contact the donor when they are 18?

Looking to the future

One of the key issues to think about is what and how you will tell your child about the way they were conceived. Ideally, you will be able to talk openly about it from birth onwards. It is crucial that your child learns about their origins from you, and not from other people, so it is worth thinking about when it would be most helpful to introduce them to the idea - perhaps when they are asking questions about where babies come from, for example. Later, as they become more aware of the facts of life, you may want to give them a more detailed explanation.

If you, as the parent, are open about how your child was conceived, and treat it as normal, there is no reason they should feel any different to any other child. As they grow older, they will start to understand the implications, but if donation has been part of the family story for as long as they can remember this shouldn't be a problem. Some are likely to want to know more about their donor while others won't be particularly interested.

The Donor Conception Network publishes books and other materials to help you tell children about donor conception and it can be helpful to talk to and potentially meet other parents who have experience of sharing this information. Once a donor-conceived person reaches the age of 18, or earlier if they plan to marry, they can ask for information about their donor from the HFEA Register.

Using Donated Sperm, Eggs or Embryos

In donor insemination (DI), the sperm are put into a thin tube which is then used to place the sperm at the entrance to your cervix (the neck of your womb) or into the womb itself, using IUI (see page 20). After this you will be advised to rest for a while before going home. It is often possible for your partner to be with you - ask your clinic.

Success rating

As with all treatments using your own eggs, the younger you are, the greater your chances of success are likely to be. For women under 35, the success rate is around 14 per cent for each attempt. This falls to 8-9 per cent for the 35-39 age group and 4-5 per cent for those between 40 and 42.

The expert says...

'If the male partner has no sperm, or a very poor sperm count, and other treatments have failed, or when he risks passing on an inherited disease, we recommend DI. Where the woman has no fertility problems of her own, some couples prefer DI to ICSI as it avoids them having to go through IVF.'

YOU ASK...

We would like to have more than one child. Will we be able to use the same sperm donor in the future?

Yes, provided the sperm is available (this may not always be possible) and the donor's consent permits this. It is worth letting your clinic know that you may wish to use the same donor in the future.

We have a child conceived using an anonymous donor. If we have another child using sperm from the same donor, can he still be anonymous?

Yes. However, the donor can re-register to be identifiable any time now and in the future. If he does, then your existing child and any other children born from his donation will be able to obtain identifying information about him from the HFEA Register (see left).

How many other women can use the same donor as me?

A donor's sperm may be used to create up to ten families excluding their own. So your children may share a partial genetic link with children in up to ten other families.

Will I be considered for treatment if I don't have a partner?

Clinics have different eligibility criteria. It is worth checking these with your chosen clinic at the outset. By law, before the clinic treats any patient, they have to consider your potential baby's welfare (including "the need for a father" specifically mentioned in the 1990 HFE Act). If you do not have a partner, it is likely they will ask about your plans for caring for the child on your own.

I've heard there's a shortage of donor sperm in the UK. Can I get some from abroad?

Clinics can import sperm from abroad for your treatment but they must apply to the HFEA in advance to do so. Standards should be the same as for UK donors. For example, donors must provide identifying information (see page 30) and should have been screened to UK standards, etc. If sperm from abroad is used you need to think about what you will tell your child about this.

Our story: **A child has a right to know**

Judy, 52, and her husband Matthew, 42, have a son, Patrick, 12, who was conceived by donor insemination (DI). Judy tells their story:

Treatment time

'After two years of trying for a baby we went to our GPs and learnt that Matthew had no sperm. The GP suggested donor insemination (DI). I was pregnant after four treatments but miscarried at nine weeks. We went through another 20 treatments and several donors with no success and were about to give up when I became pregnant with Patrick.'

Feelings

'We were both upset but Matthew had more to come to terms with knowing that he would never have his own genetic child. Our initial reaction to DI was very negative. The idea of having somebody else's baby was appalling. There was a definite 'yuk' factor too. It took several years for us to realise that ultimately being a parent was more important than the genetic aspect.'

'We were anxious to keep the whole thing secret. It was only after going to the support group and hearing other people being so open about their experiences and fears that we began to tell family and close friends.'

Our relationship

'The whole process made us feel closer, although during counselling we were surprised to find that we were thinking rather different things about the effects of not having a child. Matthew's greatest fear was that I would miscarry again, while my worst fear was of a kind of emptiness that would stretch on into the future.'

Our tips

- Get support. After my miscarriage the clinic nurse, who was always incredibly supportive, suggested that we try the clinic's support group, which we found very helpful.
- Be open. We've always been open with Patrick about his origins and strongly believe that a child has the right to know where they came from. Be positive, be optimistic and keep communicating with each other.

