in the know

What No One Tells You About Fertility

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Foreword

Most people take for granted their ability to have a child, so when we first try to conceive we think it will happen soon. Then as the months go by we become increasingly disappointed and wonder if we will ever realise our dream of becoming parents. Where can we go for information about help that is available?

You will find *In the Know* a helpful guide along the pathway to becoming a parent. Now revised for an Australian and New Zealand audience, it contains insightful and practical information and advice. The booklet's author, Dr Alice Domar, is an international pioneer in the relationship between mind and body when it comes to infertility. With her many years of caring for others in a similar situation to you, Dr Domar is able to clearly explain how you might feel during the process and how to manage things when times are tough.

We know it can be difficult to acknowledge an infertility problem because it is natural to hope that a pregnancy will happen easily. If this is where you are right now, it's important to know that you are not alone. Up to one in six couples around the world will experience difficulties conceiving. The good news is that most treatments are simple and effective. It is important to seek help sooner rather than later as fertility declines with age.

Infertility can be an isolating experience but there is lots of support available through your clinic and also patient associations like AccessAustralia. Don't hesitate to get the help you need and deserve.

All of us at AccessAustralia wish you every success as you try to have a child.

Sandra K. Dill AM, BComm MLS

Sandra Dill is CEO of AccessAustralia, and Chair of the iCSi international patient leader community. Sandra has brought patient perspectives to national and international scientific, and governmental organisations and NGOs including: the World Health Organisation and the United Nations. In 1996, Sandra was appointed as a Member of the Order of Australia for community service as an advocate in the area of infertility. In 2003 she was honoured with Life Membership of the Fertility Society of Australia. Sandra has a Masters degree in law and is undertaking doctoral research examining surrogacy, bioethics and the law.

Preface

We have never officially met, but I know you. I know that you want to have a baby, perhaps more than you have ever wanted anything else in your life. I also know that you are feeling frustrated, because the months keep flying by and you can't seem to achieve what seems to come so easily to everyone else. I know that you want to stay optimistic, you might even worry that you need to stay optimistic in order to get pregnant, and you feel guilty because your hope is beginning to turn to despair. I know this because I've worked with thousands of women just like you. Each woman's story may have a different narrative, but each wish is the same – to have a healthy baby. The sooner the better.

Women are magnificent; YOU are magnificent. The female body has the ability to get pregnant and experience the miracle of life growing within. Women have the strength and endurance to deliver a baby into the world and nourish it with their own breasts. It is this amazing capability that truly distinguishes women from men. So when a woman's body does not perform in a way that it seems biologically destined, it can affect a woman down to the core of her existence. Feelings of inadequacy, anger, isolation, sadness and even hatred at the body's betrayal are all common emotions and are totally normal. You are not alone. On occasion, you might wonder what is wrong with you and others might have told you that you are taking this too seriously and should not be this upset. Trust me, you are normal. They are the ones who don't know how hard this can be.

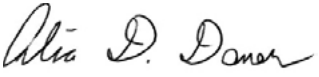
I know something else … most of the women who I have met over the years who faced the challenges of infertility have gone on to conceive and are now enjoying their ever-growing families. Most are so busy changing nappies and chasing toddlers that their original fertility issues seem like distant memories. For those who were unable to conceive naturally, they too have created families through adoption or egg or sperm donation. The bottom line is if you want to be a mother, your dream can eventually be fulfilled.

Taking the steps needed to address your fertility concerns may not be easy, and I have immense respect for your persistence and courage. It would be much easier to bury your head in your pillow, cry and blame everything on everyone around you, but you know that isn't going to bring the outcome you desire. You know you can do this; YOU are doing this. After all, what is the alternative?

My sincerest wish is that you realise that achieving motherhood may not be as difficult, expensive or unobtainable as you might fear. You and your body are not separate entities; your body is not the enemy. Respect your wholeness. Believe it or not, your body, despite your current infertility, is doing a lot more right than it is doing wrong. It might just need a little help.

I wish you the best of luck on your journey!

Sincerely,



Alice D. Domar, Ph.D.

Alice D. Domar, Ph.D., is a pioneer in the application of mind/body medicine to women's health issues. The founder and director of the Domar Center for Mind/Body Health at Boston IVF, Dr Domar has earned an international reputation as one of the top women's health experts in the United States of America. She has conducted research on a range of women's health issues including infertility, breast cancer and premenstrual syndrome. She is the author of numerous books, including a bestseller in the USA, *Self-Nurture; Be Happy Without Being Perfect*; and *Conquering Infertility*, Publishers Weekly's 'Best Book of 2002' in the category of health.

Dr Domar received her M.A. and Ph.D. in Health Psychology from Albert Einstein College of Medicine/Ferkauf School of Professional Psychology of Yeshiva. Currently, she is an Assistant Professor of Obstetrics, Gynecology, and Reproductive Biology at Harvard Medical School, and a senior staff psychologist at Beth Israel Deaconess Medical Center.

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Introduction

Let's face it, when you envisioned planning your family, you probably never imagined reading a booklet like this one. After all, you had a plan and so far it was working out beautifully. You met and married the partner* of your dreams, perhaps even started a career, settled down into a nice little house or unit, and maybe even got a dog. It took a lot of work and energy to get to this stage in your life, but it paid off and now you feel ready to welcome a bouncing baby into the nest.

Now comes the fun part – trying to get pregnant. You keep it spontaneous at first, keeping an eye on your cycle, but indulging when the mood strikes. After a few months and a couple of negative pregnancy tests, you become more diligent about timing your romantic interludes. You check your diet and take your prenatal vitamins each day. You might start taking your temperature, spending your coffee money on home ovulation test kits, inspecting all cervical mucus more than you care to admit, and keeping stress levels in check (well, sort of!). Your calendar starts filling up with all sorts of circles, crosses, arrows and degrees.

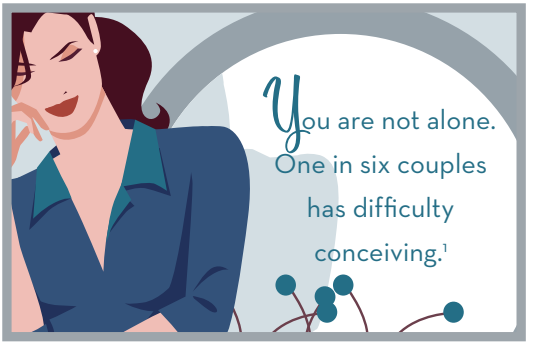
As more months float past and more negative pregnancy tests accumulate in the rubbish bin, sex doesn't become the source of pleasure it once was. No, now it becomes a job with an intended purpose, and the joys of slumber are replaced with questions, "Did it work? Could this be it? Am I FINALLY pregnant?" Two weeks later: another negative pregnancy test.

