Regional Fertility Hub

Information Booklet

Contents

Part 1:
Your guide to the regional fertility hub service

Part 2:
Your Guide to fertility

Part 1:
Your guide to the regional fertility hub service

Introduction

Around 1 in 6 heterosexual couples may experience challenges in getting pregnant. Single and same sex individuals who wish to parent are additionally challenged as they need donor sperm, donor eggs or surrogacy.

There are a number of issues that can cause fertility problems – some may be related to women, some to men. In many couples, it can be a mixture of both, and in some cases, no cause is found as to why heterosexual couples may be struggling to conceive.

20-30% male related problems

20-35% female related causes

25-40% causes in both partners

10-20% no cause is found

That is why, for couples, the fertility team will look after both of you as a unit. It is important that you both attend clinic appointments and are both involved in the care available and the decisions being made.

At present, donor fertility services are not included in the state's public funding program. It is hope they will be in the future. However, single and same sex women may be referred to the fertility hubs if they have known fertility-related medical conditions.

Regional Fertility Hubs

There are six Regional Fertility Hubs based in public maternity hospital networks across the country. Fertility services are organised around these hubs and they are staffed by specially qualified doctors, nurses, admin staff and scientists. You must attend the hub in your area. There is no cost to patients for tests or treatment in the Regional Fertility Hubs.

The fertility teams at the hubs offer fertility tests, investigations, treatments and advice. These include:

- relevant blood tests
- specialised scans and x-rays
- semen analysis
- fertility-related surgery
- medical management of fertility challenges including ovulation induction with follicle tracking.

Many people will have their fertility issues managed at this stage at the hub. If recommended by a Reproductive Medicine Consultant at the fertility hub, you may be referred for further advanced treatment.

The Regional Fertility Hub will have further information on the specialist tests and treatments available and the access criteria for publicly funded advanced treatments such as IUI and IVF.

GP Referral

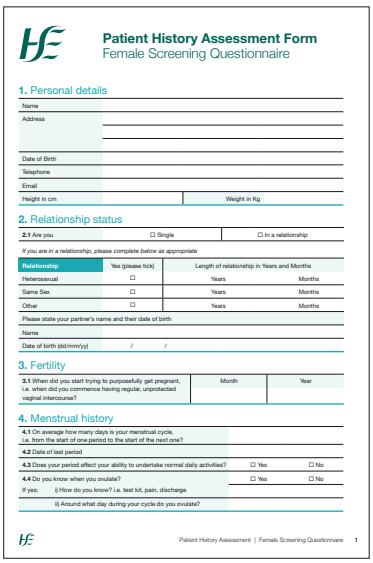
The team at the Regional Fertility Hub has received your referral from your GP. In your consultation with your GP, they will have advised you about your fertility journey. Your GP will also have arranged blood tests for female patients and may be following up with you on some of these results. This might include recommending updating your vaccinations.

Your GP has shared the results of your tests and investigations with the fertility team as part of your referral. Your GP will also have told us if they are arranging any further care for you.

What Happens Next

Screening Questionnaires

When the regional fertility hub received your referral, the fertility team at the hub sent you a male and a female questionnaire to complete and return (as part of this pack). The information you give in these questionnaires will help the team to have a complete picture of your health, medical history and your fertility journey to date. This will help the fertility team to plan your care based on your needs.



Patient History Assessment Form
Female Screening Questionnaire

1. Personal details

Name
Address
Date of Birth
Telephone
Email
Height in cm | Weight in Kg

2. Relationship status

2.1 Are you ☐ Single ☐ In a relationship

If you are in a relationship, please complete below as appropriate

Relationship	Yes (please tick)	Length of relationship in Years and Months	
Heterosexual	☐	Years	Months
Same Sex	☐	Years	Months
Other	☐	Years	Months

Please state your partner's name and their date of birth
Name
Date of birth (dd/mm/yy) / /

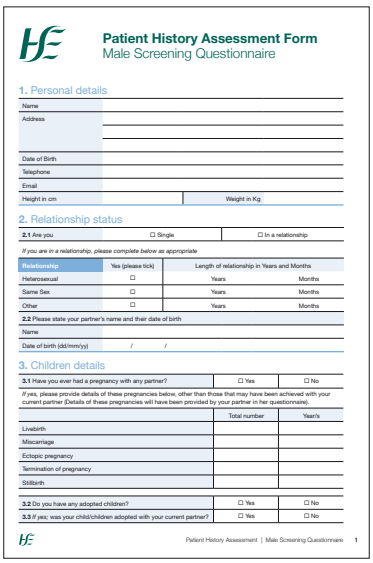
3. Fertility

3.1 When did you start trying to purposefully get pregnant, i.e. when did you commence having regular, unprotected vaginal intercourse?	Month	Year

4. Menstrual history

4.1 On average how many days is your menstrual cycle, i.e. from the start of one period to the start of the next one?
4.2 Date of last period
4.3 Does your period affect your ability to undertake normal daily activities? ☐ Yes ☐ No
4.4 Do you know when you ovulate? ☐ Yes ☐ No
If yes; i) How do you know? i.e. test kit, pain, discharge
ii) Around what day during your cycle do you ovulate?

Patient History Assessment | Female Screening Questionnaire 1



Patient History Assessment Form
Male Screening Questionnaire

1. Personal details

Name
Address
Date of Birth
Telephone
Email
Height in cm | Weight in Kg

2. Relationship status

2.1 Are you ☐ Single ☐ In a relationship

If you are in a relationship, please complete below as appropriate

Relationship	Yes (please tick)	Length of relationship in Years and Months	
Heterosexual	☐	Years	Months
Same Sex	☐	Years	Months
Other	☐	Years	Months

2.2 Please state your partner's name and their date of birth
Name
Date of birth (dd/mm/yy) / /

3. Children details

3.1 Have you ever had a pregnancy with any partner?	☐ Yes	☐ No

If yes, please provide details of these pregnancies below, other than those that may have been achieved with your current partner (Details of these pregnancies will have been provided by your partner in her questionnaire).

	Total number	Year/s
Livebirth		
Miscarriage		
Ectopic pregnancy		
Termination of pregnancy		
Stillbirth		

3.2 Do you have any adopted children? ☐ Yes ☐ No
3.3 If yes; was your child/children adopted with your current partner? ☐ Yes ☐ No

Patient History Assessment | Male Screening Questionnaire 1

Initial Investigations

Once we receive your screening questionnaires back, the fertility team will arrange for you both to have further specialised fertility tests and an appointment with the consultant.