Using Donated Sperm, Eggs or Embryos

Using donated eggs

Is it for you?

This may be an option if:

- you have no ovaries or have had them removed
- you have had cancer treatment which has damaged your ovaries
- you are post-menopausal
- you are producing few or low quality eggs
- you have tried to conceive unsuccessfully using fertility drugs or IVF
- you have had several recurrent miscarriages
- you have irregular periods caused by hormonal imbalance
- you have a high risk of passing on an serious inherited disorder (see also genetic screening, page 25).

What to expect

FOR WOMEN

You and your donor's menstrual cycles are synchronised and your womb is prepared to receive the eggs. The eggs are collected from your donor and mixed with your partner's or with donor's sperm. Alternatively, the sperm can be introduced directly into the eggs (ICSI, see page 26) to fertilise them. When the embryos begin to develop, they are transferred to your womb as in standard IVF (see page 22). Occasionally eggs and sperm are transferred together before fertilisation takes place (GIFT, see page 28).

FOR MEN

Unless you are using donor sperm, you will give a sperm sample to check that your sperm are healthy and active. On the day that the eggs are collected you give another sperm sample which is mixed with the donor eggs or introduced directly into the to fertilise them. Occasionally eggs and sperm are transferred together before fertilisation takes place (GIFT).

Success rating

There is an average 25 to 40 per cent success rate for each treatment using donor eggs. This is slightly higher than the average success rate for conventional IVF across all age groups, as donor eggs must come from someone aged 35 or under.

YOU ASK...

How do I find donor?
Some clinics may offer to put you on a waiting list for an egg donor - do ask them about how long they would expect you to wait. There are some ways you can speed up this process:

- You can advertise for an egg donor.
- You can ask suitable friends or relatives.
- Some clinics enable you to 'share' eggs. This is when another woman receiving treatment donates some of her eggs for you to use (provided enough are collected).

If I'm using donated eggs, who is the legal mother of any children born?
The woman having treatment is considered by law to be the baby's mother, not the woman who donated the eggs. If the woman who is treated has a husband or male partner who gave his consent to the treatment, he is considered by law to be the baby's father.

The waiting list for donor eggs in the UK is too long - should I go abroad for treatment?
The HFEA inspects clinics in the UK regularly, and licensed clinics have to abide by the HFEA Code of Practice. We do not regulate clinics in other countries. These may be subject to local standards and regulations, which vary from country to country. You should find out more about the standards of treatment you can expect from a clinic you are considering. Egg donation is not without risk for the donor. In the UK, donors are not paid and are required to give informed, written consent. They must also be offered counselling and provide information about themselves. This is not standard practice outside the UK. Ask the clinic about their egg donor recruitment processes, and what information about the donor will be available to you and to any child born from the donation. In the UK, the egg donor has no legal responsibility or rights in respect of children born as a result of their donation - this may not be the case in other countries, so you will need to seek independent legal advice.

Can I be treated in the UK using donated eggs from abroad?
Eggs, sperm and embryos can be imported from abroad, but this requires an import direction from the HFEA. Imported sperm, eggs and embryos must have been obtained under conditions comparable to those in the UK; for example, the donors should have been screened. Each application is looked at by the HFEA on a case-by-case basis.

Using donated embryos

Is it for you?

This may be an option if:

- you, your partner, or both of you have the sort of fertility problems that mean you are less likely to be successful using your own sperm and/or eggs
- you or your partner both have a serious condition that would be inherited by any children you have and you wish to avoid passing it on, such as Huntington's disease (see page 27)
- you are single and post-menopausal

What to expect

You have IVF treatment in the same way as if you were using your own frozen embryos (see page 39). The physical characteristics of the donors can be matched as closely as possible with those of yourself and your partner.

YOU ASK...

What happens if I want to use embryos from abroad?
If you want to import embryos back to the UK for treatment, this must be authorised by the HFEA and will be considered on a case-by-case basis.

Who donates embryos?
Most donated embryos are from people who have completed their treatment. If their treatment has been successful, there will be brothers or sisters to your own child. Some couples donate embryos they cannot to use in their own treatment and which they do not wish to freeze.

Using Donated Sperm, Eggs or Embryos

Becoming a donor

There are many reasons to become a donor. You might want to help others or, if you have children of your own, you might want others to have the opportunity to be a parent. Your decision will have an important impact on the people who receive your donation, on any children born as a result and on you. It's important to think carefully about how you feel now and how you may feel in the future.

