Getting started
Your guide to fertility treatment
www.hfea.gov.uk
This guide is for general information only: the HFEA does not provide medical or legal advice to individuals. If you are considering fertility treatment, you should first get professional advice based on your specific circumstances.

While we have made every effort to ensure that the guide is accurate as at September 2017, we make no representations or warranty of any kind, express or implied, as to its accuracy, completeness, suitability or reliability.

We accept no liability for any consequences that may arise from your acting or not acting in reliance on the information in this guide.
We’re here to help

When you’re exploring fertility treatment, it’s difficult to know where to start. There’s so much information out there and it’s hard to know which sources you can trust. I know this from personal experience.

We are the Human Fertilisation and Embryology Authority (HFEA), the UK regulator of fertility treatment and research. We work hard to make sure that the treatment you have is high quality, whatever the outcome.

As chair of the HFEA, I am proud that we have used our expertise and years of experience to produce this guide, which is an excellent resource, and one which I would have very much appreciated when I was a fertility patient. It brings together authoritative, independent information on a wide range of topics to help you through your journey, providing a holistic view of the advice, treatment and support available.

You can find more information on our website www.hfea.gov.uk

Sally Cheshire CBE
HFEA Chair
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How and when to seek fertility treatment

If you are thinking about having fertility treatment, it can be difficult to know where to start.

This section gives you an overview of the initial steps you may take, depending on your situation, and how this guide might be useful to you in each case.
While every person is different and it’s impossible to map out every scenario, we have identified the most common reasons for seeking fertility treatment. In every case there will be sections of this guide which are relevant to you.

If you are having problems conceiving

If you are having trouble becoming pregnant, you’re not alone. About one in seven couples have difficulty conceiving naturally.

If you have been trying for a baby for over a year you should see your GP. You should see your GP sooner if you are aged 36 or over, have been diagnosed with a cause of infertility or have a history of problems which may affect your fertility.

(S)he will listen to your concerns, make a note of your medical history, ask you questions about your diet and lifestyle and perhaps give you a physical examination.

Your GP may also arrange for you to have some initial tests. For women, this may include:

- a cervical smear test if you haven’t had one recently
- a urine test for chlamydia, which can block your fallopian tubes, preventing you from becoming pregnant
- a blood test to see if you are ovulating (this is done by measuring progesterone in a blood sample taken seven days before your period is due)
- a blood test during your period to check for hormone imbalances – measuring follicle stimulating hormone (FSH), luteinising hormone (LH) and oestradiol.

For men initial tests may include:

- a urine test for chlamydia, which, as well as being a known cause of infertility in women, can also affect sperm function and male fertility
a referral to your local hospital or fertility clinic for a sperm test to check for poor morphology (abnormal shape), poor motility (not moving normally), or both.

If your test results are normal and you have been trying for a baby for less than 18 months, your GP may suggest you make a few lifestyle changes and continue trying to conceive naturally.

If the tests reveal a possible fertility issue, especially if you are in your 30s or older, they may make an appointment for you to see a specialist for further tests. This could be at your local hospital or at a fertility clinic, where you would also go on to have treatment if necessary (see p24 for advice on choosing a fertility clinic).

For women, the tests you may have at your local hospital or clinic include:

- a full hormone profile to measure any hormone imbalance
- blood tests to find out whether you are ovulating
- an ultrasound scan to look at your womb and ovaries
- follicle tracking – a series of ultrasound scans to follow the development of a follicle to see if an egg is developing
- hysterosalpingogram – an x-ray to check your fallopian tubes
- laparoscopy – an operation to check for any blockages in the fallopian tubes
- hysteroscopy – a procedure which involves using a telescope with a camera attached to view your uterus to check for conditions such as fibroids or polyps
- hysterosalpingo-contrast sonography (HyCoSy) – a scan which uses a vaginal ultrasound probe to check the fallopian tubes for blockages
- occasionally, a tissue sample may be taken from the endometrium lining of your uterus to be analysed.
For men, depending on the results of a semen analysis, the tests you could have at your local hospital or clinic include:

- blood tests to find out the reason for any sperm abnormalities
- karyotyping – a test to examine chromosomes
- a testicular biopsy to find out the reason for a low sperm count.

If you are unable to produce sperm, you may have surgical sperm retrieval – a procedure to remove sperm from the epididymis or the testicles – so that diagnostic tests can be performed.

Diagnosis

When there is a fertility problem in men, this is usually linked to low numbers or poor quality of sperm. This might be due to past medical treatments, genetic abnormalities or lifestyle factors, but more often than not there is no obvious cause.

In women the causes of fertility problems are more varied. They include the failure to release an egg every month (to ovulate), endometriosis, damage to the fallopian tubes, and polycystic ovary syndrome (PCOS).
Key facts

- Endometriosis is a condition in which endometrial cells, which normally line the womb, implant themselves around the outside of the womb or ovaries (or both), causing internal bleeding and pain and reducing fertility.

- Polycystic ovary syndrome is a condition in which many small cysts form on the ovary resulting in hormonal imbalances, which can cause infertility.

Women also become less fertile as they get older. Of women aged 35 and under who have regular unprotected sexual intercourse, 95% will get pregnant within three years of trying, while by the age of 38 only 75% of women will do so.

Your lifestyle can affect your chances of conceiving, particularly if you are a heavy smoker or are significantly overweight or underweight.

In a quarter of cases, despite investigations, a clear cause of infertility is never established. This is often called unexplained infertility.

Whatever your diagnosis, your clinician will explain the treatment options that are available to you.

How this guide can help you

This booklet gives you a variety of useful information to guide you through your journey – from information about NHS funding and private treatment to how to choose a fertility clinic, what to expect at the clinic and the treatment options and support available. A typical route through this guide might be as follows:
Getting started: your guide to fertility treatment

How and when to seek fertility treatment

How to choose a clinic

What to expect at a clinic

Treatment options:
- IVF (p40)
- ICSI (p46)
- IUI (p50)

Using donated sperm, eggs or embryos in your treatment

You plan to freeze your unused embryos (IVF and ICSI only)

Storing eggs, sperm and embryos (p66)

What to think about before starting treatment (p75)

Get support and advice (p87)
If you are in a same sex female couple

More and more same sex female couples are choosing to have fertility treatment to start a family.

If you are eligible for NHS-funded treatment, you should first visit your GP for a referral; otherwise you will need to approach private clinics directly. When using donated sperm, your treatment option will usually be intrauterine insemination (IUI) unless you have fertility problems, in which case your clinician may recommend IVF.

IVF would also be used where you carry the baby but use your partner’s eggs in your treatment. Intra-cytoplasmic sperm injection (ICSI) would not normally be used as a treatment option as this is usually used when there is a problem with the sperm (ie, low sperm count, abnormal shape or when they are not moving normally), which should not be the case with donor sperm.

How this guide can help you

This guide provides you with a variety of useful information – a typical route is outlined on the next page.
Getting started: your guide to fertility treatment

How and when to seek fertility treatment

Get started (p18)

How to choose a clinic (p24)

What to expect at a clinic (p31)

Using donated sperm, eggs or embryos in your treatment (p53)

You plan to freeze your unused embryos (IVF and ICSI only)

Storing eggs, sperm and embryos (p66)

Treatment options:
- IVF (p40)
- ICSI (p46)
- IUI (p50)

What to think about before starting treatment (p75)

Get support and advice (p90)
If you are a single woman

If you do not have a partner and want to have a baby on your own, you will usually need to seek private treatment (ie, not NHS-funded), but you may still wish to visit your GP to have an initial discussion. A typical route through this guide would be similar to the diagram on the previous page.

Key facts

- We don’t regulate surrogacy and so information about this is not contained within this guide. However, as a starting point we have provided some useful information about this on our website at www.hfea.gov.uk/treatments/explore-all-treatments/surrogacy

- You can find information about other fertility treatment options, such as gamete intra-fallopian transfer (GIFF), on our website at www.hfea.gov.uk/treatments/explore-all-treatments
If you have a genetic condition

If you have a high risk of passing on an inherited disease to a child, you may want to consider using donated sperm, eggs or embryos in your treatment, depending on who carries the condition.

Alternatively, in some cases it may be possible to test your embryos so that only embryos unaffected by the condition or disease are transferred to the womb during treatment.

Your first step should be to talk to your GP to go through the options available. (S)he can refer you to see a genetic specialist or you can arrange to see one privately.

Only certain clinics in the UK offer embryo testing – find the one nearest to you by using the Choose a Fertility Clinic service on our website at www.hfea.gov.uk/choose-a-clinic/clinic-search. Select PGD in ‘Fine tune your search’.

Typical routes through this guide are outlined on the next page.

Some serious inherited conditions may be treated using a transfusion of stem cells from the umbilical cord of a matched donor. If you have a child affected by such a condition you can read about pre-implantation tissue typing on p64.
Getting started: your guide to fertility treatment

How and when to seek fertility treatment

Get started (p18)

How to choose a clinic (p24)

What to expect at a clinic (p31)

You have a genetic condition that embryos can be tested for

Genetic testing (p61)

You want to use donor sperm, eggs or embryos in your treatment

Using donated sperm, eggs or embryos in your treatment (p53)

Treatment options:
- IVF (p40)
- ICSI (p46)
- IUI (p50)
(not for genetic testing and for sperm only in donation treatment)

What to think about before starting treatment (p75)

Get support and advice (p90)
If you want to preserve your fertility

If you are concerned about your future fertility (for example because you are about to undergo cancer treatment), you may want to consider freezing and storing your eggs, sperm, or embryos for use in future treatment. In rarer cases, you may want to consider freezing and storing ovarian or testicular tissue.

Your first point of call will depend on your individual situation. For example, you may initially visit your GP, get a referral to a fertility clinic from your oncologist, or you may approach a fertility clinic directly.

To find a clinic near you, use the Choose a Fertility Clinic search function on our website at www.hfea.gov.uk/choose-a-clinic/clinic-search, selecting the freezing and storage options which are most suitable for you.
If you are trans or non-binary

Fertility may be the last thing on your mind when you’re experiencing the distress of having a body that doesn’t express your identity. However, it’s currently not possible to have children using your own sperm, eggs or embryos once you’ve had genital reconstructive surgery, and hormone therapies and medications can also lead to loss of fertility. You may find it a source of regret if you have treatment for gender dysphoria without preserving your fertility and then realise later on that you want a biological family.