And, so you sit here now, with this booklet in your hands. Whether you have just started thinking about going to your doctor to talk about fertility issues or whether you have already started fertility treatments, know that you are not alone in your quest to conceive. In fact, far from it: One in six couples has difficulty conceiving.[1]

That means there are a lot of people dealing with fertility issues, but it also means that there are a lot of specialists and organisations that are working to make dreams of conception a reality for those couples.

This booklet was created to give you a no-nonsense, easy to understand look into fertility and infertility and provide you with the tools and resources to help you along your journey to parenthood. Simply put, we want you to be 'in the know'. Of course, it's always best to speak with your doctor about your personal medical concerns. Most importantly, this booklet was designed to give you hope – your original plan to start a family was, and is, a good one. But again, you've reached a small detour on your quest, but the destination will be well worth the journey.

* While 'partner' is often referred to as the spouse or husband, we realise that this category does not apply to everyone. Feel free to substitute your partner of choice. We use 'husband' in this booklet for the sake of convenience, but most examples apply to a male or female partner equally.



Why Me?
chapter one

Babies. Signs of them are everywhere. Prams, pregnant bellies, nappy displays and distant baby coos – it's like your body is one large baby magnet, able to attract anything and everything 'baby' within a 50 km radius. Sure they're adorable, but for a woman who is trying to conceive, they serve as constant reminders that there are thousands of babies in the world, but you still don't have one.

And, you want one. You want a baby so badly that it makes your insides ache. Morning sickness, stretch marks, labour pains, bring it on! If it means you'll be giving birth to a bouncing baby boy or girl, no sacrifice is too great. But why does it seem like getting pregnant is so simple and natural for others, when it has become a full-time job for you? It just doesn't seem fair.

It's NOT fair, and it's not just strangers who seem to have the secret fertility key, but even your friends and family have it too! Baby shower invitations and birth announcements arrive almost daily, and every family gathering gets a little bigger with the latest mini addition. You love these people and are sincerely thrilled for them, but social interactions can bring about all kinds of awkward conversations. Sometimes you feel like it's easier to stay away than deal with the feelings of sadness or resentment that might bubble to the surface.

If you've kept your fertility issues a secret, you already know what to expect at the next family dinner. Everyone will be seated around a lovely meal, you'll raise your knife and fork, and your nosey Aunt Linda flutters her eyelashes and smiles sweetly, "So, dear, when are you two going to start having some babies?" And thus the act begins. You force a smile and mumble, "Oh, I'm not sure… right now, we are just enjoying being married, aren't we sweetie?" Your partner replies, "Yes, just enjoying marriage." You put your knife and fork back down, appetite gone.

It can be just as uncomfortable if your family and friends know – let's call it the 'big pink baby in the room' syndrome. It's not like you don't notice the hushed whispers, the scolding glances at

anyone who talks about babies too much and the downplaying of happy announcements. You know no one is being malicious and they all have your best interests at heart, but the emotions surrounding fertility run deep.

Speaking of emotions, this is probably the hardest side effect of trying to conceive, the constant ups and downs of the emotional fertility rollercoaster. You may feel like you are losing your mind and probably have a hard time remembering what your true personality was like before trying to get pregnant. It's like your mind has been taken over by a baby who hasn't even been born yet! Take comfort that you are NOT losing your mind, and that everything you are feeling is completely understandable. Not that it is easy, because it's not, by any means. The myriad of emotions can strike any time of day for any or no reason; a woman might go from extreme hope to extreme sadness within hours. An excerpt out of a woman's conception diary might look like this:

6:15 am I'm so excited! It's been two weeks since I ovulated and I know we had sex at exactly the right time. I haven't gotten my period yet and am feeling a little tired. Maybe this is it! Time to take a pregnancy test … fingers crossed.

6:18 am Pregnancy test is negative. Maybe I just didn't give it enough time. Still hopeful!

6:19 am The test still says negative. NEGATIVE! I really felt different this time. I feel sick to my stomach with disappointment.

6:30 am Put on my brave face and get ready for work. Husband is having coffee in the kitchen. I'm not going to even bring up the test. I'm too embarrassed that it is negative AGAIN and I don't want to ruin his morning.

8:00 am There is a crowd around the receptionist who brought in her new baby. Everyone is cooing and saying how adorable she is. I don't even want to see the baby; I'm so jealous, and I'm ashamed that I am jealous. I put on my best fake smile and give her a hug before going into my office. I close my door and hope no one can hear me cry. This sucks!

8:10 am I wipe the tears away and look at the pictures on my desk of my husband, my parents and my cat. I feel so guilty that I can't give my husband a baby or my parents a grandchild. What's wrong with me?

8:11 am I look at the photo of my cat and think about the way he sleeps with his tongue sticking out and laugh in spite of myself. Deep breath! If I can still smile, then all is not lost. I'm not going to give up. I will get through this.

Once a woman decides she is ready to have a child, pregnancy becomes a large part of your life. But, if the body is not cooperating and nature is taking too long, things can really get stressful – especially because there are so many factors in the emotional rollercoaster:

- Unpredictability – at any time you could get good news, changing your life forever
- Self-deprecating – "What is wrong with ME?"
- Guilty – not being able to provide a child for your partner
- Disappointment – every period feeling like another failure
- Sadness – wanting something desperately, only to find it elusive. Some women have the added devastation factor of actually getting pregnant, only to have a miscarriage – a personal loss so great, that it takes an enormous amount of courage and fortitude to even try again. There is a reason women are called 'the stronger sex'.

If you find the emotions are becoming too much, here are some tips to help deal with it:

- Open up to your spouse – Fertility affects both you and your husband in an exceptionally personal way. Don't let guilt or embarrassment keep you from sharing your feelings. But, keep in mind that since men and women communicate differently, you might want to approach your spouse over a nice walk or an extended car ride (men do better with conversation when they are actively doing something rather than staring across the table) and encourage him to share his feelings too. You may both find strength, comfort and acceptance in your honesty.
- Talk it out – If you feel comfortable, talk to family or close friends about your struggle. Sometimes just verbalising the fears and frustrations can alleviate some of the shame and stress of 'hiding the secret'.
- Go online – If you're uncomfortable sharing your personal struggle with those who know you, search out websites and chat rooms where you can be anonymous, but still stay connected to people going through similar experiences. But try to find moderated websites and be very aware that the women who tend to write or blog are the ones having the most difficulty. Make sure to talk to your healthcare team to confirm what you have read is medically accurate.
- Sweat it out – Get some exercise to help clear your mind and pump up endorphins. But don't go overboard – moderate exercise can be good for you, but vigourous exercise can have the opposite effect.[2,3]

- Foster your mind, body and spirit – Go to a yoga class, try a hypnotist, meditate, take a mind/body class – anything to get back in touch with your beliefs and inner strength.
- Take a break from 'baby brain' – Allow yourself up to an hour a day to educate yourself about conception, lurk on the Internet, etc., but that's it. After that, find other things to distract yourself. This may be work or doing something enjoyable such as reading, watching a movie or anything else that doesn't involve babies.
- Seek help when needed – While all the emotions are completely normal and understandable, if you feel they are interfering with the way you function or are negatively affecting your relationships, talk to your doctor, look into support groups in your area or seek counselling. It can be helpful to speak with someone who can listen objectively and who has expertise in this area.