The initial investigations will include:

- AMH blood tests for females;
- Pelvic ultrasound for females;
- Semen analysis for for males.

A brief description of why we do these tests and what they involve is set out below. You may also need other tests at this stage based on the information provided in your GP referral form and in your screening questionnaires. The fertility team will explain these to you if you need them.

AMH blood test

AMH stands for Anti-Mullerian Hormone, which is a hormone released from around the eggs in a woman's ovaries. A woman is born with all the eggs she will ever have. These eggs decline in number as the woman gets older and so too does her AMH level. This blood test can help the clinical team to estimate a woman's ovarian reserve – that is the number of eggs that she may have left in her ovaries.

A low AMH result does not mean that a person cannot get pregnant. It is simply one of many screening tests that help the fertility team to decide on the next steps that are most suitable for you.

Pelvic ultrasound

A pelvic ultrasound is a scan to check a woman's womb, your fallopian tubes and your ovaries. It can check for problems such as cysts, fibroids or severe endometriosis.

There are two types of pelvic ultrasound:

- Transabdominal (through the abdomen or tummy). A probe with gel is placed on the abdomen and moved over the skin. The woman needs a full bladder for this.
- Transvaginal (through the vagina). A long, thin probe covered with gel and a plastic or latex sheath is inserted into the vagina. This form of ultrasound is unlikely to cause you any discomfort and you do not need a full bladder. We will take all measures to ensure your comfort throughout the scan.

The type of ultrasound used depends on the reason for the ultrasound. In some cases, both methods may be needed. The fertility team will let you know which one is most suitable for you.

Sperm analysis

Sperm analysis (also called semen analysis) is one of the first tests that the fertility team will do to assess a man's fertility status. This involves the man ejaculating into a provided container. The sample is then analysed by trained laboratory staff.

The laboratory team will examine the number of sperm, how they are moving and their shape and structure. This helps the fertility team to determine what further actions or decisions may be needed in relation to your care.

The sperm test may be done on site in the regional hub or by an external provider on behalf of the regional fertility service. There is no cost for this test even if it is done by the external provider.

The fertility team will explain which option is available in their regional hub.

Reproductive Medicine Consultant Appointment

Once we have the test results back, we will make an appointment for you with a Reproductive Medicine Consultant. **In the case of couples, it is essential that both partners attend this appointment as decisions can only be made if you are both there.**

At this appointment, the consultant will review your medical history, your fertility journey to date and all the test results that are available. Based on these and a discussion with both of you, a decision will be made about the next steps. There are several options, which will be tailored to your particular needs.

1. Further targeted fertility investigations and diagnostic procedures

Further investigations may be needed to understand what the exact challenges are. These will support the Reproductive Medicine Consultant and their team to make a more informed decision about your plan of care.

In some fertility hubs, these tests will be arranged at your consultant appointment. In other cases, they may be arranged prior to that appointment. Such investigations and tests could include:

- Targeted blood tests to answer specific questions, for example to see if a woman is ovulating (releasing an egg) each month, and if not, why not?
- HyCoSy or HSG investigations. These are extra scans or x-rays used to check the shape of a woman's womb and check that there is no blockage in the fallopian tubes.
- Hysteroscopy. This is a procedure used to examine the inside of a woman's womb for any unusual vaginal bleeding, suspected polyps or fibroids or scarring. Sometimes minor surgery can also be performed during this procedure for example taking samples or removing polyps.

2. Medical management

This usually involves the administration of hormonal therapy to women who are not ovulating (producing an egg every month). It is usually in the form of tablets or injections which will hopefully stimulate the development and release of eggs. The woman's cycle can be tracked by ultrasound to establish the best time to try to conceive. If hormonal therapy is required for men for example to improve sperm production, this is usually done in conjunction with a specialist endocrinologist.

3. Surgical management

In some cases, surgery may be required to address challenges that have been identified. This surgery is usually minimally invasive surgery, i.e. keyhole surgery.

For women, this surgery could be targeted at managing ovarian cysts, endometriosis, tubal disease or pelvic scarring.

For men, this surgery could be targeted at unblocking and/or repairing the tubes that transport sperm. It is usually done in conjunction with a urologist.

4. Further specialist referrals

The fertility team may recommend that further specialist input is required to ensure the best possible care for you. This may involve a referral to another area of medicine to assess a particular element of your care.

For example, if a woman has severe and complex endometriosis, specialist input from a dedicated endometriosis team may be needed. Or if you have an existing medical condition, the fertility team may need to engage with the medical team that is managing your condition.

The fertility team may also refer you to other fertility specialists who may have expertise in particular areas in which you need support, for example endocrinology.

The fertility team will manage and organise all such referrals and engagement with other medical teams with your knowledge and agreement.

Specialist AHR treatment

The fertility team may recommend Assisted Human Reproduction (AHR) treatment for some people. This may be based on the findings and results of investigations or where treatment in the fertility hub has not resulted in a pregnancy. Assisted Human Reproduction (AHR) treatment includes IUI, ICSI and IVF.

- IUI (intrauterine insemination) is also called artificial insemination. It is when a sample of a man's sperm is injected into the woman's uterus (womb) around the time of ovulation.
- IVF (in vitro fertilisation) is where a woman's eggs are fertilised with a man's sperm in a laboratory. This can form embryos, one or two of which are then placed in the woman's womb.
- ICSI (intracytoplasmic sperm injection) involves the injection of sperm directly into an egg. It is a more specialised form of IVF used for certain sperm and embryo problems.

If you meet the access criteria for publicly funded AHR treatment, the fertility team can refer you to a HSE-approved private provider. Please see the HSE website for details of the access criteria. The fertility team will give you information about all HSE-approved private providers and refer you to whichever provider you choose. You will need to sign a consent form to say that you understand the proposed treatment and that you agree to your details being sent to the provider.

The fertility team will also give you a separate information pack about the steps involved in this process and what the treatment involves. The fertility team will also talk you through the process and answer any questions you may have.

If you do not meet the access criteria for publicly funded AHR treatment, the fertility team can refer you for private fertility treatment if you want them to. The care provided thereafter and the costs associated with it will be a matter for you and your chosen private provider.

Further information

If you have any questions about your fertility pathway, please contact your regional fertility team via the details on the letter accompanying this leaflet.