If you’ve already gone through puberty you may be able to freeze your eggs or sperm and store them until you’re ready to start a family. If you haven’t gone through puberty yet and you’re keen to start hormone therapy or puberty suppressing medication as soon as possible, it may be possible for you to store your ovarian tissue or testicular tissue, which can be collected via a surgical procedure. However, these treatments are experimental and there have only been a very small number of resulting births worldwide following replacement of the ovarian tissue, and storing sperm is still the only established way to preserve male fertility.

Alternatively, you can consider other options for having a family, such as using donated sperm or eggs in treatment or adoption. Done in the right way, using a donor is a safe and increasingly common way of creating a family (see p53).
Thinking through all these issues now and understanding your options will help you make an informed decision. Read more about the choices available to you and find links to further support on our website at www.hfea.gov.uk/treatments/fertility-preservation/information-for-trans-and-non-binary-people-seeking-fertility-treatment

**Costs and funding**

To find out whether you are eligible for NHS funding for fertility preservation or treatment the best thing to do is to talk to your GP. Otherwise you can approach private clinics directly.
Get started

When you’re starting out on your fertility journey, there are some important initial considerations. This section gives you an overview of these, along with some advice on how to boost your chances of getting pregnant.
NHS treatment

Whatever your circumstances, one of the first things to consider is whether you are eligible for, and would like, NHS treatment or if you need to pay for your own treatment (ie, be a private patient).

The criteria for whom and what is funded by the NHS varies across the UK. Your GP, local clinical commissioning group (CCG) or health board should be able to advise you on local funding arrangements.

You can also find useful information on our website at www.hfea.gov.uk/treatments/explore-all-treatments/costs-and-funding and Fertility Network UK at http://fertilitynetworkuk.org/for-those-trying-to-become-parents/nhs-funding

If you are eligible for, and would like, NHS-funded treatment, your first step is to get a referral from your GP.

Private treatment

If you are unable to access NHS funding for your fertility treatment or are planning to pay for your own, you have the option of directly approaching private fertility clinics. Depending on your situation, you may still want to visit your GP first to have initial tests or discussions (more about this in ‘How and when to seek fertility treatment’).
We don’t regulate the cost of treatment; private clinics set their own costs so prices can vary. You will therefore need to contact clinics directly to find out how much your treatment will cost.

When discussing prices with clinics, it’s important to find out exactly what the price includes. Some include consultation fees and any recommended tests in their overall price; others may not. Some clinics may offer some free counselling, and others may charge for this. Fertility drugs are usually an extra cost and can be very expensive. The cost of your treatment may also change as your treatment progresses.

Make sure your clinic provides you with a costed treatment plan detailing the specific procedures you need. More information on costs is on p76.

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**Treatment abroad**

You may be considering travelling abroad for fertility treatment due to, for example, lower costs. If so, it’s important to bear in mind that the standard of clinics in overseas countries varies greatly and not all countries will have organisations equivalent to the HFEA. Some places have no specific laws or regulations relating to fertility treatment as we do in the UK.

If you are considering this option, we advise you to carry out thorough research beforehand and only select a clinic that has a proven record on quality and safety standards.
It’s also worth doing thorough research on your treatment options in the UK, if that’s where you’d prefer to be treated. Some people assume that it’s hard to access treatment at home – eg, if you’re using donor sperm in your treatment– when it is in fact easier than expected.

**If you decide to go abroad, we suggest you take a number of issues into consideration, including:**

- standards and safety
- birth rates (and how they are calculated)
- how your medical information is stored and who has access to it
- what happens if treatment goes wrong
- how they minimise multiple births (twins, triplets or more)
- laws and rules and how they differ from the UK
- availability of counselling and support
- if applicable, donor issues such as legal parenthood and whether or not donation is anonymous (in the UK, you can find out non-identifying information about your donor and donor-conceived children can find out identifying information about them when they reach 18. Read more on p60)
- if applicable, surrogacy issues (such as legal parenthood).

You can find more information on things to consider for each of these issues on our website at [www.hfea.gov.uk/treatments/explore-all-treatments/fertility-treatment-abroad](http://www.hfea.gov.uk/treatments/explore-all-treatments/fertility-treatment-abroad)
**Boosting your chances**

If you are trying to get pregnant, there are things that you and, if applicable, your partner can do to boost your chances.

**Eat healthily**

A balanced diet will help ensure your body is healthy enough to become pregnant and can also help to keep sperm production at optimum levels.

**Exercise regularly**

Regular exercise will keep you fit and help you to maintain a healthy weight. It can also help to reduce your stress levels, in what can be an emotionally draining situation.

**Drink sensibly**

Women who are trying to become pregnant should drink no more than one or two units of alcohol once or twice per week. Men should stick within the Department of Health’s recommended daily limit of three to four units. Drinking too much can have a negative impact on semen quality and can harm a developing fetus.

**Medication and drugs**

Some prescription drugs can reduce your chances of conceiving, so if you are taking regular medication, ask your GP about suitable alternatives. All recreational drugs should be completely avoided.

**Stop smoking**

Smoking has been linked to infertility and early menopause in women and has been shown to reduce sperm quality in men. It is also a factor in premature and low birth-weight babies.

**Keep cool**

For maximum sperm production, the testes should be a couple of degrees cooler than the rest of your body. It may help to avoid tight-fitting clothing, saunas and hot showers.
Take folic acid

For women, it’s important that you take 400mcg of folic acid a day to help prevent conditions such as spina bifida in your child. This should be taken from three months before you start trying to conceive and can be bought over the counter from pharmacies and supermarkets.

Get support and advice

Fertility treatment can be an emotional rollercoaster so it’s important that you have the support you need before, during and after treatment.

Support groups

You may want to consider joining a support group. This will introduce you to people in similar circumstances to your own who will understand what you are going through. Your GP or fertility clinic can advise you on support groups in your area, or you can contact Infertility Network UK. There are also many online support groups that you can find at the back of this guide.

Counselling

Counselling aims to help you understand exactly what your treatment will involve and how it might affect you and those close to you – now and in the future.

All clinics licensed by us must offer you an opportunity to talk to a counsellor about the implications of your suggested treatment before you consent to it.

Counselling on the implications of treatment is especially important if you are considering using donated sperm, eggs or embryos or surrogacy arrangements – all of which involve complicated issues. You may need time to explore how you feel, to consider the needs and legal rights of donor-conceived children and to talk about whether this is going to be the right decision for you.

Different clinics have different costing policies for counselling so check whether you have to pay extra for counselling. For more information, contact the British Infertility Counselling Association (BICA): www.bica.net
How to choose a clinic

Choosing a fertility clinic is a very personal decision and the criteria that matter to you will depend on your circumstances. This section gives you a list of things to consider when choosing the best clinic for your needs.
Getting started: your guide to fertility treatment

Services offered
Does the clinic offer the treatment that is best for you? What about other services you may want such as a support group or free counselling? Use the Choose a Fertility Clinic tool on our website at www.hfea.gov.uk/choose-a-clinic/clinic-search to find clinics which offer the treatments and services you require.

Eligibility for treatment
Some clinics have age and body mass index (BMI) criteria for treatments. Others only treat private patients. Contact your shortlist of possible clinics to find out if you are eligible for treatment there.

Eligibility and funding information is also included on each clinic’s page on Choose a Fertility Clinic.

Cost
If you are paying for treatment, you will want to find out how much your treatment will cost. Read more about this on p76.

Location and opening times
How convenient is the location? If you choose a clinic that is further away, you may be able to have certain treatments at a local hospital (known as a satellite or transport centre). This will save you travelling to the clinic for every test and treatment, making it more convenient.

You may also want to choose a clinic which has opening times that are most convenient for you – for example, a clinic which offers early morning appointments.

Waiting times
How long is the waiting time for treatment? Contact the clinic to find out.

If you are using donor sperm, eggs or embryos in your treatment, check the clinic’s page on Choose a Fertility Clinic to see how long you’ll need to wait for donor treatment.
First appearances

When you contact or visit the clinic, think about how you feel there and about the way staff treat you. Ask lots of questions so you feel fully informed about the treatment they are recommending. If possible, talk to other patients to hear their personal experiences of the clinic.

Cycles of treatment attempted

Find out how many cycles (rounds of treatment) are attempted before trying another approach or stopping treatment altogether.

Embryo transfer policy

Clinics may replace up to two embryos in women under 40 and a maximum of three in women aged 40 or over. Transferring more than one embryo increases the risks of having a multiple birth (twins, triplets or more), the single biggest risk of fertility treatment (more on p78), so you may want to consider the following:

• What is the rate of multiple births for the clinic?
• How do you feel about this and the risks associated with multiple births?
• How does the clinic minimise the risk of multiple births?

You can find out more about multiple birth rates at clinics using our online Choose a Fertility Clinic search function. For each clinic we show firstly whether treatment resulted in a live birth and secondly whether a single baby or multiple birth occurred.

Your clinic should recommend single embryo transfer (SET) if you are at a high risk of having a multiple pregnancy (see p77). Further information is available at www.hfea.gov.uk/about-us/our-campaign-to-reduce-multiple-births
Support groups and counselling

Having emotional support is very important when going through fertility treatment. A clinic licensed by us must offer you an opportunity to talk to a counsellor about the implications of your suggested treatment before you consent to it.

Some clinics offer this service free while others charge for it. When researching clinics, you may want to ask about this and whether they have any support groups you can join.

Faith and language issues

Does the clinic provide services in a way which fits in with your religious or cultural beliefs? If needed, you may also want to find out if the clinic offers interpreters and/or translation services.

What does our inspection report say about this clinic?

Our inspection reports are available online as part of our Choose a Fertility Clinic search function. They can be useful in helping you find out more about how a clinic operates.

Birth rates

It’s only natural for you to want to know your chances of success. Choose a Fertility Clinic provides data for every clinic we license, showing the number of treatments carried out in a particular year and the number of pregnancies and births that resulted.

These birth rates should be used only as a general guide. You should not use them as a personal prediction of your own chance of success.
We show a clinic’s birth rates in two different ways:

- whether the success rate is above, below or consistent with the national average
- the number of treatment cycles a clinic carried out and how many resulted in a birth

The success of an IVF treatment can be measured by looking at how likely it is that a birth will result from a treatment cycle or from each embryo transferred. We show both in our data.