Donating sperm, eggs or embryos is very different to donating organs or blood. You are potentially creating a new human being. You will have a genetic link with any child created. The clinic will offer you counselling before you go ahead. This gives you a chance to discuss what is involved and consider future implications. You may also wish to contact the National Gamete Donation Trust (see page 45).

- How do you feel about donating when you don't necessarily know if a baby will be born as a result?
- How do you feel about the child finding out who you are and possibly wanting to meet you?
- How do your partner and your family feel about you donating?
- How do you think you will feel in the future knowing that children who are genetically related to you are being brought up by other people?
- How might a child you already have feel knowing that they have a brother or sister somewhere, conceived as a result of your donation?

Donating sperm

The HFEA has rules for clinics on selecting sperm donors to help to ensure they are healthy. Obviously this cannot be completely guaranteed. Our criteria are:

- Donors have to be between the ages of 18 and 45. Over the past ten years, the average age has increased to between 36 and 40 and many donors already have children of their own.
- Donors must be offered counselling and are encouraged to think about the implications of donation.
- All centres offering sperm donation have to freeze donated sperm samples for six months. This allows time for the donor to be tested for infections such as hepatitis and HIV. Provided the donor doesn't show any signs of these diseases or of some other, potentially inheritable, conditions, the sperm can then be used.

Donating eggs

You have the right to decide whether you want your eggs to be used for treatment or for research (or both). You also have the right to say your egg can only be used by a particular woman (a friend or relative, for example).

Your egg supply is boosted and eggs collected in the same way as for IVF (see page 22). To avoid becoming pregnant yourself, you are advised to avoid unprotected intercourse during the time you take fertility drugs, and until after your first period following egg collection.

Egg sharing

If you decide to share the eggs collected for your own IVF treatment with another woman, you are also classified as an egg donor.

As with other people donating eggs, sperm or embryos, there are many difficult emotional and social issues to consider, which have been covered elsewhere on these pages. In addition, you should consider:

- How might you feel if your eggs make a baby for another couple but not for you?
- Who are you going to tell about your decision to donate? If you feel that you can't tell anyone, this could be a sign that donation isn't for you.
- How might you feel if a child born from your donated eggs wished to make contact with you when they are 18? How might this affect you and your family - including a child born to you and who is also genetically related to the donor-conceived person?

Donating embryos

If you have completed your family or decided to call a halt to IVF, you may wish to donate any remaining embryos to another person or allow them to be used in treatment. Of course this is your decision, and your embryos can only be used in this way if you give your consent to this in writing.

If you donate your embryos to another person or couple to be used in treatment, the same rules on donation apply as to donating sperm or eggs. This means that any child born from your donation will be able to find out identifying information about you when they reach adulthood (see page 30).

- How do you feel about your embryos making a baby for another person or couple? If your eggs and your partner's sperm were used to create the embryos, the children born from them will be genetically yours.
- Who are you going to tell about your decision to donate? Particularly if you have a child born from the same batch of embryos, what are you going to tell them about possible brothers or sisters they may never meet?
- How might you feel if a child born from your donated embryos wishes to make contact with you, and possibly your children, when they are 18?

YOU ASK...

What if I change my mind after donating?

Both you and the person being treated will need to give your written, 'effective' consent. You have the right to change your mind at any time in the process until your sperm, eggs or embryos are actually used in treatment.

What legal responsibility do I have for a child born from my donation?

Any child born from your donation is the legal child of the woman treated and her husband or male partner, if she has one. You have no legal rights or responsibility for the child born. However, since the lifting of donor anonymity (see page 30), identifying information about you will be held about you on the HFEA Register and may be given to any people born from your donation once they are 18 years old.

If you are considering donating fresh sperm for use in treatment outside a clinic (for someone to use for home insemination, for example), you are considered by law to be the father of the child, with the rights and responsibilities this involves. We strongly recommend only donating sperm through a clinic.

How much will the clinic pay me for my donation?

UK clinics do not pay donors, but you can ask for reasonable expenses you incur when donating to be met. This includes compensation for loss of earnings while donating to a daily maximum of £55.19, up to a total of £250 for each cycle of egg or sperm donation.

Surrogacy

SOMETIMES, ASKING SOMEONE ELSE TO HAVE A BABY FOR YOU MAY BE YOUR ONLY REAL OPTION, BUT IT'S NOT SOMETHING YOU SHOULD CONSIDER LIGHTLY

Is it for you?

You may want to consider surrogacy if:

- you have a medical condition which makes it impossible or dangerous for you to get pregnant and give birth
- you have been unsuccessful with IVF.

Surrogacy is when another woman carries, and gives birth to a baby for you. You and your partner (if you have one) are known as the 'commissioning couple', while the woman who carries and gives birth to your baby is the 'surrogate'.