Part 2:
Your Guide to Fertility

Introduction

You may already know some of the information set out over the next few pages. However, we would encourage you to take the time to read through this guide so that you feel more confident and reassured about your level of information about your fertility.

You will be given further information about fertility problems and fertility treatments when you attend the Regional Fertility Hub.

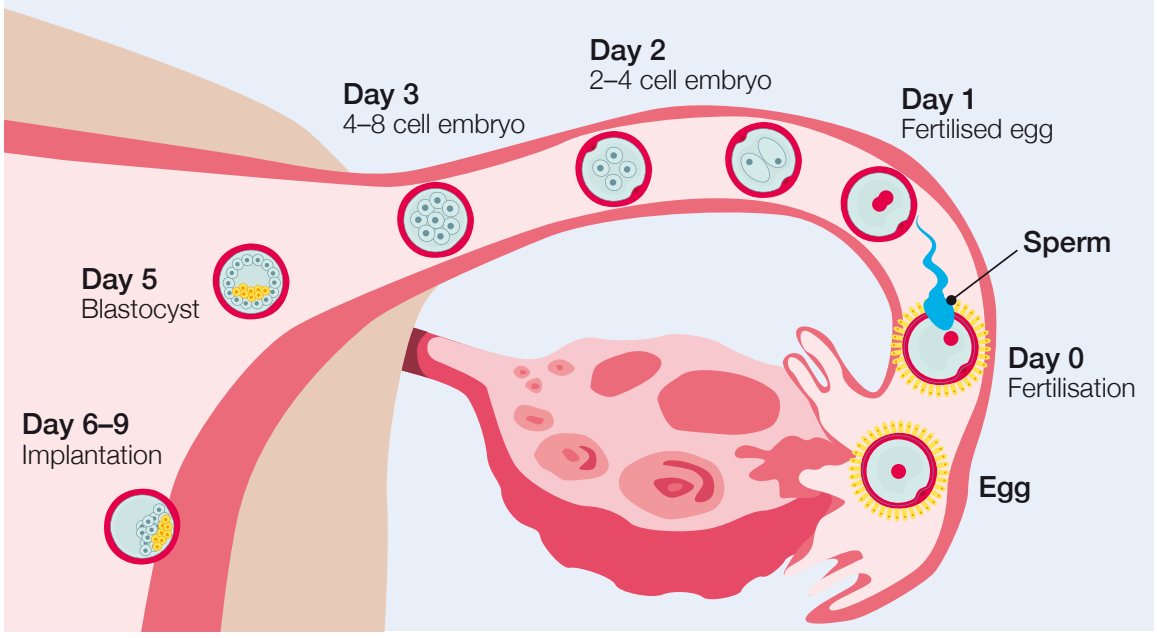
What do I need to do to become pregnant?

In heterosexual couples, in order to become pregnant naturally, a woman must produce an egg in her ovary, a man must have sperm and the couple need to have vaginal sexual intercourse so that the egg and sperm can meet and start a pregnancy. The egg is released from the woman's ovary at ovulation time and is picked up by the woman's fallopian tube. It stays there for 12 to 24 hours where it can be fertilised by sperm.

The man's sperm is released during ejaculation and must swim through the woman's vagina, cervix and uterus (womb) to the fallopian tube. Once in the tube, the sperm must fertilise the egg and then an embryo forms.

The embryo must move down the fallopian tube to the woman's womb (uterus), where it implants and starts a pregnancy. This whole process takes 7-9 days.

NATURAL CONCEPTION



About a woman's menstrual cycle

1. When does a woman ovulate?

Ovulation is where an egg is released from an ovary. On average this happens once a month, with one egg being released each month. A woman has two ovaries, one on each side of her body. Usually just one ovary releases an egg, and this occurs randomly on right or left. If a woman has only one ovary, this ovary will ovulate every month.

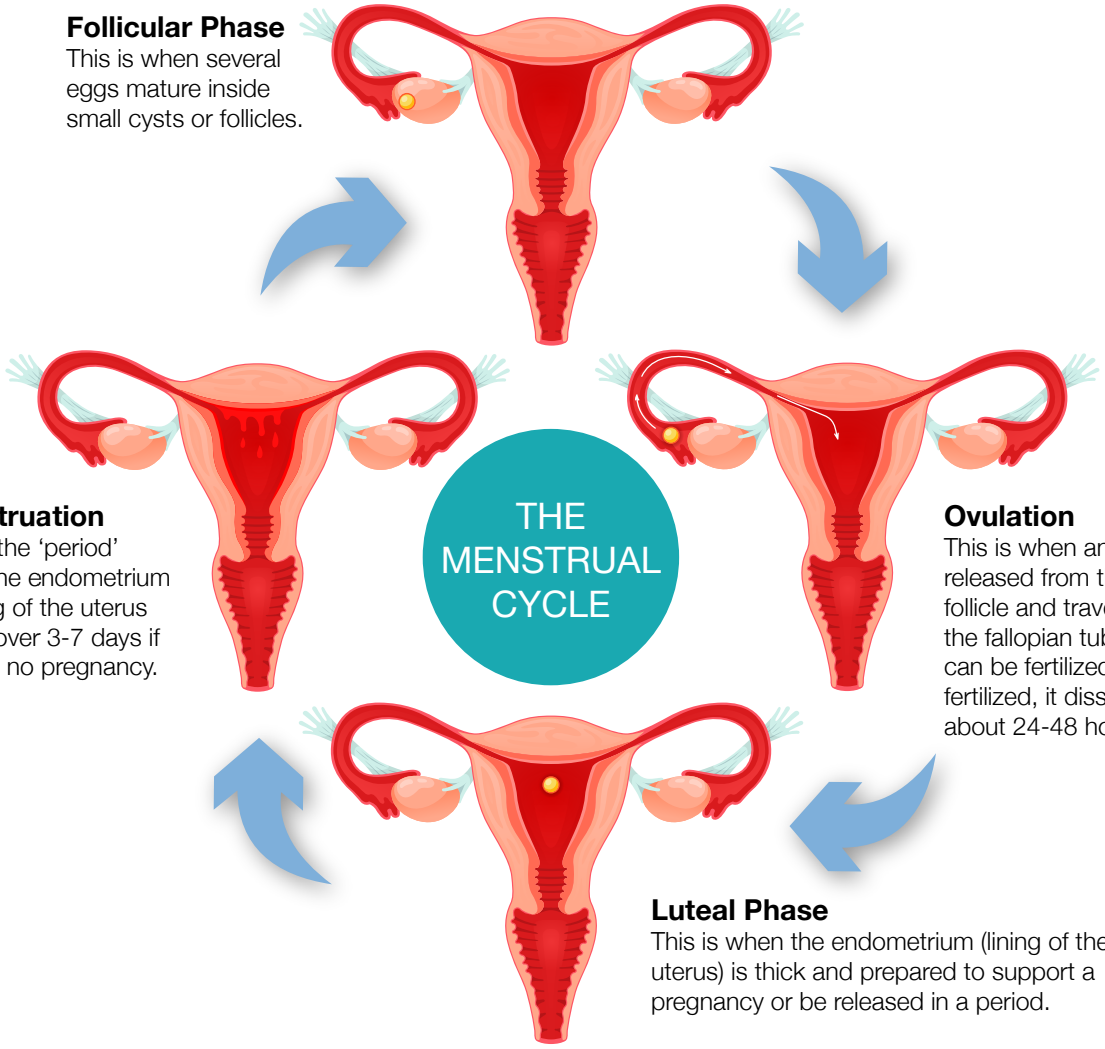
Ovulation is essential in order to conceive. The egg which is released is only fertile for around 24 hours so it is therefore important to have sex around the time of ovulation. (See "When is the best time to have sex.")