It’s understandable that you may feel you want to focus on success rates, but the reality is that most clinics are broadly all as good as each other – small differences in rates are usually down to the different types of patients treated.

To help you make the best choice for you, our Choose a Fertility Clinic service also shows how other patients and our inspectors rate the clinic.

**Patient ratings**

A great clinic isn’t just one that can give you effective treatment, it’s also about being cared for by compassionate staff, feeling part of the decision making process about your treatment, and receiving exceptional emotional support. Select a clinic from the search bar to see how patients currently receiving, or who have recently had treatment, rated their experience.

**Inspection rating**

This shows how clinics meet our standards. Our inspectors visit the clinic and look at the laboratory and equipment, the clinic’s consent and other procedures and the patient information. All clinics must have a licence to operate and the inspector’s assessment decides how long the licence should be.

We have produced a video animation for our website that further explains the factors you may wish to consider when choosing a clinic. Find this at www.hfea.gov.uk/choose-a-clinic
How can I see birth rates relevant to me?

Our Choose a Fertility Clinic service shows the type of patients each clinic treats, including their age. This may help you identify clinics that treat patients with similar needs to you and also puts the success rates for that clinic in context.

Birth rates are broken down by treatment. With IVF and ICSI, we also show separate outcomes for fresh or frozen embryos.

If you are using donated eggs, the birth rate is not broken down by age. This is because donated eggs come from women aged 35 or younger. The age of the egg donor, rather than your age as the recipient, determines the success of the treatment.

The expert says...

“The most important thing you can do when making decisions about fertility treatment is to ensure you are well informed. Read all you can, don’t be afraid to ask questions, talk to other people, including considering joining a patient-led support group. When you’re choosing a clinic, success rates are important but they aren’t the only thing that matters – location, cost, funding, what treatments are offered and even the atmosphere can all make a difference.”

Kate Brian, Fertility Network UK
Clinical pregnancy rates

Where an ultrasound scan has shown at least one heartbeat, this is a clinical pregnancy.

Clinical pregnancy rates can give you more recent data. This information is also available on the clinic’s page on Choose a Fertility Clinic under ‘Detailed statistics’. However, as not all clinical pregnancies will develop into births, these rates do not offer a complete picture.

Why do birth rates differ between clinics?

Birth rates can be affected by:

- the type of patients a clinic treats
- the type of treatment a clinic carries out
- a clinic’s treatment practices.

A clinic that treats proportionately more patients with complicated diagnoses may have a lower average birth rate than a clinic that treats more patients with common fertility issues.

Clinics may have higher birth rates for treatment if they treat women who have no male partner and are using donated sperm in their treatment. This is because the women are likely to be fertile and the donated sperm will be thoroughly screened and of a high quality.
What to expect at a clinic

Whichever clinic you choose, it is important that you feel comfortable, that you don’t feel rushed into any decisions, and that you have access to all the information you need. This section helps you prepare for visiting your clinic.
Tests

The tests you have will depend on your individual situation and what type of treatment you are having. See the relevant sections of this guide for more information.

If your own sperm, eggs or embryos are being used in your treatment, you (and if applicable your partner) will be screened for HIV and hepatitis B and C. Testing for human T cell lymphotropic virus (HTLV) I and II and other conditions may also be performed if your medical and/or recent travel history indicates you may be at risk. Patients who donate their eggs, sperm or embryos must also be screened and this may include more extensive tests.

Forms

Welfare of the child assessment

You will be asked to complete a welfare of the child assessment before starting any treatment. This is to enable the clinic to assess the impact of a potential birth on both the baby and on any other children you may have. For more information, see www.hfea.gov.uk/code-of-practice/8

If you do not have a partner, clinic staff are likely to ask about your plans for caring for the child on your own.

Consent forms

Before treatment can take place, you’re legally required to complete several consent forms. Which forms you’ll need to complete depends on your individual situation – find out more in the ‘What to think about before starting treatment’ section on p75.
If you have any relevant information, such as the results of past tests or treatments, it is always helpful to bring those with you to your appointments.

You and, if applicable your partner, will be asked questions about your medical history and further investigations may be required.

**You can make the most of your consultations by:**

- preparing questions in advance
- taking time to think things through – there can be a lot of difficult issues to consider
- remembering that the clinic staff are there to help you make the right choice.

You can find a list of questions you might like to ask on p34-35.

Your treatment options will be discussed with you. You can read more about the different treatments in this guide and important information about what to think about before starting treatment is included on p75.

Once you and your clinician have made a decision on how to proceed, your treatment plan will be discussed with you in detail.

It’s important to remember that counselling is always available (see p27).
Questions to ask at the clinic

Your consultations with a doctor or clinic can sometimes be confusing. Remember that the staff are there to help you and will be happy to discuss your questions and concerns. It’s vital that you feel fully informed and comfortable with the recommended treatment. We’ve listed some questions that you may want to ask your clinic so you can make the most of your consultations.

- What are the benefits of the treatment you’ve recommended and why do you think it’s the best option for me? Is it accepted by professional bodies?
- How many patients at your clinic have had this treatment in the last two years and how many of them have become pregnant/had a baby?
- Are there alternative treatments? If so, what do they involve and why do you think they are less suitable for me?
- What other options are available if this treatment doesn’t work?
- How does my age affect the choice of fertility treatment?
- What drugs will I have to take and what side effects may they cause?
- How will I take the drugs?
• Are there any alternatives to the drugs you have mentioned?

• Can you break down all the costs of this treatment? Might other costs arise? (Your clinic should give you a costed treatment plan).

• How can these costs be reduced?

• How can I change my lifestyle to boost my chance of success? How will this help?

• What kind of counselling or advice service do you provide? Is there a charge for this, or how many free sessions can I have?

• Does this clinic have a patient support group I can join, or are there other groups you would recommend?

• Could you tell me more about how you will assess me before you give the go-ahead for treatment?

• Which tests will I need to have and how much will they cost?

• What happens next? Do I (or my partner) need to do anything now?

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Treatment options

Your doctor or clinician will help you to decide on the best treatment for you according to your individual situation. This section gives you an overview of what each form of treatment involves.
Fertility drugs

Depending on your diagnosis, your clinic may recommend using fertility drugs alone, or you may be offered them with other treatments such as intrauterine insemination (IUI) or in vitro fertilisation (IVF).

For women

Your clinic may recommend using fertility drugs as part of other treatments (eg, IVF) and/or if:

- you have a very irregular cycle and your ovulation is totally unpredictable
- you are producing few eggs or none
- your infertility is caused by failure of the pituitary gland (this controls your hormone production).

For men

Drugs may be prescribed for men in certain situations. They include:

- antibiotics to treat infection or inflammation
- gonadotrophins for certain rare conditions in which no sperm are produced, or
- drugs that close the bladder neck if sperm are being ejaculated into the bladder instead of the penis (retrograde ejaculation).

Commonly prescribed fertility drugs

Clomifene citrate (Clomid)

Taken in pill form between days two and six of your cycle, Clomid indirectly stimulates the ovaries into producing eggs. It is used to stimulate and/or regulate ovulation (for example, if you have polycystic ovary syndrome (PCOS)).

When taking this drug, you must be monitored in a fertility clinic to check how many follicles (and hence eggs) develop. Because your ovaries are artificially stimulated to produce more eggs than would be released naturally, it increases your risk of having twins. Read more about the risks of multiple births on p78.
Metformin

Taken in tablets two to three times a day, Metformin is used to treat PCOS. It helps to stimulate ovulation.

Gonadotrophins – hormones containing follicle-stimulating hormone (FSH), luteinizing hormone (LH) or a combination

Used to stimulate the ovaries to produce eggs before cycles of IVF treatment, or to treat PCOS when Clomid hasn’t worked, these hormones are also used in cases of infertility due to pituitary gland failure and in some forms of male infertility. They are delivered through daily injections and can be followed by an injection of human chorionic gonadotrophin (hCG) to trigger the final stage of egg maturation.

Drugs to regulate your treatment cycle

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

Nafarelin Buserelin and goserelin (also known as gonadotrophin-releasing hormone (GnRH) analogues or pituitary agonists)

Taken as a nasal spray several times daily, or by daily injection, or injected monthly under the skin, this stops the natural menstrual cycle by blocking the release of hormones that regulate it. This is usually taken before and during your gonadotrophin injections.
Cetrotide and Orgalutran – gonadotrophin-releasing hormone antagonists

These drugs are usually started a few days after starting gonadotrophin injections and are delivered as daily under the skin (subcutaneous) injections. They stop ovulation until the eggs are ready to be collected as part of the IVF cycle.

Progesterone (including Cyclogest, Gestone or Crinone)

Taken to thicken the lining of the womb, progesterone can help to maintain pregnancy after IVF or IUI. It can be taken as a vaginal suppository, pill or gel, or by injection into the buttock. It is delivered either on the day the embryos are returned to the womb, or after the injection of the pregnancy hormone hCG.

Bromocriptine and Cabergoline

Taken in tablet form to reduce high levels of the hormone prolactin, which can interfere with the production of FSH, these can help reduce the effects of ovarian hyper-stimulation syndrome (OHSS) if you are at risk.

Side effects

You may experience side effects while taking fertility drugs, or you may feel fine.

Make sure you let your clinic know if you have any unexpected reactions. The following symptoms have all been associated with their use: stomach pains, hot flushes, mood swings, heavy periods, breast tenderness, insomnia, increased urination, spots, headaches, weight gain, dizziness, and vaginal dryness. Read more about the risks of fertility treatment on p77.
In vitro fertilisation (IVF)

IVF treatment involves the fertilisation of an egg (or eggs) outside the body. The treatment can be performed using your own eggs and sperm, or using either donated sperm or donated eggs, or both.

Is IVF for me?

Your clinic may recommend IVF if:

- you have been diagnosed with unexplained infertility
- your fallopian tubes are blocked
- other techniques such as fertility drugs or intrauterine insemination (IUI) have not been successful
- there are problems with your sperm but not severe enough to require intra-cytoplasmic sperm injection (ICSI)
- you are using your partner’s frozen sperm in your treatment and IUI is not suitable for you
- you are using donated eggs or your own frozen eggs in your treatment
- you are using embryo testing to avoid passing on a genetic condition to a child (see p61).

How does IVF work?