Remember all those pregnant bellies and babies that seem to follow you everywhere? Well, there is something you should know: Infertility affects about three million Australian men and women, which represents about one in six couples who are in their childbearing years.

> Don't wait to talk to someone about the many different feelings you might have about your trouble conceiving.

After a year of trying, about 85% of couples will conceive.[4] So, sure, all those people look like they got pregnant the easy way, but many went through the same rollercoaster you are on now. It might be strange to think that two or three years from now when you are in the shopping centre, pushing a stroller, some woman may be looking at you jealously thinking, "Why can't I be more like her?"

chapter two

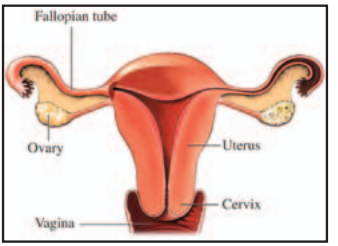
Bio 101

The Birds and the Bees

Remember sex education back in high school biology class? The outdated movie filmed in the 70s, followed by a lecture from a teacher who seemed as uncomfortable as the giggling teenagers in the back of the room. Chances are, only two things stuck with you: Sex involves intercourse, and if you have intercourse, you can get pregnant. It's amazing how much time and energy you focused on NOT getting pregnant back then and how much of your time and energy is focused on getting pregnant now.

Now that you have matured and know more about your body, you are well past the basics of reproduction. But, you might not have all the details straight. Understanding the process of conception might help to explain why it can be difficult to become pregnant. The following describes the natural process of fertility.

Female Reproductive System



The ovaries store a woman's lifetime supply of immature eggs – about 400,000 – and produce the female hormones oestrogen and progesterone, which are both needed for menstruation and pregnancy. The sperm and egg meet for fertilisation in the fallopian tubes. A fertilised egg attaches itself to the lining of the uterus (the endometrium) and develops in the uterus. The vagina is the passage that leads from the outside of the body to the cervix, the opening to the uterus.

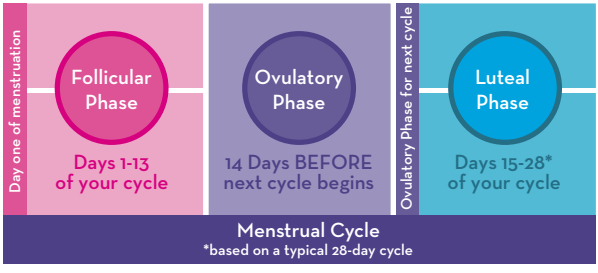
Menstrual Cycle

A regular menstrual cycle is an important element of successful conception. The menstrual cycle refers to the maturation and release of an egg as well as the preparation of the uterus to receive and nurture the fertilised egg (embryo). The hormones released during the menstrual cycle control the sequence of events that lead to pregnancy. On the first day of the cycle, when

menstruation, or your 'period', begins, the uterus sheds its lining from the previous cycle. The typical menstrual cycle lasts for about 28 days and is divided into the following three distinct phases.

Follicular Phase – Days 1 to 13

During this phase, the hypothalamus and pituitary glands in the brain release a hormone known as follicle stimulating hormone (FSH). FSH stimulates the development of a follicle, which is a tiny fluid-filled sac in each ovary containing a maturing egg. The follicle also secretes oestrogen, which produces midcycle changes in the cervical mucus. These changes help prepare the cervical mucus to receive and nourish sperm.



Ovulatory Phase – Approx. 14 Days **Before** Your Next Cycle Starts

The ovulatory phase begins when the level of luteinising hormone (LH) – also released by the pituitary gland – drastically increases or surges. LH causes the follicle to break open and release the mature egg into the fallopian tube. During her reproductive years, a woman usually releases a single mature egg each month. This process is known as ovulation. Cervical mucus is most receptive to sperm around this time and a woman has the best chances of conceiving right before and during ovulation.

It is a common misconception that the ovulatory phase begins around day 14 of your cycle; in fact, it can more easily be determined by 14 days prior to the start of your cycle, which may not be an exact 28 days. Your cycle begins on the first day

that you experience regular flow. Once you determine how long your personal cycle lasts, subtract 14 days from the predicted end of the cycle to determine time of ovulation.[5]

Luteal Phase – Days 15 to 28

During this phase, the follicle that produced the egg becomes a functioning gland called the corpus luteum. The corpus luteum produces progesterone, which prepares the endometrium (lining of the uterus) for the implantation of the fertilised egg.

Fertilisation

The ovulatory phase of the menstrual cycle is the optimal time for fertilisation. When a couple has intercourse during this time, sperm swim through the cervical mucus, into the uterus and along the fallopian tube, where they meet the egg. Although millions of sperm are released, only one sperm can fertilise an egg. The egg has the capacity to be fertilised for about 24 hours after it is released from the follicle.

Implantation

After fertilisation, the embryo travels through the fallopian tube toward the uterus. Inside the uterus, the embryo implants itself into the lining on about the 20th day of the cycle and continues to grow into an embryo and eventually a fetus. The corpus luteum continues to produce progesterone to preserve the uterine lining and help maintain pregnancy.

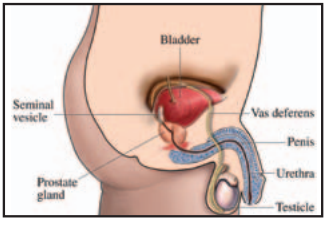
If fertilisation does not occur, the egg passes through the uterus, and the corpus luteum ceases to function on about day 26. The uterine lining then breaks down and is shed several days later as the next menstrual cycle begins.

Romantic, isn't it? Just when you think sex has become routine, biology comes along and spices things up! Luckily, the weight of fertility responsibility rests on two people, the man and the woman. This should come as some relief as there is usually so much attention put on a woman's reproductive cycle, that sometimes it seems that men are left out of the equation altogether.

No matter what, infertility is not your or your partner's 'fault', and you should not place or take blame for trouble conceiving.

In fact, infertility occurs equally in women and men. Male and female factors each account for about 40% of infertility problems. The remaining 20% is either a combination or are unexplained.[6] The following may shed some light on the workings of those special male swimmers, sperm.

Sperm Production



Similar to the female reproductive system, normal anatomy of the male reproductive organs and balanced hormones are important for fertility. The same hormones that regulate female reproductive functions also regulate the production of sperm in the male. FSH stimulates sperm production and LH stimulates the production of testosterone, which helps to maintain sperm production.

Sperm are highly specialised cells comprised of a head where chromosomes are stored, and a tail, which enables movement. Sperm are produced by the testes glands (testicles) located in the scrotum. The scrotum maintains a lower than normal body temperature to help sperm develop properly. As sperm are produced, they pass from the testes to the epididymis, an organ that stores and nourishes sperm as they mature.