It's vital that both parties are fully committed to the arrangement and that you understand the implications of what is involved now and in future years. This is why it is so essential to talk these through with an experienced counsellor before you start the surrogacy process. You will also need to get legal advice before starting out (see panel opposite).

If you are going through a fertility clinic, both you and your partner (if you have one) and the surrogate and her partner (if she has one) will have to undergo the same processes as if you were all starting any fertility treatment. This includes a 'welfare of the child' assessment (see page 13) and screening of donor eggs and sperm if applicable.

What to expect

There are two ways of having a baby with a surrogate:

1. You can use sperm from a male partner, if you have one, and the surrogate's eggs. In this case, fertilisation is usually done by artificial insemination or by IUI (see page 20). This is called full surrogacy (sometimes also referred to as traditional or straight surrogacy).
2. You can use your own eggs and your partner's sperm, or donated eggs inseminated with your partner's sperm. This involves IVF (see page 22) which must take place in a licensed clinic. This is called partial surrogacy (also referred to as gestational or host IVF surrogacy).

Pause for thought...

- What are you going to tell your family, friends and colleagues?
- How are you going to feel about another woman carrying your baby?
- How confident and trusting do you feel about the surrogate?
- How do you feel about the possibility of the surrogate having a multiple birth?
- If you or the surrogate already have children, what are you going to tell them about the pregnancy and new arrival? How will you prepare them, and deal with their questions and possible anxieties or jealousy?
- If the surrogate is a friend or family member, how will you feel about them seeing you bringing up the child they have carried?

A matter of law

Surrogacy is a very complicated legal area, which is why we recommend that you seek advice from a solicitor before making any decisions.

The legal mother of the child at birth

The surrogate, as the woman giving birth, will be the legal mother of the child and will be put on the birth certificate until you have applied through the courts for a parental order or adoption. Then legal parentage is transferred to you, or to you and your partner as a couple.

The legal father of the child at birth

Usually the surrogate's partner or husband will be the legal father of the child and will be put on the birth certificate. In Scotland, it is possible for your partner to be named on the birth certificate, giving him legal parentage. Otherwise, you will have to apply through the courts for a parental order or to adopt the child.

Parental order or adoption

You may only apply for a parental order if you and your partner are married, domiciled in the UK and if the child is genetically related to either one or both of you. To apply for a parental order, the surrogate and the father of the child must consent unconditionally to this being made, and the order must be applied for within six months of the birth. You will need legal advice on applying for a parental order.

If you cannot apply for a parental order, your only option is to adopt the child. In such circumstances, the clinic would be breaking the law if they went ahead and provided treatment before being satisfied that a registered adoption agency is involved in the process (a requirement under the Adoption and Children Act 2002). Again, you will need to seek legal advice on adoption.

YOU ASK...

How can we find a surrogate?

It is illegal for a clinic to find a surrogate for you, so you will need to do this yourself. A relative or friend may be willing to help or you may prefer to find a surrogate who is not already known to you. It's worth talking to other people who have experience of surrogacy to learn how they found their surrogate. By law, you are not allowed to advertise.

What should we look for in a surrogate?

Trust is vital, not least because you will need to agree on issues like antenatal testing - for example, for spina bifida or Down's syndrome - and decide what you will do if the baby had a congenital problem. Of course, any potential surrogate should be capable of a safe and healthy pregnancy and birth.

Do we have to pay the surrogate?

No. In some parts of the world surrogates are paid but this is not allowed in the UK. You can pay 'reasonable expenses' - costs incurred by the surrogate such as clothes, travel expenses and loss of earnings.

What if the surrogate mother changes her mind?

It doesn't happen often but she does have the legal right to change her mind, even if the baby is not genetically related to her. This is extremely difficult and painful for everyone concerned, which is why it is so essential that you trust each other and are clear and committed to your arrangement from the outset.

Our story: **Ginny and I hit it off right away**

Mel, 38, and her partner Christopher, 45, have five children aged between 11 and 19. She had IVF to become a surrogate mother to Bruno for Virginia and Ian. Mel tells their story:

Treatment time

'Ian and Ginny's sperm and eggs were used to create embryos and they were placed in my womb by IVF. I became pregnant on the second cycle. We had planned a home birth but Bruno was ten days overdue so I ended up being induced at a local hospital. Ginny caught him as he was born and they stayed with him while I went to the ward.'