IVF techniques vary according to your individual circumstances and the approach of your clinic. Before your treatment starts, you will need to complete various consent forms (see p81). You and, if applicable, your partner may also need to have blood tests to screen for HIV, hepatitis B, hepatitis C and human T cell lymphotropic virus (HTLV) I and II.
Treatment then typically involves the following stages:

**For women**

1. **Suppressing your natural monthly hormone cycle**
   As a first step you will be given a drug to suppress your natural cycle, which you can administer yourself in the form of a daily injection or a nasal spray. The drug treatment continues for about two weeks.

2. **Boosting the egg supply**
   After your natural cycle has been suppressed, you will be given a type of fertility hormone known as gonadotrophin (see p38). You will usually take this as a daily injection for around 12 days. The hormone will increase the number of eggs you produce.

3. **Checking on progress**
   The clinic will monitor your progress throughout the drug treatment through vaginal ultrasound scans and, possibly, blood tests. Between 34 and 38 hours before your eggs are due to be collected you will be given a hormone injection to help your eggs mature. This is likely to be human chorionic gonadotrophin (hCG).

4. **Collecting the eggs**
   Your eggs will usually be collected using ultrasound guidance while you are sedated. A hollow needle is attached to the ultrasound probe and is used to collect the eggs from the follicles on each ovary. You may experience some cramps, feel a little sore and bruised and/or experience a small amount of bleeding from the vagina. After your eggs have been collected, you will be given medication in the form of pessaries, injection or gel to help prepare the lining of your womb for embryo transfer.
5. Fertilising the eggs
Your eggs will be mixed with your partner’s or the donor’s sperm and cultured in the laboratory for 16–20 hours after which they are checked for signs of fertilisation.

Those that have been fertilised (now called embryos) will be grown in the laboratory incubator. The embryologist will monitor their development and the best will then be chosen for transfer.

Any remaining embryos of suitable quality can be frozen for future use. Read more about embryo freezing on p67.

6. Embryo transfer
If you are under the age of 40, one or two embryos may be transferred. If you are 40 or over, a maximum of three may be used.

The number of embryos transferred is restricted because of the risks associated with multiple births. Due to this, your clinic will recommend single embryo transfer (SET) if they feel it is the best option for you (see p78).

The transfer may happen after two to three days, when the embryo(s) has reached what is known as the ‘cleavage stage’, or up to six days later when it has reached the ‘blastocyst’ stage.

Many clinics transfer embryos at the blastocyst stage to improve chances of pregnancy after SET. This is particularly useful if you are a younger woman with a good chance of achieving pregnancy from IVF.
Your doctor may also suggest you try blastocyst transfer if you have produced good quality embryos in a previous IVF cycle but they failed to implant in the womb.

More information is available on our website at www.hfea.gov.uk/treatments/explore-all-treatments/decisions-to-make-about-your-embryos

During the procedure, a doctor or nurse will insert a speculum into your vagina. This is similar to having a cervical smear taken, when a speculum is used to hold the vagina open so the cervix is visible.

A fine tube (catheter) is then passed through the cervix, normally using ultrasound guidance. The embryos are passed down the tube into the womb.

This is normally a pain-free procedure and usually no sedation is necessary, but you may experience a little discomfort because you need a full bladder if ultrasound is used.

Key facts

The latest figures show that around a third of women under 35 have a baby after undergoing IVF or ICSI treatment with their own fresh eggs (ie not eggs stored from a previous treatment cycle).

For the latest figures visit www.hfea.gov.uk

For men

Around the time your partner’s eggs are collected, you will be asked to produce a sample of sperm.

The sperm will be washed and prepared so the active, normal sperm are separated from the poorer-quality sperm.

If you have stored sperm, it will be removed from frozen storage, thawed and prepared in the same way.
IVF treatment options

Natural cycle IVF
In natural cycle IVF, the one egg you release during your normal monthly cycle is collected and fertilised. No fertility drugs are used in this treatment.

Mild stimulation IVF
With mild stimulation IVF, you receive a lower dose of fertility drugs over a shorter period of time than with conventional IVF.

In vitro maturation (IVM)
In the IVM process, eggs are removed from your ovaries when they are still immature. They are then matured in the laboratory before being fertilised.

Assisted hatching
Before an embryo can attach to the wall of the womb, it has to break out or ‘hatch’ from its outer layer, the zona pellucida. It has been suggested that making a hole in, or thinning, this outer layer may help embryos to hatch, which may increase the chances of pregnancy.

Pre-implantation genetic screening (PGS)
PGS (also known as aneuploidy screening) involves checking the chromosomes of embryos conceived by IVF or ICSI for common abnormalities.

Chromosomal abnormalities are a major cause of the failure of embryos to implant, and of miscarriages. They can also cause conditions such as Down’s syndrome.
Is PGS for me?

Your specialist may recommend PGS if:

- you are over 35 and have a higher risk of having a baby with a chromosome problem (such as Down’s syndrome)
- you have a history of recurrent miscarriages
- you have had several unsuccessful cycles of IVF where embryos have been transferred, or
- your sperm are known to be at high risk of having chromosome problems.

How does PGS work?

The procedure for PGS is usually as follows:

1. You undergo normal IVF or ICSI treatment to collect and fertilise your eggs (see p40 and 46).
2. The embryo is grown in the laboratory for two to three days until the cells have divided and the embryo consists of about eight cells.
3. A trained embryologist removes one or two of the cells (blastomeres) from the embryo.
4. The chromosomes are examined to see how many there are and whether they are normal.
5. One, two or three of the embryos without abnormal numbers of chromosomes are transferred to the womb so that they can develop. Any remaining unaffected embryos can be frozen for later use (see p71).
6. Those embryos that had abnormal chromosomes are allowed to perish or may be used for research (with your consent) – see p84.

There are possible variations to this procedure and the trophectoderm biopsy technique described on p63 can be used in some cases. Find out more on our website at www.hfea.gov.uk/treatments/embryo-testing-and-treatments-for-disease/pre-implantation-genetic-screening-pgs
**Intra-cytoplasmic sperm injection (ICSI)**

Intra-cytoplasmic sperm injection (ICSI) differs from conventional in vitro fertilisation (IVF) in that the embryologist selects a single sperm to be injected directly into an egg, instead of fertilisation taking place in a dish where many sperm are placed near an egg.

**Is ICSI for me?**

ICSI enables fertilisation to happen when there are very few sperm available.

Your clinic may recommend it if:

- you have a very low sperm count
- other problems with the sperm have been identified, such as poor morphology (abnormal shape) or poor motility (not moving normally)
- during previous attempts at IVF there was failure of fertilisation or an unexpectedly low fertilisation rate
- you need sperm to be collected surgically from the testicles or epididymis (a narrow tube inside the scrotum, where sperm are stored and matured); for example because you have had a vasectomy, you do not ejaculate sperm, or because you have extremely low sperm production
- you are using frozen sperm in your treatment which is not of optimum quality
- you are using embryo testing to avoid passing on a genetic condition to a child (see p61).
How does ICSI work?

Before your treatment starts you will need to complete various consent forms (see p81) and you, and if applicable your partner, may need to have blood tests to screen for HIV, hepatitis B and C and human T cell lymphotropic virus (HTLV) I and II.

Treatment then typically involves the following:

For women

You take fertility drugs to stimulate your ovaries to produce more eggs, as for IVF, and your progress will be monitored through vaginal ultrasound scans and possibly blood tests (read more about this on p41).

The eggs are then collected using the same procedure as IVF (see p41) and each egg is injected with a single sperm from your partner or donor. The rest of the process is also the same as IVF – see ‘fertilising the eggs’ and ‘embryo transfer’ on p42-43.

You are more likely to become pregnant with twins or triplets if more than one embryo is transferred so your clinic will recommend single embryo transfer (SET) if they feel it is the best option for you. Read more about this and the risks of multiple births on p78.
Any suitable remaining embryos can be frozen for future use. More information on freezing embryos is available on p67.

For men

An embryologist will examine your sperm under a microscope and decide whether ICSI could increase your chances of fathering a baby.

The next step depends on whether you are able to provide sperm without a medical procedure:

• If you can, you produce a fresh sperm sample on the same day as your partner’s eggs are collected.

Or:

• Sperm can be collected directly from the epididymis using a type of fine syringe. This is known as ‘percutaneous epididymal sperm aspiration’ or PESA.

• Sperm can also be retrieved from the testicles, a process known as ‘testicular sperm aspiration’ or TESA.

• It is also possible to remove tiny quantities of testicular tissue from which sperm can be extracted. This procedure is called ‘testicular sperm extraction’ or TESE. For more information about PESA, TESA and TESE, speak to your doctor.

Or:

• If you have stored sperm, it will be removed from frozen storage, thawed and prepared for treatment.
A single sperm is then injected into each egg. ICSI provides the opportunity for fertilisation to happen, but it is not guaranteed to succeed.

Finally, if fertilisation does take place, the embryos will be cultured in the laboratory for up to six days and then between one and three of the best-quality embryos will be transferred to the womb.

**Zero sperm count**

If you have a zero sperm count (other than caused by vasectomy), the chances of retrieving sperm surgically by PESA, TESA or TESE may be very low.

In this situation, you might consider having a surgical retrieval as a ‘dummy run’ and storing any sperm that are obtained. If no sperm are retrieved, you may want to consider donor insemination (DI) or IVF with donor sperm instead.

### Key facts

- ICSI success rates are very similar to IVF rates.
- A low sperm count caused by genetic problems could be passed on to a male child, so you may want to undergo genetic tests before going ahead with ICSI. Infertile men with a low sperm count or no sperm in their ejaculate may be tested for cystic fibrosis genes and for chromosome abnormalities. You may want to discuss the full implications of taking these tests with your clinician and the clinic’s counsellor before going ahead.
Intrauterine insemination (IUI)

IUI involves a laboratory procedure to separate fast-moving sperm from more sluggish or non-moving sperm. It can be performed with your partner’s sperm or donor sperm (known as donor insemination).

Is IUI for me?

You may be offered IUI if:

- you are using donated sperm in your treatment (donor insemination)
- you are unable (or would find it very difficult) to have vaginal intercourse, for example because of a physical disability or psychosexual problem
- you have a condition that means you need specific help to conceive (for example, if you’re a man who is HIV positive and you have undergone sperm washing to reduce the risk of passing on the disease to your partner and potential child).

In the past IUI was offered if you had unexplained infertility, mild endometriosis or male fertility problems. However, the National Institute for Health and Clinical Excellence (NICE) (an organisation which provides national guidance and advice to improve health and social care) has advised that it should now not routinely be offered in these situations except for exceptional circumstances.