When a man releases fluid from his penis during intercourse, sperm from the epididymis combine with a fluid from the seminal vesicle and prostate glands to create semen. The fluid is deposited into the woman's vagina. Sperm can live for 48 to 72 hours within the female reproductive tract, while retaining the ability to fertilise an egg.

Now that you are very familiar with the male and female reproductive systems, we're going to delve into potential causes of infertility. We have detailed many of these from lifestyle to biological factors, while separating out specific causes in women and men. By definition you are considered infertile if you're younger than 35 and unable to conceive after a year of regular, unprotected intercourse, or if you are older than 35 and unable to conceive after six months of trying.[7]

Lifestyle

Keep in mind that certain lifestyle choices can affect your fertility. You might want to consider temporarily altering your lifestyle to see if anything here applies to you or your partner:

- Alcohol consumption and smoking have been shown to compromise fertility of both men and women. Doing both is even more of a problem than either alone.
- Being underweight, overweight or obese may reduce a woman's fertility.
- Prolonged exposure to high heat from hot baths and saunas can lower sperm quality.
- Lubricants such as petroleum jelly or vaginal creams may affect sperm quality.
- Higher amounts of caffeine (more than 200 mg/day or about 2 cups) have been shown in some studies to make it harder to conceive and can increase the risk of miscarriage.[8] Be aware that some coffee shop drinks can have up to 560 mg in a single beverage.[9] Cola drinks (about 40–49 mg caffeine) and energy drinks (80 mg caffeine per 250 ml) should also be avoided.[10]
- Exposure to toxic substances on the job, such as pesticides, radioactivity, X-rays, and electromagnetic or microwave emissions, may lead to sperm abnormalities.
- Some drugs for heart disease and high blood pressure may cause infertility in men.

FEMALE FACTORS

There are a number of biological issues that can cause infertility in women.

Ovulatory Issues

Approximately 25% of all infertile women have problems with ovulation.[11] The normal ovarian cycle is so complex that even small changes may disrupt the cycle and prevent ovulation. In the majority of cases, the problem is caused by hormonal imbalances (e.g. not having enough of a certain hormone or not releasing a hormone at the right time). This can be caused by faulty communication between the brain and the glands responsible for releasing the hormone. Sometimes, abnormal ovulation may also be associated with significant changes in weight (loss or gain) including extremely low body weight or being overweight.

Physical Issues

If the problem is not with your ovulation cycle, then there are some physical problems that can cause fertility issues in women:

- Blocked fallopian tubes – though there are many causes for this, including past infections or sexually transmitted diseases (STDs), blockages can prevent the sperm and egg from uniting or they can prevent embryo implantation
- Cervical disorders – some cervical problems can prevent the sperm from entering the uterus
- Endometriosis – this common condition causes cells that normally line the uterus (also called the endometrium) to also grow outside the uterus; on the ovaries or other pelvic organs. Endometriosis is found in about 30% of women who suffer from infertility.[12]
- Polycystic Ovary (Ovarian) Syndrome (PCOS) – one of the leading causes of infertility in women, PCOS is a condition in which cysts develop in the ovaries due to abnormal hormone levels, sometimes causing the ovaries to enlarge.

Your History

Here are some red flags just for women; if you fit into any of these categories, then you should contact your doctor:

- Over age 35
- Irregular or absent periods
- Two or more miscarriages
- Prior use of an intrauterine device (IUD)
- Endometriosis/painful menstruation
- Breast discharge
- Excessive acne or hirsutism (body hair)
- Prior use of the birth control pill and no subsequent menstruation

MALE FACTORS

There are a number of factors that can lead to fertility issues in men.

Sperm Issues

Many male fertility issues are related to sperm disorders. During intercourse, millions of sperm are deposited into the vagina, but only a few hundred will get close to the egg and have a chance to fertilise it. Many factors play a role in determining whether or not the sperm will succeed:

- Sperm count (number of sperm)
- Motility (ability to move)
- Morphology (forward progression, quality of movement)
- Size and shape

Physical Issues

If the problem is not with the sperm, then there are some physical problems that can cause fertility issues in men:

- Erectile dysfunction – inability to get or sustain an erection
- Undescended testis – testis has not reached its normal position in the scrotum, causing it to function abnormally and potentially not produce sperm

- Retrograde ejaculation – ejaculate containing the sperm flows backwards into the bladder instead of leaving the penis
- Scrotal varicocele – the most common cause of identifiable male infertility, this occurs when a varicose vein is around a testicle, which may hinder sperm production

Medical and Family History

Talk to your partner and see if he has experienced any of the following. These are male-specific issues that can lead to trouble conceiving:

- Mumps after puberty
- Previous urologic surgery
- Prostate infection
- Family history of cystic fibrosis or other genetic disorders

FACTORS THAT MAY AFFECT BOTH

There are some factors that may cause fertility issues in both men and women:

- History of sexually transmitted disease
- History of pelvic/genital infection
- Previous abdominal surgery
- Reversal of surgical sterilisation
- Chronic medical condition (e.g. diabetes, high blood pressure)
- History of chemotherapy or radiation therapy

The bottom line is: If you feel like some of these apply to you or your partner, then talk to your doctor. Don't dread and prolong making the call; most of the causes of infertility listed are treatable.

WHEN YOU OVULATE

Here's a quick cheat sheet to calculate when you may ovulate[5]:

☐ # of days in your cycle – 14 = ☐ approximate day you ovulate

Remember: Your cycle begins on the first day that you experience regular flow.

chapter three

Getting Help

Getting Help

You feel it in your gut – it's not working. First, you admit it to yourself, and finally, you vocalise it to each other as a couple. You've been trying to get pregnant for a year and it just isn't working. You know it's time to get help.

Overcoming the apprehension of asking for help can be an overwhelming task in itself. This apprehension is normal. For many, admitting to a stranger, even a healthcare professional, that you can't get pregnant feels like an admission of defeat. Will this person judge me and think I'm a failure? What if he or she gets my hopes up on treatments only to find we can't afford them? Do I face years of unpredictable and invasive procedures? What if we are ultimately told that we are unable to have children?

There are two important things you should know about asking for help:

1. It can empower you. It gives you knowledge and most importantly provides you with options and hope. YOU will decide what course of action to take. No one can force you to do anything. YOU are in charge of your body and will make the best choice for you. That is control, not defeat.
2. You are going to have to ask for help a lot, pregnant or not. Look at this first step as the icebreaker. If and when you do become pregnant, you will at some point need to ask for help with simple manoeuvres like tying your shoelaces or, even more embarrassing, getting in and out of the bathtub. Once you have the baby, you may need help with breastfeeding, getting your body back in shape or dealing with a colicky baby. So look at this as your first step toward admitting "I NEED HELP!" and take the help. It will make your life a million times easier, plus no one should have to go through it all alone.

So, how do you know if the time is right to talk to a doctor? Couples should seek medical help if they are under the age of 35 and unable to become pregnant after one year of regular, unprotected intercourse, or six months if the woman is over 35 years old. The sooner you see a doctor, the sooner a problem may be diagnosed and treated.