Feelings

'I have always wanted to become a surrogate. I get the most enormous pleasure from my own children and for someone to have the possibility of having children taken away from them seems so unfair. Ginny and I hit if off right away. Barely a day goes by when she doesn't text me a photo of Bruno. We talked and talked before deciding to go ahead. From the outset it was always their baby but of course you do bond with them; there's no way you can't especially towards the end of pregnancy and there was a bit of sadness there when I handed him over. But all in all it has been the most rewarding experience. I feel hugely privileged to have carried their baby and to think that I have changed the future history of their family.'

Our relationship

'My partner and kids were fully behind me all the way. He looked after me throughout the pregnancy and was there for the birth. I couldn't have done it without him.'

Our story: **As I held Bruno in my arms, it felt right**

Virginia, 39, and her husband, Ian, 38, already had two children but longed for another. However, Virginia has a disease of the womb called Asherman's syndrome. After four operations to try and put things right they learnt the only option of having their own baby was host surrogacy.

Treatment time

'I had two cycles of stimulation and egg collection at a centre which supported surrogacy. We decided we would do three cycles and then decide whether to carry on trying but on the second attempt Mel became pregnant.'

Feelings

'The pregnancy felt quite surreal. After going through so much I couldn't let myself believe we were actually going to have a baby. It did feel odd someone else being pregnant with our child. Until I held him in my arms I couldn't quite believe it but Mel was fantastic, she really made us feel a part of it from the start. The birth was the most amazing experience. As soon as I held Bruno in my arms it felt right. Mel always made it clear that he was not her baby but we were respectful of the enormous part she had played. We want Bruno to be proud of being a surrogate baby. We will stay in touch with Mel and she will always be in our minds as Bruno grows up. I want her to be proud of us and the way we bring him up. She's a real inspiration.

Our relationship

'We were totally committed to surrogacy and our relationship with Mel and her family. IVF and surrogacy are an emotional rollercoaster. You need a strong relationship at the outset. Coming through this has made us even stronger.'

Our tips

- It's vital that there is absolute trust between you. I never doubted Mel.
- Get support. It's stressful, both emotionally and physically. We could not have survived it without the support of friends and family.
- Go to a clinic that supports surrogacy. We took time to choose one. It's also important that the hospital where the baby will be born is understanding.
- Don't go it alone. Get advice and support. We chose the organisation Surrogacy UK because we found the message board and regular get-togethers invaluable. We went to a mediation session to go through everything involved.
- Never give up on your dream.

Freezing and storing embryos

IF SOME OF YOUR EMBRYOS CREATED DURING AN IVF CYCLE ARE NOT USED YOU CAN HAVE THEM FROZEN AND STORED FOR USE AT A LATER DATE

During IVF treatment, your ovaries may be stimulated to produce more eggs than usual, which means that you may end up with more healthy embryos than you can use. Under HFEA rules, clinics can only transfer a maximum of two embryos if you're under 40 and three embryos if you are 40 or over (and using your own eggs). This is designed to reduce the risk of multiple pregnancy (giving birth to twins, triplets or more).

Most clinics will give you the chance to freeze and store suitable 'spare' embryos for future use. This can be as part of the IVF or ICSI package, or as an extra service for which you may have to pay. Your embryos may also be able to be stored for future use if your planned treatment needs to be cancelled after egg collection - for example, if you have over-responded to the drugs (see page 24).

Is it for you?

If you store your embryos it means that if you decide to have another go at IVF you don't have to go through the expensive, and sometimes difficult, process of egg stimulation and collection all over again. It also means you don't have to take fertility drugs that put you at risk of ovarian hyper-stimulation syndrome or OHSS (see page 24) and you can maximise your chance of conception from one egg collection.

Making decisions together

Before your embryos can be stored, the clinic asks you and your partner to sign a form agreeing to their freezing and storage. This includes how long you want your embryos stored for, how they may be used and what you want to happen if one of you dies or becomes incapable of withdrawing your consent.

Storage times

Embryos can normally be stored for up to five years, though this can be extended under certain circumstances (see below). You can change your mind at any time, in which case you should let the clinic know about your decision. While the embryos are in storage, the clinic should contact you regularly to check that you want them to remain in storage. Don't forget to let the clinic know if you move, or if your circumstances change in other ways,

for example, if you split up or divorce. Should you divorce, this does not automatically mean that either person's consent is withdrawn.

Towards the end of the storage period, the clinic will get in touch and ask you what you wish to do next, such as extend the storage period, allow the embryos to perish or donate them for research or to another patient.

In certain situations you may be allowed to store your frozen embryos for up to ten years. For example, if you or your partner have been diagnosed as infertile and are likely to want to use your embryos for future tries at IVF or if you are at risk of having a child with a genetically inherited condition.