Instead, if this applies to you, you are advised to try to conceive for a total of two years before IVF will be considered (this can include up to one year before your fertility investigations).

IUI options

If your clinic has recommended IUI treatment, you may want to have a discussion with your clinician about the risks involved in using fertility drugs to boost egg production and whether IUI without fertility drugs might be suitable for you.
How does IUI work?

Patency health tests

IUI can only begin once it has been confirmed that your fallopian tubes are open and healthy. This will usually be checked through a tubal patency test as part of your assessment by the fertility clinic.

This may involve a laparoscopy, an operation in which a dye is injected through your cervix as the pelvis is inspected for blockages with a telescope that has a tiny camera attached (a laparoscope).

Alternatively, you may undergo a hysterosalpingo-contrast sonography (HyCoSy) – which involves using a vaginal ultrasound probe to check the fallopian tubes for blockages – or a hysterosalpingogram, an x-ray of your fallopian tubes.

The procedure

For women

If you are not using fertility drugs, IUI will be performed between day 12 and 16 of your monthly cycle – with day one being the first day of your period. You will be given blood tests or urine tests to identify when you are about to ovulate.

Or:

If you use fertility drugs to stimulate ovulation, vaginal ultrasound scans will be used to track the development of your eggs. As soon as an egg is mature, you will be given a hormone injection to stimulate its release.

The sperm will be inserted 36–40 hours later. The doctor will first insert a speculum into your vagina, as in a smear test, to keep your vaginal walls apart. A small catheter (a soft, flexible tube) will then be threaded into your womb via your cervix. The best-quality sperm will be selected and inserted through the catheter.

The whole process only takes a few minutes and is usually painless. Some women may experience a temporary, menstrual-like cramping. You may want to rest for a short time before going home.
For men

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

The sperm will be washed to remove the fluid surrounding them and the rapidly moving sperm will be separated out from the slower sperm.

The rapidly moving sperm will be placed in a small catheter to be inserted into the womb.

If you are using donated or frozen sperm, it will be removed from frozen storage, thawed and prepared in the same way.

If IUI is unsuccessful

You may want to talk to your clinician about other procedures, such as IVF.

Key facts

• Latest figures (2014) show that when not using fertility drugs, 10.8% of women under 35 having IUI with partner sperm get pregnant. When using fertility drugs, the percentage rises to 12.9%. For more figures, visit the Choose a Fertility Clinic section of our website www.hfea.gov.uk/choose-a-clinic/clinic-search

• IUI itself is normally quite straightforward and painless. However, there are risks associated with the fertility drugs that are often used with this treatment. It can also be time consuming as it involves multiple trips to your clinic.

• Your clinic should provide you with the contact details of a counsellor to support you through your treatment.
Using donated sperm, eggs or embryos in your treatment

Around 1,750 babies are born in the UK each year as the result of treatment with donated sperm, eggs or embryos. The experience of people who have had donor-conceived children shows this can be a very positive way to create a family.

Is donor conception for me?

Using donated sperm, eggs or embryos is a major decision and you should take your time to think about whether it is right for you. You may want to discuss your feelings with friends, family or a professional counsellor before proceeding.

A clinic is likely to recommend donor conception if:

- you are not producing eggs or sperm of your own
- your own sperm or eggs are unlikely to result in conception
- you have a high risk of passing on an inherited disease
- you are in a same sex relationship, or
- you are single.

If you are considering using donated sperm, eggs or embryos, you will need to think about some complex issues before starting treatment. For this reason, you will be offered counselling; many clinics regard it as essential and will not offer donor conception treatment without it. Try to also talk to people who already have donor-conceived children.
You may want to contact the Donor Conception Network, a supportive network of families with donor-conceived children: www.dcnetwork.org

Where do I start?
Once you have decided, in consultation with your clinician, that using donated sperm, eggs or embryos in your treatment is suitable for your circumstances, a donor who is acceptable to you must be found.

Some clinics recruit their own sperm and egg donors and have a range of suitable donors available. At other clinics you may be put on a waiting list – ask them about how long they would expect you to wait.

It is worth contacting a number of clinics at the start to establish availability so you can choose a clinic which best meets your needs (see p24-30 for more information on how to choose a clinic).

If you are looking for a sperm donor, some clinics may give you the option of using imported sperm from overseas. You can find more information about this on our website: www.hfea.gov.uk/treatments/explore-all-treatments/using-donated-eggs-sperm-or-embryos-in-treatment/

Clinics may offer you eggs or sperm which have been donated as part of a ‘sharing’ arrangement. This is where another man or woman who is undergoing fertility treatment donates some of their eggs or sperm to you in return for benefits from the clinic such as discounted treatment, reduced storage costs or decreased waiting times.

Alternatively, you may wish to ask someone you know, such as a friend or suitable relative, to donate sperm or eggs at your clinic for use in your treatment.

It is also possible to find a donor via an introduction website but be aware that these sites are not regulated by us and vary enormously in how they operate.
If you use a website to find a sperm donor, the safest route for all those involved is for donation and treatment to take place at a clinic licensed by us, rather than undergoing a private arrangement (ie, where a man provides his sperm directly to the woman). The same applies if you are using donor sperm from a friend or suitable relative.

We recommend that donation and treatment takes place at a clinic licensed by us because:

- donors must answer a series of questions to ensure they are suitable.
- licensed clinics check donors’ personal and family medical histories for inherited diseases.
- all donors go through stringent screening checks to ensure they are not carrying infections such as HIV, hepatitis B and C or cytomegalovirus (CMV).
- clinics ensure there are limits on the number of families created by each donor.
- the donor will have no legal rights or responsibility for the child (see p60).
- the donor-conceived child can find out identifiable information about the donor when they reach 18.

**Co-parenting**

It may be possible to have treatment with someone you know, but who you are not in a relationship with, where you both wish to be the legal parents of the child.

In these circumstances, the person you are having treatment with will not be registered as a donor but will be required to undergo screening to reduce the risk of transmitting infections such as HIV.
What can I find out about my donor?

If you are using a donor you don’t know, you can find out non-identifying information about them from your clinic at the point of treatment or from us after your child is born. This information can include:

- a physical description (height, weight, eye and hair colour)
- the year and country of birth
- their ethnicity
- whether they had any children at the time of donation, how many and their gender
- their marital status
- their medical history
- a goodwill message they have written to any potential children.

Your child will also be able to apply to us for non-identifying information when they are 16. When they turn 18, they can obtain identifying information including name, date of birth and last known address (as long as the donor donated after 1 April 2005; before that donation was anonymous).

Donors are entitled to request information from us about the number, sex and year of birth of any people born as a result of their donation. No other information can be obtained so the onus is on a donor-conceived child to get in touch with their donor should they wish and not vice versa.

Using donated eggs

Donated eggs can be used in either in vitro fertilisation (IVF) or intra-cytoplasmic sperm injection (ICSI). Read more about these treatments in the previous sections.

How does using donated eggs work?

Before treatment takes place, you will need to complete various consent forms (see p81).

The procedure for using donated eggs varies depending on your clinic and the fertility treatment you are undergoing. A typical procedure may involve the following steps:

Key facts

- Professional guidelines state that sperm from both known and unknown donors (or from a man you are not in an intimate physical relationship with) should be quarantined for six months before your treatment. This is to allow time to detect infections such as HIV which are sometimes only evident after a period of time. However, in some circumstances this may not be the case if your clinic checks the sperm using ‘serological and nucleic acid amplification testing’.

- If you know your donor and you both want him to be involved in some way in your child’s life, you may want to consider a donor or co-parenting agreement. But these agreements are not legally binding and you should seek independent legal advice before drawing one up.
For women

1. You and your donor will be given medication to synchronise your menstrual cycles. You will also be given medication to prepare the endometrium lining of your womb for embryo transfer.

2. The donated eggs will be fertilised using IVF or ICSI.

3. When the embryos begin to develop, they will be transferred to your womb as in conventional IVF. As the eggs will be from donors aged 35 or younger, no more than two embryos will be transferred.

Alternatively, the embryos may be frozen after they have been fertilised. This avoids the need to synchronise your menstrual cycle with that of the donor and may reduce the stress of the treatment.

For men

1. Unless you are using donor sperm, before treatment takes place you will give a sperm sample to check that your sperm are healthy and active.

2. On the day that the eggs are collected, you will give another sperm sample.

3. In the laboratory, the sperm sample is mixed with the donor eggs to fertilise them, or fertilised by ICSI and then transferred to the womb.
Using your eggs in your partner’s treatment

If you are in a same sex female couple and you want to use your eggs and your partner carry the baby, the process for collecting your eggs will be as follows:

1. After being screened for sexually transmitted diseases and some genetic disorders, you will be given a series of hormone injections to help develop and mature the eggs within the ovaries.

2. Once the eggs are matured, they are collected while you are sedated by inserting a needle into the ovaries through the vagina.

The eggs will then be fertilised, usually using IVF.

Using donated sperm

Donated sperm can be used in intrauterine insemination (IUI) (known as donor insemination) or IVF. The treatment you have will depend on your individual circumstances. Read more about the process for each on p50-52 and p40-45.

Using donated embryos

Embryos can be donated by people who have completed their fertility treatment or by those who cannot use them in their own treatment.

How does using donated embryos work?

Before treatment takes place, you will need to complete various consent forms (see p81).

The donated embryos will have previously been frozen. You can read more about the procedure for using frozen embryos on p67.
Legal considerations

Legal parenthood

If you undergo treatment at a UK clinic licensed by us, the donor has no legal rights or responsibility for the child.

The woman giving birth to the child is always the legal mother when the child is born. However, if you are using donor sperm or embryos and you or your partner are not married or in a civil partnership, your partner will only be the legal parent of the child if you both complete the relevant legal parenthood consent forms before treatment. Full details of how the law affects you are available at www.hfea.gov.uk/code-of-practice/6. More information on the consent forms you will need to complete is on p81.

Withdrawing consent

The sperm, egg or embryo donor can change their mind about their donation up to the point of embryo transfer or insemination. The donor can also withdraw their consent to the future use of their frozen sperm, eggs (even where embryos have been created) or embryos.