What happens when you see a doctor for fertility concerns? Generally, they will conduct an evaluation that begins with a review of your and your partner's medical and personal histories. You'll likely discuss everything from family medical history, to diet and lifestyle, to your current sexual practices. Be prepared to answer questions about your and your partner's medical history, how long you have been trying to conceive and if you would be at risk for having a particular fertility issue.

They will also conduct a physical exam. Depending on your medical and personal history, your doctor may conduct some tests, beginning with the simplest and least invasive ones. At a later point, you may need to undergo a more advanced physical evaluation. It is important to check the level of your private insurance to find out how much of the initial tests and procedures are covered.

What kind of specialist should I see?

Some couples first talk to their general practitioner (GP). Your GP may refer you to a gynaecologist who specialises in reproductive health or to a fertility clinic. It may also be recommended that your partner visit a urologist or andrologist, or have an independent sperm analysis.

What questions should I ask during my medical visit?

Being prepared with questions will ensure you get the most out of your visit. It helps a lot if you write everything down. How many times have you left a doctor's office only to remember that question you meant to ask?

Don't be shy and if you don't understand the answers, don't hesitate to ask your healthcare provider to repeat them or to put them in layman's terms.

- What specific tests would you recommend to diagnose my infertility?
- When should my partner be tested? What are the tests for male infertility?
- How long will it take to diagnose our problem?
- Based on the test results, what are my treatment options, and how much do they cost?
- What should I expect for each treatment?
- Can you explain how it works?
- What is the national success rate for those treatments in terms of live births?
- Will Medicare or my private health insurance cover the cost of the testing and/or treatments?
- Will your clinic help me determine what Medicare and my private health insurance will cover?
- Where do you recommend I go to learn more about potential causes of infertility?
- Are there any websites or magazines I should seek out to learn more or to get support?
- How long have you been doing this?
- What is your success rate?
- How will I communicate with you during this whole process?
- Does your clinic provide emotional counselling, or can you refer me to a counsellor who deals with fertility problems?
- Do you recommend any complementary healthcare practices such as massage or acupuncture?

Here are some additional questions that may help you if you need to look into Ovulation Induction (OI) and/or In Vitro Fertilisation (IVF).

Ovulation Induction

- How many OI cycles do you recommend before moving to IVF?
- At what point would you convert me to IVF or cancel my OI cycle?

In Vitro Fertilisation

- What is the success rate for IVF in terms of live births per embryo transfer?
- How many embryos do you typically transfer per cycle?
- If necessary, can you help me access donor egg, embryo or sperm programs?

Seeking Information and Support

AccessAustralia is a national organisation that provides numerous services and resources for people having difficulty conceiving. See www.access.org.au or phone 1800 888 896. In New Zealand, FertilityNZ at www.fertilitynz.org.nz also has good information.

Another good resource is the website www.fertility.com In addition to personal stories and frequently asked questions, it offers a number of practical 'tools' to assist you including an ovulation calculator, a questionnaire and advice on your most appropriate coping method.

Couples should seek medical help from a healthcare professional if they are under the age of 35 and unable to become pregnant after one year of regular, unprotected intercourse, or six months if the woman is over 35 years old.[7]

chapter four

Treatment overview

After you and your spouse have completed physical exams, gone over your medical history in painstaking detail, had blood drawn, and a semen analysis performed, as well as any other tests you might have needed, your doctor may recommend starting treatment. While some might meet this with apprehension, most couples see it as a step forward. **Finally, an action step toward achieving your dream of getting pregnant.**

Before you agree to undergo any kind of treatment, take some time to talk to your doctor about its likelihood of success and its risks. You may also wish to inquire about a timeline for each phase of treatment. That way, if a certain treatment isn't working, you'll know when it may be appropriate to consider more advanced treatments.

By thinking ahead, you and your partner may find it easier to make personal decisions during this difficult phase. It may even be helpful to create a personalised fertility plan to help put the medical, emotional and financial aspects of your treatments into perspective.

The members of your healthcare team – including your doctor, fertility clinic nurses and counsellor – are your allies and will work diligently to help you decide on a treatment course for you. Try not to get overwhelmed by the medical jargon and/or the possibility of having to try multiple treatments. It is important to be aware of next steps, but instead of feeling inundated, find the positive in the potential treatments available for you to conceive. The following are the most common infertility treatments.

Initial Treatments

Clomiphene Citrate is a prescription medication used to induce ovulation. It comes in a pill, is relatively inexpensive and generally well tolerated. Therefore, it's typically the initial treatment for most women whose infertility is due to ovulation problems.

Clomiphene citrate has been shown to induce ovulation in roughly 80% of women who have trouble ovulating on their own. About half of these women achieve pregnancy during treatment over the course of multiple cycles.[13]

Surgery – Depending on your diagnosis, your specialist may recommend surgery as an initial treatment. For example, when conditions like endometriosis or fibroids are diagnosed, surgery could potentially correct those problems, which may be interfering with conception. In other cases, surgery might be reserved as a later option. Your specialist will consider the specifics of your case when recommending a plan of care.

Advanced Treatments

Ovulation Induction (OI) – If fertility testing reveals an ovulatory problem and clomiphene citrate proves to be ineffective, or was not appropriate to begin with, other fertility medications may be used to induce follicle development and ovulation. Your specialist or your fertility clinic healthcare team usually recommends these prescription medications, which are given in the form of injections.

To get a better idea of how OI works, it helps to look at a woman's reproductive cycle while she is taking OI medications.

During the follicular phase of a woman's reproductive cycle, a human follicle stimulating hormone (FSH) is given for several days or weeks. FSH stimulates the development of follicles in the ovaries and helps produce eggs.

Around the 11th day of the cycle, a single injection of a human chorionic gonadotrophin (hCG) may be given to facilitate the last step in the maturation of the developing eggs and trigger ovulation.

The eggs are released, ready to be fertilised. At this point, fertilisation is attempted either through sexual intercourse or artificial insemination (AI).

Artificial Insemination (AI) – AI is a procedure in which your doctor inserts the partner's sperm directly into a woman's reproductive tract. AI is usually performed in cases where a woman has poor or absent cervical mucus or a man has low sperm count or motility. A common AI procedure is intrauterine insemination, a procedure in which sperm is inserted directly into the uterus near the time of ovulation.

Assisted Reproductive Technologies (ART) – ART is the umbrella term for a variety of medical procedures used to bring eggs and sperm together without sexual intercourse. The objective is to create an embryo by bypassing the factor(s) causing the fertility problem.