Very occasionally, you may be allowed to store your frozen embryos for even longer than ten years, for example, if you or your partner become infertile as a result of cancer treatment. In this case the embryos cannot be stored once you reach 55 (unless you turn 55 during the first five years of storage).

The freezing process

Only embryos which are developing normally and have not fragmented are suitable for freezing. Before your embryos are stored they are frozen in a vat of liquid nitrogen.

The medical term for this is cryopreservation, from the Greek word cryo meaning cold. A special liquid called a cryoprotectant is added to protect the embryos against freezer damage.

Even when great care is taken, however, some embryos do not survive freezing and thawing. This is why, when it comes to your next treatment cycle, you may be advised to have more embryos thawed than can actually be transferred.

Both of you will need to consent again to any future use of your embryos.

Donating your embryos

Alternatively, if you have completed your family or decided to call a halt to IVF, you may wish to donate your embryos to another person or allow them to be used in research. Of course this is your decision, and your embryos can only be used in this way if you give your consent to this in writing.

If you donate your embryos to research, they could be used in studies to help IVF technology, or in stem cell studies.

For more information about research projects licensed by the HFEA, visit www.hfea.gov.uk.

If you donate your embryos to another person to be used in treatment, the same rules on donation apply as to donating sperm or eggs. This means that any child born from your donation will be able to find out identifying information about you when they reach adulthood (see page 30).

YOU ASK...

We want to have another go at IVF using our frozen embryos. What are our chances of success?

Your chances of having a baby using a thawed frozen embryo are slightly lower than with a fresh embryo. The good news is that your chances of becoming pregnant with a thawed frozen embryo are not affected by how long the embryos have been stored.

What happens when we want to use some of our frozen embryos?

It all depends on why you need fertility treatment and what your doctor advises. If your periods are regular and your clinic offers treatment every day, your doctor may suggest using a natural cycle. In this case, ultrasound scans may be used to check your developing eggs and urine or blood tests to check when you are ovulating (releasing an egg). This means your doctor can thaw and replace the embryos when the lining of your womb is at its most receptive.

If your periods aren't regular, or you don't have them at all, your doctor may suggest you use drugs to dampen down your natural hormones and trigger a 'false' period. You are then given progesterone to help prepare your womb for an embryo. The embryos are then thawed and replaced in the womb (see page 22).

What happens if my partner or I withdraw consent? Who do the embryos belong to?

The law states that if either of you withdraws consent, the clinic has to remove the embryos from storage. Under HFEA rules, the clinic must inform both parties that this is about to happen, either by telephone or in writing. This is why it is so important to let your clinic know if your contact details change.

Wasn't there a high profile mix-up with some frozen embryos, which led to a couple having another couple's baby? Could this happen to us?

It is very unlikely these days. All clinics have a system for double-checking the couples being treated and the identity of the eggs, sperm and embryos throughout the culture process. Before embryos are transferred, the woman's identity is also double-checked. The HFEA's Incident Alert System, which was introduced after this mix-up occurred, means that licensed clinics can share any lessons they have learnt from actual incidents or near misses to keep reducing the risk of anything like this happening again.

If you become pregnant

MAKING THE SWITCH FROM BEING A FERTILITY PATIENT TO A MUM-TO-BE MAY NOT BE AS EASY AS YOU IMAGINED. BUT THERE ARE WAYS TO MAKE THE TRANSITION SMOOTHER

Most clinics will offer you a pregnancy test a couple of weeks after your treatment but if you want to do one for yourself, home pregnancy test kits will also give you a pretty accurate reading at a couple of weeks - do bear in mind that there's a risk of a test showing a false positive result if it is done too early.

If the result is negative, or you get a weak positive, it's worth doing another test two weeks later just to double-check. Whatever the result, don't forget to inform the clinic so they can enter it on the HFEA register.

If you are pregnant, you may start to notice other clues such as missing your period, feeling or being sick, sore breasts, wanting to go to the loo more often, tiredness, sensitivity to strong tastes and smells, as well as mood swings.

Next steps

Some clinics stay in touch during the early weeks of pregnancy and do one or more ultrasound scans to make sure your baby is developing normally. Others do not offer continued care, in which case you will need to make your own arrangements for your antenatal care and birth.

If you are going to have NHS care, the first step is to visit your GP who will arrange a booking visit at the hospital where you will meet the midwives and doctors who will look after you during your pregnancy. If you are going privately, then you will need to make an appointment with a private consultant.

Finding support

If your treatment is successful, don't be surprised if you are not as overjoyed as you expected to be. It can take time to adjust and you may go through a rollercoaster of emotions. This is quite normal. The important thing is to accept your feelings whatever they are, and to remember that most mums-to-be go through a mix of emotions on discovering they are pregnant whether they have been through fertility treatment or not.