Telling your child about their origins

If your child or children are conceived as a result of donation, telling them about their origins can be a sensitive issue. However, if discussed honestly and at the right time, it doesn’t need to be difficult to talk about. If you, as the parent, are open about how your child was conceived there is no reason they should feel any different from any other child.

Read about the rights of donor-conceived people and their parents, as well as how to get the support you need, on our website at www.hfea.gov.uk/donation/donor-conceived-people-and-their-parents.
Genetic testing

Embryos created through in vitro fertilisation (IVF) or intracytoplasmic sperm injection (ICSI) can be tested for certain inherited conditions or abnormalities before they are transferred to the womb. This helps to ensure that only unaffected embryos are put in the womb during treatment.

Conventional pre-natal tests for genetic diseases cannot be carried out until the 11th week of pregnancy. Testing embryos before they are implanted can help avoid miscarriage or having to make a difficult decision about whether to end an existing pregnancy.

If you are considering genetic testing, you should talk to your GP to go through the options available. Your GP will also refer you to see a genetic specialist at your local hospital or fertility clinic.

There are only a small number of clinics in the UK that offer embryo testing – you can find the one nearest you using the Choose a Fertility Clinic search function on our website at www.hfea.gov.uk/choose-a-clinic/clinic-search and refining by embryo testing facilities.

Pre-implantation genetic diagnosis (PGD)

Pre-implantation genetic diagnosis (PGD) enables people with an inheritable condition in their family to avoid passing it on to their children. It involves checking the genes and/or chromosomes of embryos created through IVF.

Is PGD for me?

Your specialist may recommend PGD if:

- you have ended previous pregnancies because of a serious genetic condition
- you already have a child with a serious genetic condition
- you have a family history of a serious genetic condition, or
- you have a family history of chromosome problems.
Which genetic conditions can be tested for during PGD?

PGD can be used to test for virtually any genetic condition where a specific gene is known to cause that condition. It is currently approved to screen for over 250 genetic conditions – the full list is available on our website at www.hfea.gov.uk/pgd-conditions

If you want to screen for a condition which has not been approved, your clinic will need to make an application to us. For it to be approved, we must, by law, agree that the genetic condition meets certain criteria (including that it is serious enough). Even if we have approved a condition for testing, clinics must make their own judgment about whether PGD is appropriate for you.

How does PGD work?

The procedure for PGD is usually as follows:

1. You undergo normal IVF or ICSI treatment to collect and fertilise your eggs (see p40 and 46).

2. The embryo is grown in the laboratory for two to three days until the cells have divided and the embryo consists of around eight cells.

3. A trained embryologist removes one or two of the cells (blastomeres) from the embryo.

4. The cells are tested to see if the embryo from which they were removed contains the gene that causes the genetic condition in your family.

5. The embryo unaffected by the condition is transferred to the womb to allow it to develop.

6. Any suitable remaining unaffected embryos can be frozen for later use (see p67). Those embryos that are affected by the condition are allowed to perish or, with your consent, used for research (see p84).
**Trophectoderm biopsy**

It is possible that, instead of removing and testing one or two cells from a two to three-day-old embryo, some clinics may allow the embryo to develop to five to six days, when there are 100-150 cells.

At this stage, cells within an embryo have separated into two types: cells which will form the fetus (inner cell mass) and cells which will form the placenta (trophectoderm).

More cells can be removed at this stage (from the trophectoderm) without compromising the viability of the embryo, possibly leading to a more accurate test.

**Sex selection**

In the UK, it is illegal to use embryo testing for social sex selection. You can use sex selection only to avoid having a child with a serious medical condition, not for non-medical reasons.

- Find out more about PGD on our website: [www.hfea.gov.uk/treatments/embryo-testing-and-treatments-for-disease/pre-implantation-genetic-diagnosis-pgd](http://www.hfea.gov.uk/treatments/embryo-testing-and-treatments-for-disease/pre-implantation-genetic-diagnosis-pgd)

**Key facts**

- Genetic testing can also reveal other information about you. Have a full discussion with your genetic counsellor about what information you could find out and the implications of this.
Pre-implantation tissue typing (‘saviour siblings’)

For children with life-limiting blood disorders such as beta thalassaemia, Fanconi’s anaemia and Diamond Blackfan anaemia, one of the best available treatments is a transfusion of stem cells from cord blood provided by a tissue-matched donor.

Preimplantation tissue typing (PTT) offers parents the chance of conceiving a child who is a tissue match with their older sibling. Using a tissue-matched donor who is a close relative of the recipient often means that treatment is more likely to be successful than using a tissue-matched unrelated donor.

In the media, those born following this procedure have sometimes been referred to as ‘saviour siblings’.

Is PTT for me?

You should talk to the clinician who is treating your child about whether PTT is an appropriate option for you. It may be suggested as an option if:

• your child has a life-limiting blood disorder that can only be treated through a donation from a compatible donor
• there are no closely-related compatible donors available in your family and your clinician has established that an unrelated donation from a tissue bank would not be suitable
• the condition your child suffers from has an established genetic basis and you also want to ensure that any future children you have do not inherit the condition.

How does PTT work?

PTT uses the same technique as PGD but involves testing the tissue type of the embryo. Read more about PTT on our website at www.hfea.gov.uk/treatments/embryo-testing-and-treatments-for-disease/pre-implantation-tissue-typing-ptt
**Treatment add ons**

During fertility treatment, your clinic may offer you ‘extras’ on top of IVF or ICSI, such as reproductive immunology, time-lapse imaging and pre-implantation genetic screening (PGS). These add ons could be at an additional cost, or some clinics might include them with their treatment packages. Some add ons are also offered on the NHS.

Treatment add ons are typically emerging techniques that could have shown some promising results in initial studies but haven’t necessarily been proven to be effective and some may actually cause you harm.

We would recommend that you have a full discussion with a specialist at your clinic about the evidence for these treatments and why a certain one might be particularly recommended for you. You may also want to carry out your own further research before choosing whether to proceed. To make it easier to identify which add ons have good evidence supporting their effectiveness and safety we have created a rating system on our website, giving the treatments either a green, yellow or red symbol based on these criteria.

Find out more about what add on treatments involve and what evidence there is for them so you can make an informed decision at www.hfea.gov.uk/treatments/explore-all-treatments/treatment-add-ons
Storing eggs, sperm and embryos

You may consider storage if you want to preserve your fertility, or if you have surplus embryos or sperm after IVF or ICSI treatment which you want to use in future treatment. This section gives you an overview of what’s involved in the freezing process.
Getting started: your guide to fertility treatment

To be stored, eggs, sperm and embryos are frozen by cooling them slowly or by using a process called vitrification (fast freezing and then storing in tanks of liquid nitrogen).

Your clinic will ask you to fill out a consent form specifying how long you want to store for (more on p81). – The standard storage period is 10 years and this can be exceeded only in certain circumstances. Your clinician will be able to explain whether you can do this and for how long you may be able to store for.

You must let the clinic know if you change address. This is so that they can contact you when the storage period is coming to an end. If they cannot contact you when the storage period ends, they may take your eggs, sperm or embryos out of storage and allow them to perish.

Where do I start?

If you haven’t had fertility treatment before and want to store your eggs, sperm or embryos, for example to preserve your fertility, you can find your nearest clinic using the advanced search on our Choose a Fertility Clinic search function: www.hfea.gov.uk/choose-a-clinic/clinic-search

If you have an infectious disease, such as HIV, you will need to find a clinic which has dedicated storage facilities to keep eggs, sperm or embryos. You can filter for this using the advanced search option.

Freezing and storing embryos

Often with IVF or ICSI, people have a number of unused embryos after their first cycle. Some people choose to freeze them for use in later treatment cycles or to donate for use in others’ treatment, research purposes or training.

Your chances of becoming pregnant with a thawed frozen embryo are not affected by the length of time the embryo has been stored. But not all embryos will survive freezing and eventual thawing when they come to be used. Very occasionally no embryos will survive.
Is embryo freezing and storage for me?

You may consider freezing your embryos for the following reasons:

- It gives you the option of using the embryos in future IVF or ICSI cycles.
- If your treatment needs to be cancelled after egg collection (for example, if you have a bad reaction to fertility drugs), you may still be able to store your embryos for future use.
- If you have a condition, or are facing medical treatment for a condition, that might affect your fertility (embryo freezing is currently the most effective way for women to preserve their fertility).
- You are at risk of injury or death (eg, you’re a member of the Armed Forces who is being deployed to a war zone).
- You are due to undergo a sex change operation.

What happens when embryos are frozen and stored?

You and, if applicable, your partner will need to give written consent for your embryos to be stored (see p82).

Embryos will be created through IVF or ICSI and those of suitable quality will be frozen. See p40 and 46 for more information on IVF and ICSI.

What happens when I want to use the frozen embryos?

The exact procedure for using your frozen embryos varies, depending on your personal circumstances and the type of treatment your clinic offers.

The initial steps depend on whether you are ovulating regularly.
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 the thickness of the endometrium lining of your uterus. Urine or blood tests may be used to check when you are ovulating (releasing an egg).

If your periods aren’t regular, or you don’t have them at all, your doctor may suggest you use drugs to suppress your natural cycle and trigger a ‘false’ period. You are then given medication to help prepare the endometrium lining for an embryo.

When the endometrium is at its most receptive, the clinic’s embryologist thaws the embryos. Up to two or three embryos may be transferred using the embryo transfer procedure described on p42. Your clinic will recommend single embryo transfer (SET) if they feel it is the best option for you due to the risks associated with multiple births (see p78).

Key facts

- You may also decide to freeze your unused embryos for research or training purposes, or for use in others’ treatment.

- Find out more about donating your frozen embryos on our website at www.hfea.gov.uk/donation/donors/donating-your-embryos You can learn more about the human embryo research we license at www.hfea.gov.uk/donation/donors/donating-to-research
Freezing and storing sperm

Sperm cells have been frozen, thawed and successfully used in treatment for more than 40 years, although not all sperm survive the freezing process.

Is sperm freezing and storage for me?

You may want to consider it if:

- you have a condition, or are facing medical treatment for a condition, that may affect your fertility
- you’re about to have a vasectomy
- you have a low sperm count or the quality of your sperm is deteriorating
- you have difficulty producing a sample on the day of fertility treatment
- you had a medical procedure to collect sperm for ICSI treatment and there are surplus sperm which you’d like to store for use in future treatment
- you’re at risk of injury or death (eg, you’re a member of the Armed Forces who is being deployed to a war zone)
- you’re about to undergo a sex change operation.