The menstrual cycle is a series of changes that a woman's body goes through every month as she ovulates and her uterus (womb) prepares for a possible pregnancy. The cycle is described as starting on the first day of a woman's period (Day 1) and ends on the day before the next period (Typically day 28.)

However a normal cycle length can be anywhere between 26 and 35 days. Ovulation usually occurs 13-15 days prior to your period commencing. For example, in a 28 day cycle, ovulation is likely to occur on Day 14.

During the cycle, different hormones are produced by the woman to support ovulation and a possible pregnancy. These hormones can be measured by blood tests.

Follicular Phase
This is when several eggs mature inside small cysts or follicles.



Menstruation
This is the 'period' when the endometrium or lining of the uterus sheds over 3-7 days if there is no pregnancy.

Ovulation
This is when an egg is released from the biggest follicle and travels through the fallopian tube where it can be fertilized. If it is not fertilized, it dissolves in about 24-48 hours.

Luteal Phase
This is when the endometrium (lining of the uterus) is thick and prepared to support a pregnancy or be released in a period.

2. How does a woman know she is ovulating?

It can be difficult to know exactly when you are ovulating but don't over focus on exact timing.

The signs of ovulation are different for everybody, and are not obvious at all for some people. If you are concerned, discuss this with your fertility team.

Signs that you are ovulating can include:

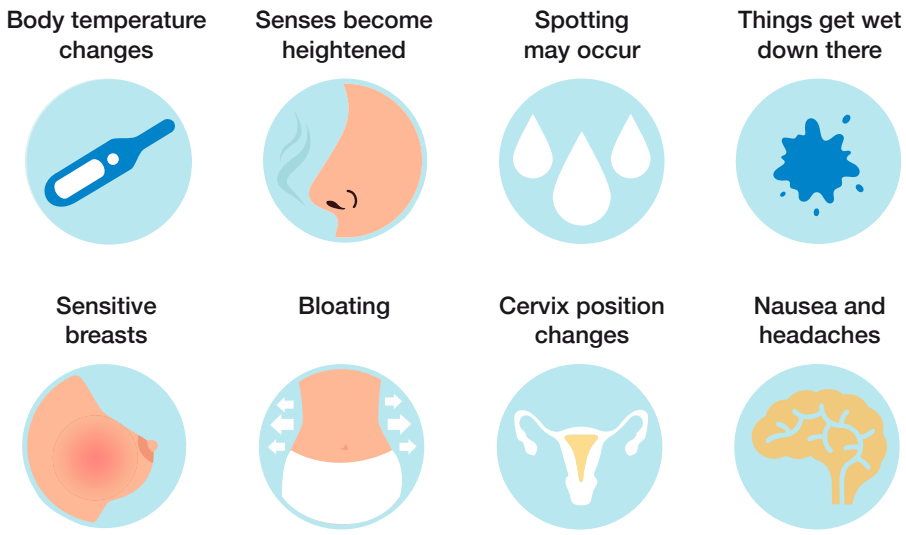
- **Regular cycle**
  Some women "are like clockwork" and get a period exactly every 28 days. Most women, however, have a bit of variation. A variation of up to 7 days is entirely normal. So, 27 days one month and 33 the next is fine. If your cycle is consistently less than 26 days, more than 35 days or very irregular, make sure to discuss this with your fertility team.

- **Changes in your cervical mucus**
  Coming up to the time of ovulation, the amount of cervical mucus increases, and it becomes thinner, clearer and has a slippery consistency, similar to raw egg white. It has been shown that pregnancy rates are highest when intercourse occurs on the day of maximum mucus. If you don't notice mucus, don't worry. It's not essential but, if you do, it helps to reassure you that you are ovulating and when.

- **Ovulation pain**
  Around the time of ovulation some women get a pain in one ovary. This is triggered by the release of the egg. It is a useful way of detecting ovulation, and if you have not had sex coming up to this time, it would be important to do so that day if possible. Ovulation pain is normal and can vary from cycle to cycle. If you do not feel it, again do not worry, that is very normal.

- **Changes in sex drive**
  A woman's sex drive often increases coming up to ovulation. This is seen as something that has evolved in humans to maximise fertility.

- **Other symptoms**



3. What is an ovulation predictor kit, and should we use one?

There are many home ovulation kits available in pharmacies and online. Most of these all act by measuring a woman's Luteinising Hormone (LH) hormone, which is produced by the woman just before ovulation and triggers the egg to be released. Some kits also measure oestrogen which also rises before ovulation.

The vast majority of these kits measure the hormone levels in the woman's urine but there are some that use saliva. There are also lots of apps which aim to predict the time of ovulation.