- In Vitro Fertilisation (IVF), the most common ART procedure is used to overcome a variety of fertility difficulties, particularly tubal problems and sperm deficiencies. During IVF, medications are often used to stimulate the development and release of a woman's eggs. The eggs and sperm are then collected and placed together in a laboratory dish to fertilise. If the eggs are successfully fertilised, the embryos are transferred into a woman's uterus. Hopefully, one of the fertilised eggs will implant and begin to develop.
- Intracytoplasmic Sperm Injection (ICSI) is used in conjunction with IVF in which a laboratory technician, using a microscope, attempts to inject a single sperm directly into each egg. ICSI is often used if the male partner has very low sperm count, low sperm motility or poor-quality sperm. If fertilisation occurs after ICSI, the embryo(s) are transferred into the uterus.
- Assisted Hatching. Prior to implanting in the uterus, the embryo must emerge from its covering in a process called hatching. In some women, the membrane seems to harden, particularly as they age. This can interfere with the hatching process. In these cases, the hatching may be assisted by making a hole in the embryo membrane with a dilute acidic solution

or laser prior to embryo transfer. It may increase the chance of pregnancy in older women or those who have not achieved pregnancy after several IVF cycles. Assisted hatching may also be done in some cases following cryopreservation and embryo thawing (see information below).[14]

- Egg and Sperm Donation. Egg donation involves one woman (a donor) 'donating' her eggs so that another woman (a recipient) might be able to conceive. In egg donation, IVF is performed in the usual manner, except that the donor receives fertility medications to stimulate the production of multiple eggs in her ovaries. At the same time, the recipient (the intended mother) also receives medications so that her cycle mirrors the cycle of the donor and her body is prepared to receive the embryo(s). The eggs are then fertilised in a laboratory and the embryos are transferred into the recipient's uterus.
- Preimplantation Genetic Diagnosis (PGD) is a technique that can be used during IVF to test embryos for a variety of genetic disorders. PGD testing is done before the embryo is transferred to the uterus. This decreases the risk of having a child with a serious inherited disorder. The procedure can detect Down syndrome, cystic fibrosis, haemophilia A, Tay-Sachs disease, and Turner syndrome, along with other disorders.
- Egg and Embryo Freezing. Cryopreservation, also known as 'freezing', involves storing embryos at a very low temperature so they can be thawed and used later. Many fertility clinics now offer this option. Some clinics have begun to offer egg freezing as well.

Take a deep breath. That was a lot of information and although it sounds like many of the treatments are complicated and invasive, it is important to remember that **most infertile couples** (85% to 90%) are treated with conventional therapies, such as

medication and surgery, and less than 3% of couples are treated with the more sophisticated procedures.[15]

It's important to know that advanced fertility treatment can be stressful for couples. Following a strict treatment schedule involving daily injections can seem overwhelming. Your specialist will help set expectations, provide injection training, monitor treatment response, and check for side effects. Patient response and pregnancy success rates can vary. Follow doctors' orders and report any adverse events such as severe abdominal pain, which can be serious. The use of fertility treatments increases the risk of multiple pregnancies. However, due to the associated health complications with twins or triplets, in Australia, single embryo transfer is recommended.[16]

Remember, these treatments were designed to bring you closer to starting or building your family.

Concentrate on the most important facts, which are: Infertility can be treated AND many patients who complete treatments succeed in having a child. You are well on your way!

"I was relieved to learn from my doctor that many patients struggling to get pregnant have success when using FSH (follicle stimulating hormone). I am so happy I tried it! I think it really made a difference in my success in starting a family."

– Adrien

PHARMACY HOURS
Dollars and
sense
chapter five

Couples who are struggling to conceive face the daunting reality of medical costs long before the costs of raising a child are even a blip on the radar screen. It is not uncommon to hear stories of couples so desperate to have a child that they put themselves in debt or take out a second mortgage to pay for multiple medical procedures or adoption. Who can blame them? Most people would do anything in their power, even if it were beyond their budget, to have a child.

But, don't sell your car or start borrowing from relatives yet because there is GOOD news! In Australia, Medicare will help cover many of the costs associated with treatment, while if you are a New Zealand citizen, you may be eligible for up to two government funded cycles of IVF. AccessAustralia and FertilityNZ keep a close watch on government policy to ensure government reimbursement remains.

With so many treatment options available to couples today, the range of costs can vary dramatically. Some preliminary tests and medications may cost up to several hundred dollars, whereas multiple techniques could cost several thousand. The costs involved in your treatment will vary depending on how much and the type of assistance you require as well as the fertility clinic or specialist you choose.

Private Health Insurance

If you are considering any fertility treatments, the first step is to review your health insurance policy with a fine-toothed comb. Depending on your coverage, private health insurers will pay the fees relating to your day surgery procedure from the hospital and anaesthetist. Before you begin treatment, it is recommended that you ask your private health insurance company about the most appropriate level of cover for you. It is also worth noting that many companies require you to take out cover with them for 12 months before the baby is born.

Treatment Costs in Australia

Before you begin treatment, most fertility clinics or specialists in Australia, provide you with a detailed list of the costs involved and a timeline of when fees are due. A large portion of the costs of your cycle can be refunded through Medicare and private health insurance depending on your level of cover. In addition, the Medicare Safety Net subsidises some of the costs once you have paid a certain threshold amount (see information below).

Clinic costs of an IVF cycle usually include:

- planning and management by staff
- blood tests during your cycle
- ultrasound scans during your cycle
- some medications
- egg collection
- laboratory services
- embryo transfer
- frozen embryo storage for an initial period (e.g. can range from six months to two years).

The following may not be included in the cycle cost:

- any doctor consultations, blood tests, ultrasound scans conducted prior to the start of IVF treatment
- clinic registration fee
- day surgery costs
- some medications are not covered by Medicare (check with your doctor)
- anaesthetists' charges
- frozen embryo storage past a certain period (e.g. after six months).

Depending on your level of cover, private health insurance may cover some or all of these costs.

What is the Medicare Safety Net?

In addition to the standard automatic Medicare rebate you receive, the Medicare Safety Net covers a certain amount of the out-of-pocket costs for medical services provided after a particular threshold amount per calendar year is reached. Out-of-pocket costs are the difference between the Medicare benefit and what your doctor charges you. This includes specialist consultations and outpatient IVF services.

In order to be eligible, all of your family members must register for the Medicare Safety Net (even if they are listed on your Medicare card) as individual medical costs are combined and you will reach a threshold sooner. Individuals are automatically registered.

Many couples accessing fertility treatment for the first time are unlikely to have reached the Medicare Safety Net threshold prior to beginning treatment. This means that your first treatment cycle is likely to cost you more than the subsequent treatment cycles within the same year. Please note that at the end of December each year, your amount towards the threshold is returned to zero not rolled over to the next year.

For more information on the Safety Net threshold amount relevant to you and to register, call Medicare on 132 011 or by filling in an online form available at www.medicareaustralia.gov.au

Publicly Funded Treatment Costs in New Zealand

Joining a PHO (Primary Health Organisation) will entitle you to subsidised visits to your general practitioner and may also cover the costs of certain laboratory tests. Specialist care through the public system is free but waiting times will vary depending on your region and the type of treatment required. Private health insurance may pay a certain amount of your costs towards certain tests e.g. laparoscopy and hysteroscopy, depending on your level of cover. For more information visit www.moh.govt.nz/primaryhealthcare

Government Funded Fertility Treatments

If you are a New Zealand citizen or have permanent residency, you may be eligible for two 'packages' of government funded fertility treatment. A 'package' means:

- **one full IVF cycle** including transfer of any frozen embryos
- or four cycles of **interuterine insemination** (IUI)
- or other treatment such as **ovulation induction, donor sperm insemination** or **surgical sperm retrieval**.