What happens when sperm are frozen and stored?

1. Before you agree to the freezing and storage of your sperm, your clinician will explain the process involved.
2. You will be screened for infectious diseases, including HIV and hepatitis B and C.
3. You will need to give written consent for your sperm to be stored (see p81).
4. At the clinic, you produce a fresh sample of sperm.
5. The sperm are frozen and then stored in a storage tank containing liquid nitrogen.
What happens when I want to use my sperm?

Your treatment options may include IUI, IVF or, if your sperm are not of optimum quality, ICSI. You can read more about these treatments in this guide.

Freezing and storing eggs

The use of frozen eggs in treatment is a relatively new development. Very few babies have been born in the UK after treatment using patients’ own frozen eggs (although more have been born from donor eggs).

However, vitrification has recently been shown to improve the chance of eggs surviving the freeze-thaw process and therefore increase the success rate.

Is egg freezing and storage for me?

Storing your eggs may enable you to use them for treatment in the future. You may want to discuss storing your eggs with your clinic if:

• you have a condition, or are facing medical treatment for a condition, that may affect your fertility
• you are concerned about your fertility declining as you get older and are not currently in a position to have a child
• you are at risk of injury or death (eg, you’re a member of the Armed Forces who is being deployed to a war zone)
• you are about to undergo a sex change operation.

What happens when eggs are frozen?

The procedure for freezing and storing eggs is as follows:

1. Before you agree to the freezing and storage of your eggs, your clinician will explain the process involved, including the risks. Your clinic should also offer you the opportunity to discuss your feelings and any concerns with a specialist counsellor.

2. You will be screened for infectious diseases, including HIV and hepatitis B and C.
3. You will need to give written consent for your eggs to be stored (see p82).

4. Eggs are collected using the same procedure as for conventional IVF (see p40).

5. Cryoprotectant (freezing solution) is added to protect the eggs when they are frozen.

6. The eggs are frozen either by cooling them slowly or by vitrification.

**What happens when I want to use my eggs?**

Your treatment options may include in vitro maturation (IVM), IVF or, if the sperm you are using is not of optimum quality, ICSI. You can read more about IVF and ICSI in this guide and information about IVM is available on our website at [www.hfea.gov.uk/treatments/explore-all-treatments/ivf-options](http://www.hfea.gov.uk/treatments/explore-all-treatments/ivf-options)

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**Ovarian tissue freezing**

If you are about to have treatment for cancer which may affect your future fertility and you are not able to freeze your eggs or embryos, ovarian tissue freezing may be an option.

**Is ovarian tissue freezing for me?**

Ovarian tissue freezing is in the very early stages of use but it may be a suitable option for:

- girls or some women wishing to preserve their fertility before undergoing cancer treatment (eg, if there is not enough time to undergo an egg collection before treatment starts)
- girls who are undergoing medical treatment which may affect their future fertility but who have not reached puberty yet and do not therefore have any mature eggs to collect from their ovaries for egg freezing.
For advice on ovarian tissue freezing, please speak to your relevant medical professional, such as oncology and/or fertility specialists.

**What does ovarian tissue freezing involve?**

Ovarian tissue freezing involves either taking a whole ovary or small pieces of tissue from an ovary, containing eggs, which is then frozen and stored.

The ovary or tissue could later be transplanted back to potentially restore natural fertility. However, ovarian tissue is fragile under some freezing conditions and putting it back into the body carries the risk of re-introducing cancerous cells.

Currently only a few centres in the UK offer the service of storing ovarian tissue.

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**Testicular tissue freezing**

Researchers are also currently exploring testicular tissue freezing as a fertility preservation option for men and boys undergoing cancer treatment.

**Is testicular tissue freezing for me?**

Storing sperm is the only established way to preserve male fertility. Studies have shown that sperm can be retrieved and stored from patients as young as 13 years old and storing sperm for a long time should not alter their ability to fertilise an egg.

Testicular tissue freezing is still highly experimental but may be an option for:

- younger boys wishing to preserve their fertility before undergoing cancer treatment
- men who are unable to produce sperm.
What does testicular tissue freezing involve?

Currently only a few centres in the UK offer testicular tissue freezing.

The technique involves taking a small piece of tissue from a testicle which is then frozen and stored (either as individual cells or as a piece of tissue).

The cells or tissue could later be injected or transplanted back to potentially restore natural fertility.

Alternatively, in the future, researchers may be able to produce sperm from these cells in a laboratory. This sperm could then fertilise an egg in a laboratory and be used in fertility treatment.

Key facts

- Your chemotherapy treatment can in some cases be affected when you delay cancer treatment in order to freeze your sperm, eggs, embryos or tissue.

- Only a small number of babies have been born worldwide following transplantation of frozen-thawed ovarian tissue.

- The chance of successfully conceiving following ovarian tissue freezing is low and we do not yet know whether ovarian tissue from pre-pubertal girls can result in a successful pregnancy when transplanted back after puberty.

- There have been no births reported following testicular tissue freezing.
What to think about before starting treatment

It’s vital that you feel fully informed and are comfortable with the recommended treatment. This section goes through the various things you’ll need to consider before starting treatment.
Cost

If you are paying for fertility treatment, your clinic should give you a costed treatment plan detailing the specific procedures you need. This can help you understand how these costs are calculated.

Some clinics may offer you extra services, such as new technologies, which will carry an additional cost. We recommend that you conduct thorough research into any of these treatments to ensure you are fully informed about whether you require these optional services (see p65 for further details).

Your clinic should give you regular cost updates as your treatment progresses or changes. If you don’t understand what a particular charge is for, or how it is calculated, ask your clinic to explain.

Some clinics offer IVF cycles at a reduced cost if you donate some of your eggs for others to use (egg sharing) or for research.

Some clinics also offer IVF cycles at a reduced cost if a man donates his sperm for others to use (sperm sharing) or for research.

Key facts

If you are thinking about donating your eggs, sperm or embryos there are various things to consider. For more information, visit www.hfea.gov.uk/donation/donors
HFEA fees

We do not charge individual patients for fertility treatment. Clinics, both NHS and private, pay us a fee towards the costs of being regulated and inspected.

The fee is based on the number of treatments clinics carry out.

Some private clinics pass on this fee to their patients. Others cover the cost in their overall treatment fees. If you are paying for treatment, ask your clinic about their practice.

Our fee enables us to make sure your clinic is complying with the law and is providing safe and appropriate treatment.

Risks

Like all medical procedures, fertility treatment carries risks. Your clinic should discuss them with you before you go ahead.

Risks can include reactions to fertility drugs that may be prescribed, as well as the risks associated with any pregnancy. Keep in touch with your clinic throughout your treatment so that any problems can be dealt with promptly.

It’s also important to know that one of the biggest risks of fertility treatment is that it might not be successful.

Latest figures show that around a third of women under 35 get pregnant after having IVF or ICSI using fresh embryos created with their own fresh eggs. This national average success rate declines as a woman gets older.

Other treatments such as IUI have even lower success rates. For more information on success rates, see p27.
**Multiple births**

A multiple birth (twins, triplets or more) is the single greatest health risk of fertility treatment as it carries risks to the health of the mother and the unborn children. For example:

- at least half of twins are born before 37 weeks and with low birth weights, making them at high risk of serious health problems

- over 90% of triplets are born before 37 weeks and many are born so early that they have a greater risk of long-lasting, serious health problems or may die soon after birth

- a small percentage of twins have severe health problems that will affect their entire lives (for example cerebral palsy, which affects between four and six times as many twins compared with singleton babies).

You are more likely to become pregnant with twins or triplets if more than one embryo is transferred. To reduce this risk, your clinic will recommend transferring one embryo (single embryo transfer (SET)) if they feel it is the best option for you.

This will depend on factors such as your age and the number and quality of embryos you have available for transfer.

If you are a suitable patient, you can largely remove the risk of a multiple birth, while maintaining your overall chance of having a baby, by having SET. Any remaining embryos with a good chance of implantation can be frozen and stored. If you do not become pregnant, the frozen embryos can be thawed and transferred one at a time until you become pregnant or all the embryos have been used (read more about freezing and storing on p66).

For more information on SET and the risks of multiple births, see the one at a time website: [www.hfea.gov.uk/about-us/our-campaign-to-reduce-multiple-births](http://www.hfea.gov.uk/about-us/our-campaign-to-reduce-multiple-births)
The expert says...

“Women are designed to have one baby at a time, as a singleton pregnancy provides the safest outcome for both mother and baby. Historically IVF and ICSI have relied on replacing multiple embryos to bolster pregnancy rates, but unfortunately this has led to a huge increase in the number of multiple pregnancies. Now, as IVF techniques have advanced, particularly our ability to select the best embryos for transfer and successfully freeze surplus embryos, doctors have become more confident in replacing a single embryo and maintaining excellent live birth rates.”

Professor Adam Balen, British Fertility Society

Ovarian hyper-stimulation syndrome (OHSS)

OHSS is a potentially dangerous over-reaction to the fertility drugs used to stimulate egg production. This complication is unlikely to develop if you are using mild fertility drugs such as clomifene. However, with IVF and ICSI, where a larger cluster of eggs is being stimulated to grow, one in 20 patients develop some symptoms.

Your ovaries will be regularly scanned during treatment, so the clinic staff will be aware if you may be at risk of OHSS.

The symptoms include a swollen stomach and stomach pains. In a more severe case, you may experience nausea and vomiting, severe stomach pains and swelling, shortness of breath, faintness and produce less urine.
OHSS can result in a hospital admission and can very occasionally be life-threatening. If you start to experience any of the above symptoms, you must contact your clinic immediately. Never feel you are wasting the clinic’s time.

**Ectopic pregnancy**

An ectopic pregnancy is when an embryo implants outside the womb. It most commonly occurs in the fallopian tube, although occasionally an ectopic pregnancy can develop in the ovary. The major risk is that the pregnancy will rupture through the tube and cause internal bleeding.

The chances of an ectopic pregnancy seem to be higher in women receiving IVF, especially if they already have problems with their fallopian tubes. The first symptom is usually a one-sided low abdominal pain, followed by vaginal bleeding or dark brown or red vaginal discharge. As the pregnancy continues, the pain increases. Speak to your doctor straight away if you have any stomach pain or vaginal bleeding in early pregnancy.