Antenatal care doesn't usually start until around the 12th week of pregnancy but you may feel you need some support during these first few weeks. Some clinics will encourage you to stay in touch and you may find it helpful to talk to one of their counsellors. The clinic may be able to put you in touch with other women who have had a baby after fertility treatment and will be able to empathise with how you are feeling. There are also groups you could join, such as ACeBabes, or an internet support group (see page 44).

Making connections

If you had fertility treatment at a large NHS hospital with a maternity unit attached (even if you paid privately), or in a large private hospital with a maternity unit, there may be links between the two and your notes can be passed from one to the other so they know your history.

If this is not the case, it will be up to you to tell the doctors and midwives caring for you about your fertility treatment and it's worth thinking carefully about how much you want to disclose. For example, if you are an older woman but used donor eggs (ie, from someone under 35) in your treatment, and if your doctors do not know this, they may suggest antenatal tests that are, in your case, unnecessary.

Checkpoint

Emotionally, you may find being pregnant tough but physically your pregnancy should not be any different to someone who didn't have fertility treatment. There are some situations which may mean you need more scans or appointments at the hospital. These include:

- previous miscarriages or stillbirths
- age - the older you are the greater your risk of complications such as pregnancy diabetes and pre-eclampsia (the high blood pressure condition of pregnancy)
- expecting twins, triplets or more
- your general health

Natural concerns

More than a million babies around the world have now been born as a result of assisted conception treatment such as IVF and the chances are you will give birth to a healthy baby. But as well as huge benefits, all medical treatments carry some risks. There is no way of ruling out the slight chance of problems, no matter how the baby was conceived, and most problems are relatively minor. You may find it hard, but try to relax and enjoy your pregnancy if you possibly can. You have come on a long journey and now you are about to set out on another.

YOU ASK...

Will I be more likely to miscarry after fertility treatment?

The average rate of miscarriage following IVF is slightly higher than following natural conception. This is because, firstly, women who have fertility treatment will have a pregnancy test very early on in the pregnancy. A woman who conceived naturally may experience what she considers to be a 'late period' when in fact an embryo has been created, but failed to implant. Secondly, the risk of miscarriage rises with the mother's age. Women who have fertility treatment tend, on average, to be older than those who conceive naturally.

I've been told my risk of an ectopic pregnancy is higher because my tubes are blocked or damaged. What is this?

An ectopic pregnancy is one in which the embryo starts to grow outside the uterus, usually in the fallopian tube, but sometimes in the ovary, cervix or elsewhere in the abdomen. The risk is slightly higher if your tubes are not working properly.

Tell-tale signs to watch out for include pains low down in your stomach and vaginal bleeding. If you do experience either of these, get medical advice immediately. Ultrasound scans and blood tests can help to confirm the diagnosis.

Moving on

SOMETIMES TREATMENT DOESN'T WORK AND YOU MAY NEED TIME TO RECOVER PHYSICALLY AND EMOTIONALLY BEFORE THINKING ABOUT TRYING AGAIN

After the physical stress of treatment and the build-up of hopes, it can be devastating if your treatment doesn't work. Many experts recommend that you wait for a couple of months before trying again, which gives you a break from the stress of treatment and a chance for your body to recover.

You may want to talk to your specialist about whether to try again - using the same or a different method - and whether there is anything you can do to boost your chances of conception. Seeing a counsellor can also help you to talk through your feelings.

Remember that, just as in any pregnancy, many embryos are lost early on. Were you not having treatment, you might just think this is a late period, rather than a miscarriage. But when you are having fertility treatment, you're only too aware that the embryo transferred to your womb has failed to implant and that you have 'miscarried'.

The reasons why

There are two main reasons why things can go wrong.

1. Treatment may have to be cancelled before the eggs are collected or before the embryos are put back in the womb if:

- the ovaries don't respond to the drugs used to stimulate egg production
- the ovaries over-respond (ovarian hyper-stimulation) to the drugs used to stimulate egg production
- no eggs are found during egg collection - for example, if the follicles (egg sacs) have developed but they are found to be empty
- the collected eggs don't fertilise so there are no embryos to be transferred to the womb
- the embryos fail to develop in the laboratory, so cannot be transferred to the womb.