To be eligible, your doctor will assess you by using a scoring system called the Clinical Priority Assessment Criteria (CPAC). You need to score 65 points to qualify, which is based on such aspects as prognosis without treatment, woman's age, duration of infertility and previous children.

Factors which make patients ineligible for public funding include:

- women who smoke
- women who have a BMI greater than 32 must reduce weight
- women aged 40 or older
- having two or more children aged 12 or younger living at home.

Factors associated with a higher CPAC score:

- severe cause of infertility e.g. no or very poor sperm, severe endometriosis, damage to both the fallopian tubes, unsuccessful ovulation induction treatment
- longer duration of infertility.

Ask your doctor for more information.

Support Organisations

AccessAustralia www.access.org.au
Ph: 1800 888 896; Email: info@access.org.au

AccessAustralia is the National Infertility Network and provides numerous services and resources for people having difficulty conceiving. Its services include:

- fact sheets covering many aspects of infertility
- website with the latest news, blogs, online membership area and secure direct contact with other members
- OPTIONS groups which provide contact for those sharing a particular infertility experience
- a Contact Request Network to put people in touch by email, letter or phone
- a list of infertility clinics licensed by the Reproductive Technology Accreditation Committee (RTAC)
- vigilance with federal and state governments about reimbursement and access to ART
- Infertility Counsellors Network, comprised of professional counsellors throughout Australasia who work in the field of infertility.

Andrology Australia www.andrologyaustralia.org
Ph: 1300 303 878; Email: info@andrologyaustralia.org

Provides factsheets, journal articles and the latest news on male reproductive health.

Donor Conception Support Group www.dcsg.org.au
Ph: (02) 9793 9335; Email: dcsg@optusnet.com.au

The Donor Conception Support Group of Australia is a self funding organisation run by volunteers. Its members include those who are considering or using donor sperm, egg or embryo, those who already have children conceived on donor programmes, adult donor offspring and donors. It offers a newsletter, information nights, a library of books and articles and telephone support.

Endometriosis Association (Qld) www.qendo.org.au
Ph: (07)3321 4408; Email: info@qendo.org.au

This association provides information and news relating to the latest research and treatments for endometriosis.

New Zealand Endometriosis Foundation Inc www.nzendo.co.nz
Ph: 0800 733277 (support line); Email: nzendo@xtra.co.nz

Polycystic Ovarian Syndrome Association of Australia (POSAA)
www.posaa.asn.au; Ph: (02) 8850 9429 or (02) 8250 0222;
Email: info@posaa.asn.au

POSAA is a self-help association for women with polycystic ovarian syndrome (PCOS) and those who suspect they have it. Its website includes information on upcoming workshops, support groups and fact sheets.

SANDS is a self-help support group comprised of parents who have experienced the death of a baby through miscarriage, stillbirth, or shortly after birth. It provides 24-hour telephone support, information resources, monthly support meetings, name-giving certificates and other support.

- Vic: www.sandsvic.org.au; Ph: (03) 9899 0218 (support) or (03) 9899 0217 (admin); Email: info@sandsvic.org.au
- Qld: www.sandsqld.com; Ph: 1800 228 655 (support) or (07) 3254 3422; Email: sandsqld@powerup.com.au
- SA: www.sandssa.org; Ph: (08) 8277 0304; Email: support@sandssa.org (quick response) or info@sandssa.org (general query)
- New Zealand: www.sands.org.nz/home.html; Ph: (04) 478 0895; Email: contact@sands.org.nz

FertilityNZ www.fertilitynz.org.nz
Ph: (03) 332 7790 or 0800 333 306;
Email: contact.us@fertilitynz.org.nz

FertilityNZ is New Zealand's national network for those seeking support, information and news on fertility problems. It provides various services including:

- regional support and contact groups
- general advice and contact service
- comprehensive information brochures
- a forum for confidential feedback on any issues or concerns
- a chatroom where you can seek on-line support from people in similar situations.

Your partner

chapter six

Your Partner

Do you remember when you and your partner were so infatuated, that when you looked in each other's eyes, it was like talking about everything from world politics to your favourite childhood cartoons. No subject was off limits and you felt safe in your private cocoon made for two.

As in every relationship, the way you communicate and act with each other will change the longer you are together. A quick peck on the cheek replaces the passionate kiss before you both race off to work or the day's task. Not that this is a bad thing, it is just change and every couple goes through it. After all, if infatuation stayed as intense, no one would go to work or get out of bed. So, change is a good thing.

Your partner is your confidante, the person you have chosen to build a life and start your family with. The thought of bringing a child into the world is exhilarating, but it can be stressful under even the best of circumstances. As mentioned earlier, infertility can be an extremely taxing, emotionally charged issue. Unfortunately, when we are under stress we tend to take it out on those closest to us, namely our partner.

Men and women are different. Men problem solve differently, process information differently and sometimes it seems like they don't deal with emotions at all. It's easy to sit down and list the many ways men 'just don't get it', but it is much more productive to talk about how they 'just don't get it ... the same way'.

The most important point you need to keep ingrained in your psyche is that you BOTH want a child and are BOTH frustrated and hurt that it is so difficult. That is key, because it chisels away some of those stubborn walls and barriers. At the core, you both want and feel the exact same thing.

As women, we have a tendency to want to talk everything out. We can spend hours on the phone with our girlfriends and still have plenty of energy to share all the details with our husbands.

We might deluge our husbands with infertility websites and books, facts and figures and chat room messages mirroring our situation. Some husbands might feign interest before returning to their newspapers; most don't stop reading and throw in a token, "That's interesting, honey". For women, this seeming lack of interest can be nothing less than infuriating. After all, we are talking about conceiving a child!

In your partner's defense, this may be information overload; it could be too much for him to process at once. Chances are men think about wanting to have a child just as much, but would rather get their information straight from the doctor's mouth in a one-on-one meeting. That way they can ask questions and most important, make an action plan. Men like to solve things; they don't know what to do with a lot of superfluous information.

Even though infertility is a couple's issue, it can be a lonely road. Here men are definitely at a disadvantage. Women seem naturally able to share feelings with other women and seek out support groups; men tend to try and work things out on their own. The stress of infertility can spur emotions to quickly spiral out of control. If tension is getting the best of your relationship, seek counselling sooner rather than later. In the meantime, try to avoid these common phrases when communicating with your partner:

"Why am I the only one doing any research, can't you pick up a book for a change?"