**Drug reaction**

Some people experience a mild reaction to fertility drugs, including symptoms such as hot flushes, headaches, restlessness, or feeling down and irritable.

There are different types of fertility drugs and different ways to use them. You should ask your clinic what they use and what side effects are likely.

If you have any unexpected reaction to treatment, you should always contact your clinic.
Consent to treatment

When you are going through treatment there are lots of things to think about and paperwork is probably the last thing on your mind. However, by law, sperm, eggs and embryos can only be used or stored if you (and, if applicable, your partner) provide your written consent. There are also other important decisions to be made, such as what you would like to happen to your unused sperm, eggs or embryos (see ‘Donation’ on p84 and ‘Storing embryos’ on p67).

The purpose of all these forms is to ensure that your sperm, eggs, embryos and information are only used in the way that you want them to be and, where applicable, you (and where relevant, your partner) are legally recognised as your child’s parent(s).

Before filling in these forms, your clinic needs to make sure you are given all the relevant information you need to make fully informed decisions. This includes information about:

- the different options set out in the forms
- the implications of giving your consent
- the consequences of withdrawing your consent
- how to make changes to, or withdraw your consent, and
- an opportunity to have counselling.

If you’re unsure, or think that you have not been given all of this information, speak to your clinic. Without it, your consent may be invalid.

As outlined previously on p32, the specific consent forms that you will need to complete will depend on your individual circumstances. However, they fall into five broad themes:
Consent to fertility treatment and/or storage (freezing)

These forms ask you whether you consent to your treatment and/or for your sperm, eggs or embryos to be stored (and if so, how long for).

They also ask questions about whether you are happy for your eggs, sperm or embryos to be used for training purposes (to allow healthcare professionals to learn about, and practice, the techniques involved in fertility treatment). This option is most often considered when there are surplus sperm, eggs or embryos to your treatment, although sperm can be collected solely for training purposes. Ask your clinic about what training purposes your eggs, sperm or embryos to be used for as this can vary from clinic to clinic.

Some of these forms also ask you what you would like to happen to your sperm, eggs or embryos if you were to die or become unable to make decisions for yourself. Take your time to complete these forms and don’t hesitate to ask your clinic if you have any questions.

Disclosure of information

Your clinic holds identifying information about you such as your name, address and date of birth as well as information about your treatment or care.

By law, your clinic must submit some of this information to us to be stored on a secure fertility treatment database called the Register.
Sometimes your clinic may want to share some of this identifying information with other parties. For example:

• to discuss your medical history with your GP to plan the most appropriate treatment

• to discuss your treatment with another healthcare professional outside your clinic (eg, gynaecologists or oncologists at another hospital) in order to give you the best possible medical care

• to share information for clerical or financial reasons (eg, with administrative staff or auditors reviewing your clinic’s finances).

Sometimes your clinic or the HFEA may also want to share some of this identifying information for medical research investigating, for example, how fertility treatment can be made safer or more effective.

For more information on disclosing identifying information for research purposes, visit www.hfea.gov.uk/code-of-practice/5

Your clinic and the HFEA are not allowed to share identifying information with these parties unless you provide your written consent for this (apart from in a medical emergency). These forms allow you to provide your consent to sharing your information for these reasons.
Donation

Some people decide to donate sperm, eggs or embryos for use in others’ treatment (for example, as part of an egg or sperm sharing agreement – see p84).

In this case, you will need to complete a form outlining how you want your sperm, eggs or embryos to be used and stored.

Donating for use in others’ treatment can give some people their only chance of having a baby. If you are considering this, there are lots of things to think about.

For more information, see www.hfea.gov.uk/donation/donors

Sperm, eggs and embryos can also be donated for research purposes, helping to increase knowledge about diseases and serious illnesses and potentially develop new treatments, methods and techniques. If you’re interested in this option, ask your clinic for more information and for the relevant consent form(s).

For more information about the research we license, visit www.hfea.gov.uk/donation/donors/donating-to-research
Parenthood

If:

• your partner is having fertility treatment using donor sperm, embryos created using donor sperm or donor embryos, and

• you are not married or in a civil partnership with them, the law requires you to give your written consent if you want to be the legal parent of any child born from their treatment. Your partner must also give their consent to you being the legal parent. You must both provide this consent before egg, sperm or embryo transfer. For more information, please see www.hfea.gov.uk/code-of-practice/6

Besides making sure that you sign the right consent forms, your clinic should also:

• offer counselling about the implications of receiving treatment following consent to parenthood before treatment is provided

• provide appropriate information to you and your partner about the implications of consent to parenthood

• notify you or your partner if consent to parenthood is withdrawn or changed.
**Surrogacy**

If you are entering into a surrogacy arrangement, there are specific forms you will need to complete to consent to the use and storage of sperm, eggs or embryos.

These ask similar questions to the other consent to treatment and storage forms described earlier. There is also a separate consent to legal parenthood form which you will need to complete if you wish to be the second legal parent of the child when born (and if certain conditions are met).

**Withdrawing or changing your consent**

You can change or withdraw your consent by contacting the clinic where your sperm, eggs, or embryos are being stored, as long as they have not already been used in treatment, research or training.

To view all of the consent forms visit [www.hfea.gov.uk/about-us/how-we-regulate/consent-forms](http://www.hfea.gov.uk/about-us/how-we-regulate/consent-forms)

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**What’s it really like?**

“It’s just a long waiting game. You always seem to be waiting: waiting for appointments, waiting for results, waiting to hear what you can do next.

“I get very frustrated when nothing is happening and I’m not taking any drugs or trying to help things along. The emotions are such a rollercoaster – one minute low, the next as high as a kite and then we’d hit rock bottom.”

Michelle and David had various fertility treatments and sadly still do not have a positive outcome.
Get support and advice

Whichever stage you’ve reached in treatment, it can help to talk things through. This section gives you information about support groups, websites and professional counsellors that can help you through your journey.
As outlined in the ‘Get started’ section of this guide, it’s important that you seek emotional support when going through fertility treatment. Talking to a counsellor before, during and after treatment can help you through your journey, which many people describe as an emotional rollercoaster. You may also want to consider joining a support group. Read more about counselling and support groups on p23.

A list of useful contacts can be found at the end of this chapter on p90-92.

**If fertility treatment fails, what next?**

Treatment doesn’t always work and you may need time to recover physically and emotionally before trying again, or you may decide not to pursue further treatment. This can be a difficult and painful decision, and it can take a long time to accept its implications.

Don’t ask too much of yourself, and remember there are always people you can talk to who have been through similar experiences.

**Take a break**

Many experts recommend that you wait for a couple of months after treatment before trying again. This gives you a break from the stress of treatment and a chance for your body to recover.

It can also be an important time to think about your options and decide whether to continue treatment. Recognising that fertility treatment may not work for you can be a long and emotionally draining process.

**Points to think about**

You may want to talk to your clinician about whether to try again – using the same or a different method – and whether you can do anything to boost your chances of conception next time.

If appropriate in your particular circumstances, you may want to talk to your clinician about using a donor or a surrogate.

A counsellor may be able to help you talk through your feelings.
**Understand why your treatment didn’t work**

Talking to your clinician about why your treatment hasn’t succeeded can help you decide what to do next. There are many reasons why things can go wrong.

**Choosing to stop treatment**

A time may come when you will have to decide whether to stop treatment.

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. You may want to consider counselling.

You may find it helpful to get in touch with More to Life, an online community of people who are childless by circumstance and not by choice: [fertilitynetworkuk.org/for-those-facing-the-challenges-of-childlessness](fertilitynetworkuk.org/for-those-facing-the-challenges-of-childlessness)

**Looking at the alternatives to treatment**

Stopping treatment can lead to further choices.

- It may help to talk to a counsellor, or to others who have been in a similar situation, as you decide how you can best move on.
- You may wish to explore the possibility of other options for having children, such as adopting and fostering.
- You may want to explore what life without children has to offer. More to Life aims to offer support for those in this situation (see p91).
Contacts

British Fertility Society
A national organisation representing professionals in the field of reproductive medicine.
www.britishfertilitysociety.org.uk

British Infertility Counselling Association
A professional association for infertility counsellors and counselling in the UK.
www.bica.net

Chana
Supports couples in the Jewish community experiencing infertility.
www.chana.org.uk

COTS – Childlessness Overcome Through Surrogacy Providing advice, help and support to surrogates and would-be parents.
www.surrogacy.org.uk

The Daisy Network
A registered charity for women who have experienced a premature menopause.
www.daisynetwork.org.uk

Donor Conception Network
A network of parents with children conceived using donated sperm, eggs or embryos; their adult offspring; and those contemplating or undergoing treatment.
www.dcnetwork.org

Endometriosis UK
A charity dedicated to providing information and support to those with endometriosis.
www.endometriosis-uk.org
Genetic Alliance UK
A national alliance of organisations with a membership of over 130 charities which support children, families and individuals affected by genetic disorders.

www.geneticalliance.org.uk

Fertility Network UK
Offers information and support to anyone affected by fertility problems. Also has a regularly updated list of support groups on its website.

www.fertilitynetworkuk.org

Macmillan Cancer Support
Provides quality-assured, up-to-date cancer information, written by specialists for patients, relatives and carers.

www.macmillan.org.uk

The Miscarriage Association
Provides support and information for those suffering the effects of pregnancy loss.

www.miscarriageassociation.org.uk

The Multiple Births Foundation
A vital resource to professionals and families alike, it aims to improve the care and support of multiple birth families through the education of all relevant professionals.

www.multiplebirths.org.uk
National Gamete Donation Trust
A charity that aims to raise awareness, and alleviate the shortage, of sperm, egg and embryo donors.
www.ngdt.co.uk

Stillbirth and Neonatal Death Charity
Supports anyone affected by the death of a baby and promotes research to reduce the loss of babies’ lives.
www.uk-sands.org

Surrogacy UK
Provides information and support for anyone interested in surrogacy.
www.surrogacyuk.org

Twins and Multiple Births Association
Provides support for families with twins, triplets and other multiple births.
www.tamba.org.uk

Verity
Provides support for women living with polycystic ovary syndrome.
www.verity-pcos.org.uk
The HFEA does not guarantee the accuracy of information or advice provided by other organisations mentioned in this guide and inclusion of their details does not imply any endorsement of them.

We’re keen to hear your feedback on this guide. Please send any comments and suggestions to gettingstarted@hfea.gov.uk

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