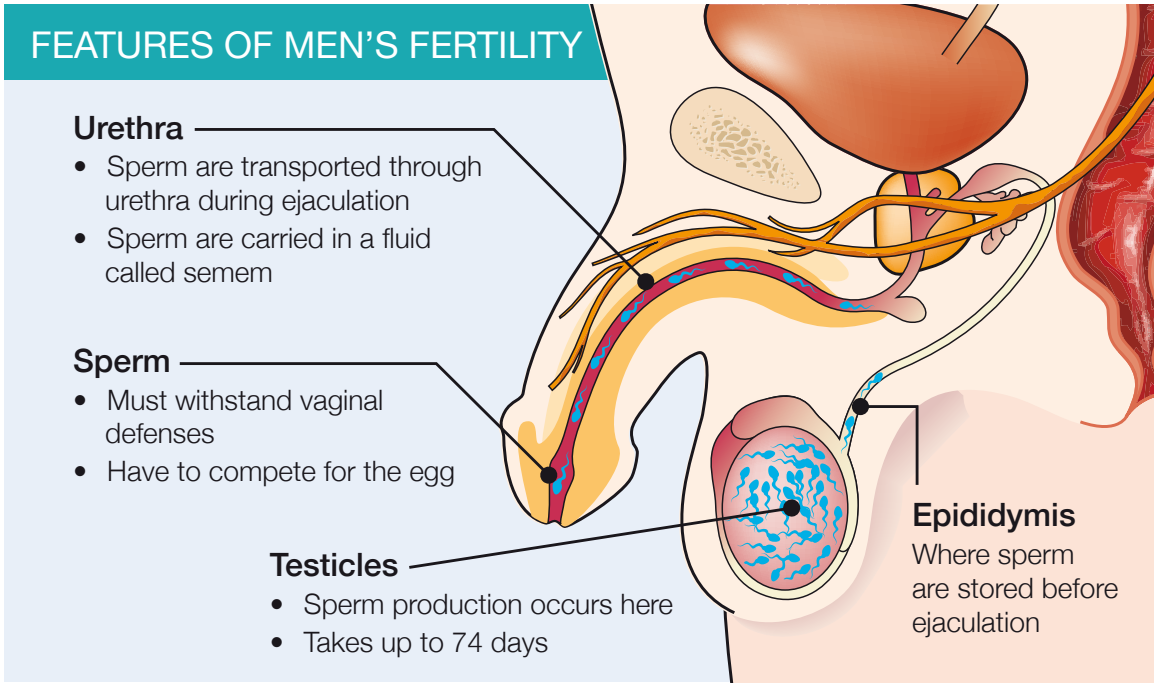
These kits may be helpful in supporting a woman to become aware of when she is ovulating. However, it is important to note that some studies have shown that the kits and apps may underestimate when the woman is most fertile and in using them, a couple may miss the critical five days coming up to ovulation. They can also cause stress and expense so we do not recommend that they are used routinely. (See later section called – When is the best time to have sex ?)

About male fertility

1. How does a man produce sperm?

Sperm are the male reproductive cells. They are produced in the testes (testicles) and can take up to 74 days to mature. Once mature, the sperm are capable of swimming and fertilising an egg. They are stored in an area called the epididymis behind the testes and are released from the penis by ejaculation, during intercourse or masturbation.

Semen is the fluid produced by a man during ejaculation. About 5% of semen is made up of sperm cells, while the remainder consists of fluids that support the sperm and help them swim.



2. Is there anything I can do to improve my sperm quality?

The entire process of producing a capable sperm takes about three months. Therefore, any intervention to improve sperm, for example, stopping smoking, takes about three months to have an effect.

The quality and number of sperm released by a man is affected by the frequency of how often the man ejaculates. If ejaculation is very infrequent, men can get a build-up of old and poor-quality sperm. So it is important to ejaculate every 2-3 days if you can. Overheating of the testes can affect sperm production and/or sperm motility.

There is evidence that sperm counts are deteriorating in the western world and this is thought to be due to environmental and dietary chemicals and toxins. Extended exposure to certain industrial chemicals, pesticides, herbicides, lead or other heavy metals, organic solvents and painting materials may contribute to low sperm counts. Anabolic steroids taken to stimulate muscle strength and growth are also detrimental.

There are some steps you can take to improve sperm quality:

- Avoid hot baths, jacuzzis and saunas.
- Wear non-support, non-insulating cotton boxer shorts.
- Maintain a healthy weight.
- Eat a healthy diet.
- Manage stress levels as best you can.
- Get some physical activity and moderate exercise.
- Stop smoking, reduce alcohol and don't take any recreational drugs or steroids
- Discuss any medications with your GP

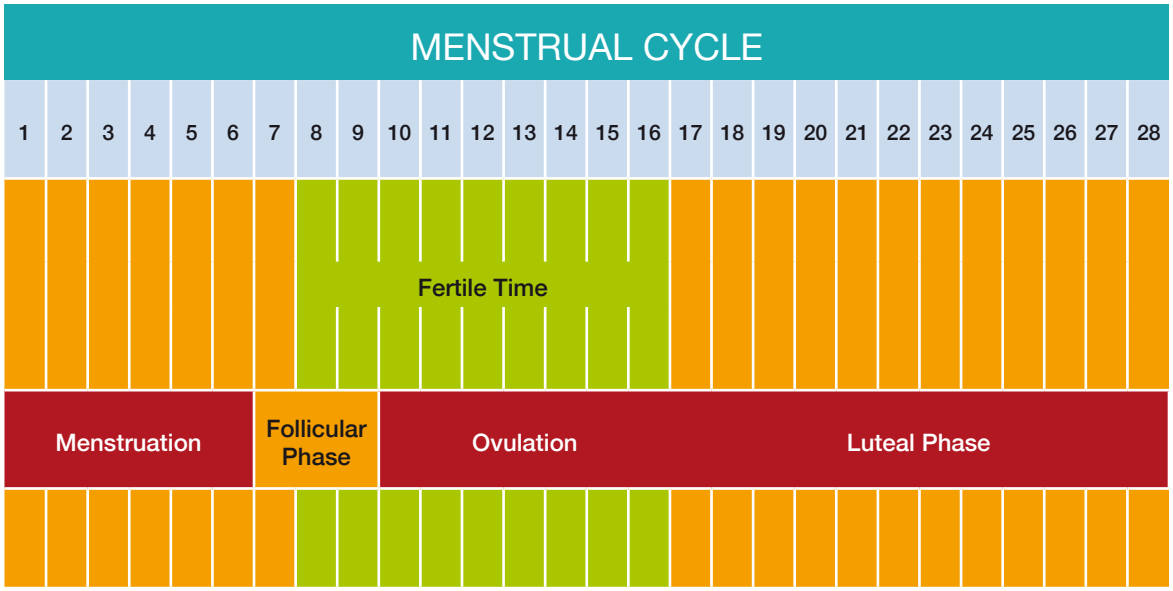
When is the best time to have sex?