2. The embryos fail to develop in the womb. This is the most common reason for treatment being unsuccessful. There is often no obvious explanation but one of the following may be the reason:

- Embryos have a reduced chance of implanting The egg may not have matured properly in the first place, or may not have divided as it should after fertilisation.
- Chromosome problems. Many embryos that look healthy have faulty chromosomes - the structures inside cells that contain genes and control how the cell works and what it does. New pre-implantation genetic screening (PGS, see page 25) is a technique that can be used to detect some chromosomal problems. This can make it easier for doctors to exclude embryos with such problems, and transfer other embryos instead.
- Poor blood flow to the womb. Even if there is nothing wrong with the quality of the embryos, if circulation to the womb is poor, you have less chance of getting pregnant and a greater chance of miscarriage if you do conceive.

Next steps

Whether you have had one or more tries at fertility treatment, sooner or later you may have to decide whether or not to give it up. You may feel you cannot afford more treatment, financially or emotionally, or your specialist may tell you that you have little or no chance of conceiving. Alternatively, you may just feel that enough is enough and you simply want to get on with your life.

It is important that you feel you are making a choice to stop treatment, and that it is not a sign that you have failed, or not done enough. Of course, it need not mean giving up all hope of having children - you may wish to explore the possibility of other options, such as adopting and fostering. Remember, there are no wrong or right choices, just the one that is right for you. It's often helpful to talk to a counsellor, or to others who have been in a similar situation, as you come to this decision about how you can best 'move on'. There is a national organisation, More to Life, which provides support for people who are exploring what life without children has to offer (see page 44).

The 'Immunology Question'

A few clinics may suggest immunological treatment. Some experts believe that there is a link between a number of immunological abnormalities and infertility, IVF failure or pregnancy loss. These are sometimes thought to be related to the level of 'natural killer cells' or NK cells.

Such tests and any recommended treatment can be expensive and it is a good idea to discuss the risks and benefits in detail with your clinic. To date, the view of the Royal College of Obstetricians and Gynaecologists (RCOG) is that there is not enough available data to justify the blood tests, endometrial biopsies and steroids that may be involved. The HFEA supports this view and will continue to monitor and review the available evidence for such treatments.

For more information, visit www.hfea.gov.uk/ForPatients and **www.rcog.org.uk**

Our story: **Our decision evolved over about five years**

Barbara, an IT consultant, had to have an ovary removed as a result of an ovarian cyst, and she also had blocked fallopian tubes. Her husband Jeremy has low sperm motility. Despite four attempts at IVF, treatment failed to work and they decided not to carry on.

Barbara tells their story

Treatment time

'We went private because the NHS waiting lists for treatment were long and we had the funds to pay. After four failed cycles the hospital suggested donor treatment. We decided to give ourselves time to consider this as well as adoption but eventually decided not to pursue treatment.'

Feelings

'Although I'm a positive person it was exhausting keeping up a front and I withdrew from a lot of activities. Our decision not to pursue treatment or adoption evolved over about five years. I can look at it reasonably strongly now but deep down I am still angry at the unfairness of it all.'

'I told my boss who was understanding, but I didn't tell anyone else at work and shortly after ending treatment, I switched jobs - partly I think in retrospect to get away from an environment I associated with loss and stress. My closest friends were sympathetic but regular chats with my mom who lives in Canada were the best support while my mother-in-law gave me the hugs and comfort that I missed from my own mom. My dad didn't really know what to say and would start talking about my brother's children - as though talking about them would 'encourage' me to be successful at IVF!'

Our relationship

'It put a strain on our relationship especially immediately after we had stopped treatment and before we were really able to think about moving on. We were both so 'lost' that if one of us had made a move to chuck it in the other might not have had the strength to do anything about it. But we stuck it out, stayed close - even without talking about it a huge amount - time marched on, and we both started realising that life is good, although it's not necessarily what we would have chosen and we are thankful that we have each other.'

Our tips

- Take it a step at a time.
- Don't let fear stop you whether it's to continue with treatment or stop.
- Don't automatically assume that others will understand what you're going through.
- If people say or do something insensitive they aren't necessarily trying to hurt you. Choose a 'technique' for dealing with it, such as silently counting to ten while smiling at them - they'll get the hint - and in most cases will feel horrified that they've hurt you.

Making a complaint

If you are not happy with your clinic, or feel things went wrong because of something they did or did not do, you may want to complain. All licensed clinics have a proper complaints procedure and a named person to handle complaints. Minor complaints can often be dealt with on the spot.

Before you decide to make a complaint, you may wish to consider what kind of outcome you are hoping for from the clinic. Do you, for example, want them to:

- investigate the matter
- accept they have made a mistake and apologise to you
- take disciplinary action against a member of staff
- offer you compensation
- reassure you that the same thing will not happen again to another patient
- a combination of these actions?

For more information about the process of making a complaint (which differs depending on whether your treatment is NHS funded or whether you are paying for your own treatment), visit www.hfea.gov.uk/ForPatients