Tip: No one likes to be told what to do and nagging doesn't help. Let him find out information at his own speed, his own way. Maybe he only reads sports magazines because he needs an escape. He may be in a lot of pain emotionally and needs a break to keep his sanity. If you do find an article or a booklet that you think is inspiring, try leaving it in the bathroom with a note saying, "Thought you might like this. Love you!" Don't ask him if he read it or even mention it again unless he brings it up.

"Obviously, having a baby is more important to me!"

Tip: Ouch! You might think you know what is going on in your partner's head, but you can't know for sure. A comment like that can wound a man deeply and might leave him feeling completely disconnected from you – "Wow, she doesn't know me at all". Just because it is easier for women to display their emotions, this doesn't mean a man doesn't feel as deeply. Instead of telling him how HE feels, just stick with telling him how YOU feel.

"I am the one who has to deal with all the medical procedures and health problems! You have no idea what this is like!"

Tip: No, he probably doesn't know what this is like for you. How could he? Only another woman truly understands what it feels like to want a baby growing inside. At the same time, you probably don't understand what he is going through. The embarrassment of 'shooting blanks', of not feeling like a real man because he can't impregnate his woman. After all, men are instinctively 'supposed' to hunt, provide and propagate, right? Remember, infertility can be devastating and emasculating to a man. Try to build him up in other ways and he will be stronger emotionally and more open to support you.

"This is all your fault!"

Tip: That one phrase could very well echo the voice he hears in his own head. Infertility is NO ONE's fault, it is a medical condition. Blame is easy to exchange when stress is involved but rarely does it work in reverse. For instance, you probably would never hear a woman yell out happily "This is all your doing!" when she gets a positive pregnancy test. If you find yourself becoming 'The Blamer' in a fit of anger, apologise as quickly as possible and get back to honesty. After all, you know it isn't his fault but it hurts so bad that it can be easy to lash out.

Many couples are caught off guard when they realise they're having difficulty conceiving. They may find themselves overwhelmed as they attempt to sort through a sea of information.

How can you help combat this? Some people draw up a personal plan with their partner and doctor to guide them through the process. It helps put things into perspective as you move forward. Putting your goals and concerns on paper can help you focus on what's important as you make difficult decisions. The plan isn't etched in stone. It's a work in progress. You can revise it anytime, particularly as your situation changes.

It can help to speak with a healthcare professional who will listen and with whom you feel comfortable. They will be able to provide you with support strategies to help you cope during the challenging times.

"I wish I had known about resources like AccessAustralia and their support groups when I was going through my treatments. It is good to know that there are others out there who are going through the same experiences and can provide some answers."

– Jodie

chapter seven

Your Family

As thriving and independent adults, it is hard to comprehend that we started as small embryos attached to our mothers' uteruses. We were born into this world screaming and helpless, looking for unconditional love and attention. This is how it has always been and likely how it will always be ... and so the family tree and ancestral line grow.

Family is a wonderful institution. Memories, holidays and traditions would hardly be worth remembering if it weren't for them. Now, no one is saying that families are perfect. In fact, if you asked a room full of people to yell out if they come from a 'normal' family, the only sound you might hear are crickets chirping in the back of the room. Many families are not 'normal', but we love them anyway.

So, the question arises, 'To tell or not to tell?' As a couple wanting so desperately to start a family, you are walking around with a tremendous burden on your shoulders. Some women consider their mothers their best friends and share intimate details of their cycles and health, even their sexual history. Others may not share such an open relationship but may have a special bond with a sister, aunt or cousin. There are others who have a hard time discussing the latest weather, let alone anything personal with their family. It really doesn't matter, what's important is that you confide only in people you feel comfortable with, if any.

Remember these tips when disclosing:

You don't owe anyone an explanation

Fertility issues are PERSONAL. You have a right not to disclose your income (except to the Taxation Office, of course), how you vote or why you don't have children. It is up to you and your spouse who you will share this information with. If you are sick of hearing the same questions and are afraid you might angrily blurt out "WE CAN'T GET PREGNANT!", try having some short answers ready like "We'll keep you posted" or "You'll be the first to know". Preferably, one that doesn't warrant a follow-up question.

Share only as much information as you feel comfortable

If you feel comfortable, only disclose as much information as you want. Make sure your spouse is on board about who and how much will be shared. For instance, if the fertility issues stem around your husband's low sperm count, he probably doesn't want his mother-in-law to know. If you find a supportive family member who genuinely wants to know more, share articles or websites you have found helpful. If you find someone is supportive, but her eyes glaze over at medical jargon, stick with your emotions. Remember, you can't take back information you put out there, but you can always give more.

Ask for what you do and don't need

Infertility is a touchy subject and many people have a hard time knowing what to say. Some say something dismissive like "It'll be fine, don't worry" or give clueless advice like "Your cousin Suzie did headstands after having sex and it worked for her". Some people cry or say things that are completely inappropriate, when usually a hug is the only response needed. Most people don't know how to react, so tell them. You have a right to say "I am sharing this with you now, but I'd rather not talk about it again unless I bring it up" or "I know you want to help, but I really need to handle this myself".

Try not to have expectations

Infertility is very hard to understand and accept for the couple going through it. It can also be hard for your loved ones who want nothing more than for you to have the family you have always wanted. They want to help, comfort and say the right thing. Sometimes, it comes out wrong, but it helps to know their intentions were good.

> Most people don't know how to react, so tell them.

chapter eight

Hope

Hope

Your timing could not be more perfect for trying to start a family. Never before has so much research and effort gone into helping couples conceive. Medical science has spent millions investigating the causes of infertility and developing treatments for it. This is an exciting time as you now have the opportunity to reap all the benefits of this medical progress.

Throughout this booklet, we have discussed the personal, financial, medical and emotional sides of infertility. You have experienced the highs and lows of trying to get pregnant, educated yourself on the latest medical research, and worked as a couple to sort through the stress and unpredictability of infertility. It has been a long and difficult process to get to this point, not to mention a lonely one.

But, this journey is no longer yours to travel alone. The pressure to spontaneously get pregnant or the constant nagging question of "What is wrong with me?" doesn't need to haunt you anymore. You are taking steps forward that could eventually lead to parenthood. You have doctors and nurses who will help you on this leg of the journey. Let them carry the burden of trying to get you pregnant while you concentrate on creating a physically and emotionally healthy body, home and relationship. For the first time in months or even years, allow yourself to be taken care of. After you have a child, you probably won't get that chance again.

This is a time of inspiration, growth, renewal and strength! Not many people have the kind of perseverance and commitment that you have to achieve your goals. One day, you may look back on this journey in amazement and with a sense of pride at how much you were able to handle. You probably inspired many others along the way.

So, now begins the next phase of your life story. You are going to do whatever it takes to make your vision of a family a reality. Keep your chin up and your eye on the prize. You are not alone in this journey!

"I want women to know that they're not alone. It is a very emotional journey going through fertility treatments. Lean on the support you have from your spouse, your family and your doctor to overcome the obstacles and stay strong. Most of all, remember, there is hope."

– Nicole

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