1. Timing of sex

A woman is most fertile for a window of about six days during the menstrual cycle. This is the day of ovulation and the five days before ovulation. 80% of pregnancies happen during this time. An egg is only capable of being fertilised for 12-24 hours after it is released from the ovary. But healthy sperm can live and remain capable of fertilising an egg in the woman's body for at least 72 hours after sex. Therefore, sex a few days before ovulation will still allow the sperm to fertilise an egg three days later. However, sex a few days after ovulation is too late as the egg will have deteriorated too much.

It is generally advised that heterosexual couples should have unprotected vaginal sexual intercourse every 2-3 days for the best chances of conceiving. If you are doing that, you don't need to try to time ovulation as you will undoubtedly be having sex at the fertile time.

If the woman knows when she is ovulating, it is good to have sex every second day during that fertile time (the day she expects to ovulate and the 5 days leading up to that). More often is fine too. If there are changes in the cervical mucus, which occur just before ovulation (described earlier), that is the best time to try.



For women with normal cycle lengths of between 26 to 35 days duration, ovulation usually occurs 14 days before the end of the cycle. So in a 28-day cycle, ovulation occurs on Day 14. In a 30-day cycle, ovulation occurs on Day 16.

Remember the 5 days coming up to ovulation are really important. So if your cycle is between 26 and 35 days, having sex between Days 8 and 21will increase your chances of conceiving.

2. Is there a recommended best position to have sex if trying to get pregnant?

There is no clinical evidence to suggest that any particular position during and after sexual intercourse can increase your chance of getting pregnant. The important thing is that sex is as comfortable and as enjoyable as possible.

After semen has been ejaculated, it is initially sticky and jelly like. But after about 15 minutes it becomes more watery. It may leak out of the vagina and that is normal. Enough sperm will have reached the female reproductive tract within a few minutes of sexual intercourse.

Fertility and your age

1. Age of a woman and fertility

Age affects the fertility of both women and men. Women are born with all the eggs they are going to have. As you get older, the number of eggs reduce, as does the quality of the eggs.

Women are at their most fertile in their early twenties. Fertility starts to reduce after the age of 30 and this reduction happens faster after the age of 35.

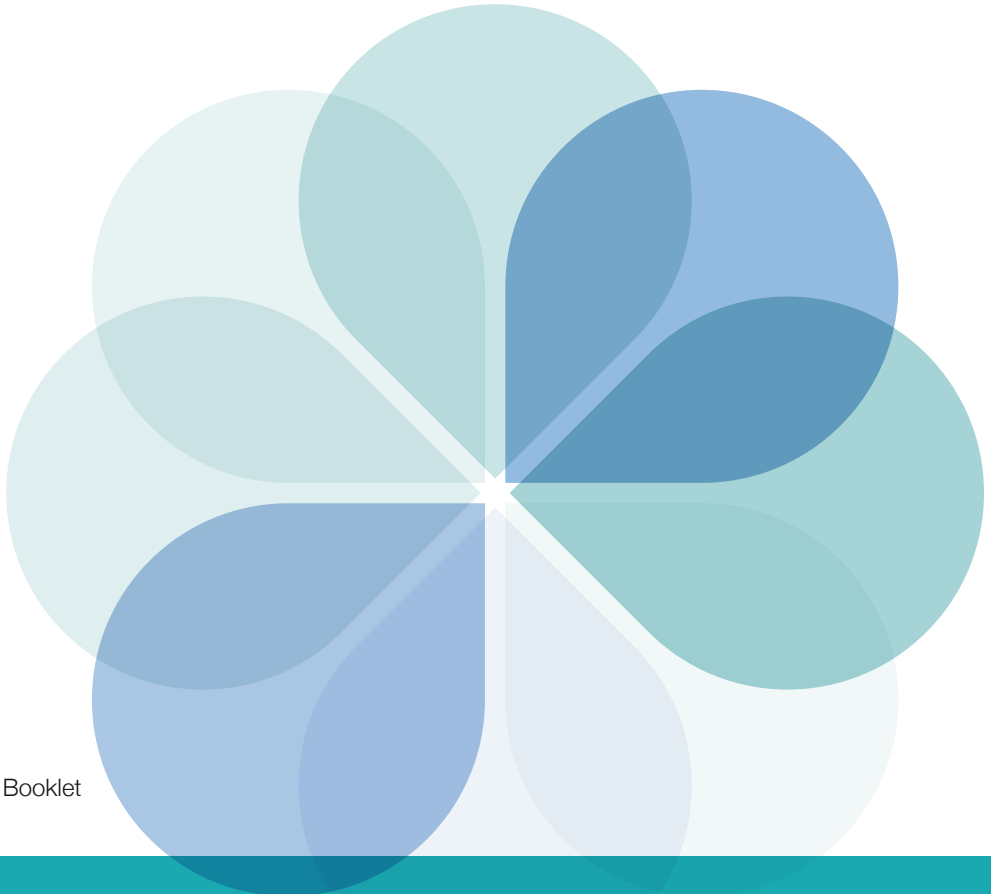
By the age of 43 or 44, most women's eggs will be of poor quality and, while possible, it is very rare to get pregnant. By the time of menopause there are no eggs left.

The reason for the reduced fertility is two-fold. The first reason is related to the fact that poorer quality, older eggs are less likely to lead to pregnancy. Even if they do, the chance of miscarriage is increased in older women, because things are more likely to go wrong with older eggs. The chance of genetic or chromosomal abnormalities rises significantly over the age of 40.

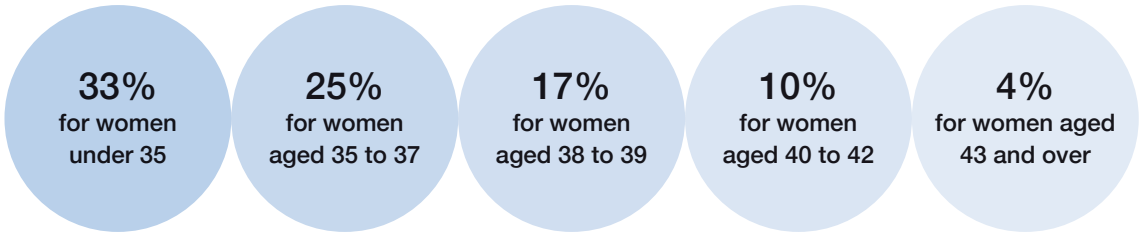
The evidence indicates the following successful rates of naturally conceiving depending on the woman's age.

Age can also increase the risk of certain complications during pregnancy. This includes miscarriage, pre-eclampsia, gestational diabetes or having a baby with a chromosomal abnormality.

Many people assume that IVF and other fertility technologies can overcome the effect of age on female fertility. Unfortunately, this is only partly true. Even with IVF, the age of the woman has a major effect.



Preliminary UK data (2021) shows that the percentage of IVF treatments that resulted in a live birth were:



You may see higher or differing success rates quoted by individual clinics but these need to be carefully interpreted as there are many ways to calculate success rates in the area of IVF treatments.

Many couples may get more than one embryo transferred so some success rates measure birth rate per embryo, while others may look at the "cumulative" success rates involving multiple embryo transfers.

Overall, we would expect more than half of all people who clinically require IVF to eventually get pregnant – but they may need more than one IVF cycle and the most critical determinant of success is the age of the woman.

2. Age of a man and fertility?

Men can conceive at an older age but evidence is now showing that male age is also important.

Research in the UK (2000) found that men older than 40 years were 30% less likely to father a child than men younger than 30 years.

In men, sperm quality and fertility start to decline around the age of 40 and IVF success rates also decline as men get older.

There is also evidence of increased miscarriage rates as men age and increased risks of foetal abnormalities, particularly neurological issues such as autism spectrum disorders and bipolar disorders.

Impact of bodyweight on fertility

Weight can affect the fertility of both male and females. Women who have a normal BMI are more likely to conceive and to have a normal pregnancy than those who do not. For women, being underweight or overweight may stop ovulation. It can also affect having regular menstrual cycles. For women who are overweight, losing 10% of their weight can lead to pregnancy in up to 50% of cases. For women who are underweight, gaining weight can lead to pregnancy.

Having a healthy weight is also important for a healthy pregnancy and to reduce pregnancy complications. Being overweight during pregnancy increases the risk of diabetes and high blood pressure.

In men, sperm counts are poorer in overweight men and obesity is associated with lower IVF success rates and increased miscarriage.

It can be really challenging to maintain a healthy weight but it is important that anyone trying to conceive tries to optimise their weight. Any improvement in trying to achieve a healthy weight will positively improve your overall health.

Following a healthy eating plan and engaging in regular exercise is highly recommended.

The HSE has further information to help manage weight.

A Guide to Managing your Weight (2018) www.hse.ie/eng/about/who/healthwellbeing/healthy-ireland/hospital-groups/weight-management-guide-2018.pdf

Talking about weight: A guide to developing healthier habits (2023) www.healthpromotion.ie/media/documents/HAL01393_HSE-Talking-About-Weight_FINAL_WEB_VERSION.pdf

Other factors that impact fertility

1. What impact does alcohol have on fertility?

Excessive alcohol use reduces fertility in both men and women. Effects in men include deterioration in sperm count, lower testosterone levels and reduced sexual functioning. In women, there are effects on ovulation and hormones.

We recommend that men and women reduce their alcohol consumption when they are trying to conceive and particularly if they are undergoing treatment such as IUI or IVF. Binge drinking is particularly harmful.

We recommend a maximum of 10 standard drinks per week for men and 4 standard drinks per week for women. Once women conceive or think they may be pregnant, the safest approach is not to drink at all. Alcohol can harm the developing brain and body of the unborn baby.

Contact the confidential HSE Drugs and Alcohol Helpline for support with stopping drinking. Freephone 1800 459 459 or contact **helpline@hse.ie**

2. Does smoking have an impact on getting pregnant?

If you smoke, then the best thing you can do for your health is to stop. This is especially true if you are trying to get pregnant. Some studies show that fertility is reduced by as much as 50% if either partner smokes. This applies to natural pregnancies as well as treatments such as IVF. For women, smoking may affect your ovarian function. For men, smoking can affect the quality of the sperm. Stopping smoking significantly improves chances for conception. The earlier you stop, the greater the benefits.

Smoking during pregnancy is very harmful to your baby and is associated with numerous risks including miscarriage, poor growth of the baby and preterm birth.

In preparation for your engagement and appointments with the fertility team, you are advised to **stop smoking. Contact the HSE's QUIT support service. Freephone 1800 201 203 or see** Quit.ie

3. Does drug use have an impact on getting pregnant?

Recreational drug use can adversely affect your health, and both female and male fertility.

For women, cannabis, cocaine and other drugs are associated with failed ovulation and impact on implantation.

For men, cannabis, cocaine, and body-building drugs like anabolic steroids, are associated with reduced sperm production, reduced sperm motility, and reduced libido.

If you are taking any recreational drugs, you should stop taking them. This will improve your chances of conceiving and sustaining a healthy pregnancy.

Using drugs while pregnant may cause a higher risk of miscarriage or early labour. In severe cases, drug use can cause a higher risk of stillbirth and delays in your baby's development.

If you are taking recreational drugs, the fertility team may not be able to carry out some fertility investigations or refer your for further for further treatment if required. The fertility team may carry out tests to check drug use.

If you are on a Methadone program, you should discuss this as soon as possible with your GP and the fertility hub team.

Contact the confidential HSE Drugs and Alcohol Helpline for support to stop drug use. Freephone 1800 459 459 or contact **helpline@hse.ie**

4. Do I need to be on a special diet to increase my chances of getting pregnant?

It is important to have a healthy, balanced diet.

Eating healthy foods will improve your general health, help you manage your weight and may also increase your chances of getting pregnant.

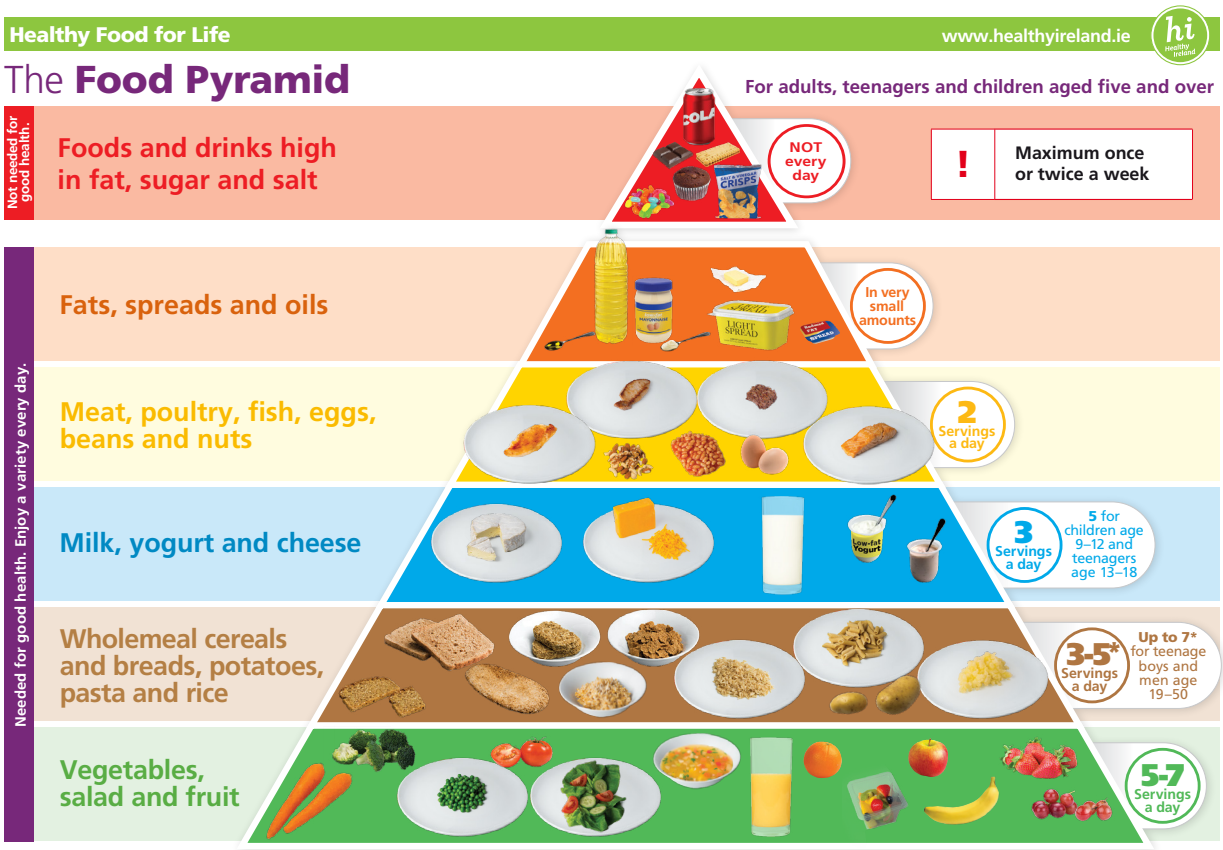
Restrictive diets that cut our entire food groups (like carbohydrates) are not ideal. You won't be able to take in key nutrients you need for healthy fertility and pregnancy. For many people, cutting out junk food and takeaways, adjusting portion sizes and increasing exercise will really help.

Choose a variety of foods from the 4 nourishing food groups every day.

- fruit and vegetables
- wholemeal and wholegrain carbohydrates
- dairy
- protein

Try to limit less nutritious foods that are high in fat, sugar and salt.

The Irish food pyramid will give you an idea of how much from each food group you should eat.



Vitamins & Supplements

Women are advised to take a 400 microgram folic acid supplement every day. You should take it for at least 3 months before you become pregnant and continue it for the first 3 months of pregnancy. Ask your pharmacist about the best product for you. It is a very safe supplement and can be taken for long periods of time.

It is also recommended that women trying to conceive take 10 micrograms of Vitamin D daily.

5. What medical conditions can affect my chances of conception?

For women, some medical conditions can affect your chances of pregnancy. These include:

- No periods, very irregular menstrual cycles or cycles shorter than 26 days.
- Gynaecological conditions like endometriosis, fibroids, cysts, polyps.
- Sexually transmitted infections (STI's), including chlamydia and gonorrhoea.
- Gynaecological surgery for endometriosis or cysts or surgery to your cervix.
- Abdominal (general) surgery especially for a condition like ulcerative colitis or Crohn's disease or a very badly infected appendix.
- Cancer treatment such as chemotherapy or radiotherapy; and
- Family history of early menopause

There are some medical conditions that can also affect male fertility, these include if you have had:

- Mumps that affected your testicles
- A vasectomy, even if it has been reversed.
- Cancer treatment, or radiotherapy
- A history of undescended testes as a child

Talk to your GP and the fertility team if either person has a significant underlying medical condition that requires them to take prescribed medication. This includes conditions such as epilepsy, severe arthritis or multiple sclerosis. It is important that you discuss the management of this condition and the implications for your fertility journey. Please give details of these medical conditions and medications in your screening questionnaires.

It is very important that you continue taking your medicine as prescribed. Do not stop taking or reduce your medication . The fertility team may consult with your treating doctor for the condition. They may also arrange a review consultation for you with that doctor to ensure that your health is optimised and your medical condition is well managed.

6. Does stress affect fertility?

The relationship between stress and fertility is complex. Stress of itself does not have a direct effect on fertility or its treatment.

However, it can have a negative effect on overall health and can affect your sex drive, meaning you have sex less often. This happens for both men and women. Stress has also been shown to interfere with people's ability to cope with investigations and treatment.

Difficulty conceiving can be a really stressful time. There can be a lot of uncertainty that affects your emotions, and appointments and tests can be exhausting.

It is often not easy to discuss fertility issues with friends and family.

But it can help to talk about it with others. You may find it comforting to know you are not alone, or you may get some insights that help you. Make sure you're getting as much support as possible from family, friends, a support group, charity or a qualified counsellor.

Try to take things one step at a time.

Make time and space for the things you enjoy doing, both as a couple and on your own.

Healthy eating and getting enough sleep is important. Things like exercise, mindfulness and yoga or meditation apps can also help.

The HSE website has more information and advice about stress and your mental health.
https://www2.hse.ie/mental-health/

Further information and supports

The regional fertility hubs have information to hand in relation to professional support groups and can make referrals where necessary to support you and/or your partner during this time.

The National Infertility Support and Information Group (NISIG) is a registered charity that gives support to those on their fertility journey. They provide facilitated peer-to-peer support meetings, both in person and online, as well as phone support and a live 'webchat' to people experiencing infertility issues. For more information, visit nisig.com

The HSE website has more information about fertility and pregnancy.

https://www2.hse.ie/pregnancy-birth/trying-for-a-baby/

https://www2.hse.ie/conditions/fertility-problems-treatments/

Notes

National
Women & Infants
Health Programme

National Women and Infants Health Programme

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