March 2026

IMAP Statement on Advancing Fertility Care

1. Introduction

1.1 Background

Infertility, recognized by the World Health Organization (WHO) as a disease, affects approximately 1 in 6 reproductive aged individuals worldwide, making it one of the most common chronic conditions faced by individuals of childbearing age (1, 2). An estimated 52.6 to 200 million couples experience an inability to become pregnant, have one or an additional child, with most residing in low- and middle-income countries (2).

Every individual has the right to the highest attainable standard of physical and mental well-being, as well as the freedom to decide the number, timing, and spacing of their children. However, infertility can pose a significant barrier to these rights, impacting personal autonomy and overall well-being (3). Beyond its medical implications, infertility carries profound emotional and financial

NOTE: This document is inclusive of women and girls and all people who can become pregnant, including intersex people, transgender men and boys, and people with other gender identities that may have the reproductive capacity to become pregnant and have abortions. For the purposes of this document, references to "women and girls" refer to all people who have the capacity to become pregnant.

consequences, which are further exacerbated in low-resource settings by unavailability of healthcare services, inadequate healthcare infrastructure, prohibitive costs, and socio-cultural barriers to treatment. In some cultures, infertility can result in social ostracization and even gender-based violence, intensifying the challenges faced by affected individuals, particularly women (2).

A priority for International Planned Parenthood Federation (IPPF) is ensuring access to high-quality, rights-based, affordable fertility care, tailored to local infrastructures and sensitive to cultural contexts. IPPF recognizes that family planning includes building a family as much as limiting its size. This guideline provides evidence-based recommendations for fertility care in sexual and reproductive health services.

1.2 Purpose of the statement

This statement provides evidence-based guidance on the recognition, diagnosis, and management of infertility, particularly in low-resource settings. This statement is a resource for IPPF Member Associations (MAs) to promote equitable access to evidence-based family-building options, dispel common misconceptions about infertility, and offer practical recommendations to optimize patient-centred care and outcomes. It was endorsed by IMAP in February 2026.

1.3 Defining the problem

1.3.1 Infertility

Infertility is diagnosed when a couple has not achieved pregnancy after at least 12 months of consistent, unprotected vaginal intercourse. Some professional societies further specify that this 12-month timeframe applies to female partners under 35, while for those 35 and older, the evaluation for conditions that can cause infertility should begin after 6 months of unsuccessful attempts to conceive (4). In women older than 40 and /or where the cause of infertility is known, such as in previous bilateral salpingectomy after ectopic pregnancy, the couple should be evaluated without delay.

While this definition applies to heterosexual, cis-gender couples, it is important to acknowledge that WHO and IPPF recognize a diverse range of individuals who may require fertility care. These include same-sex couples, individuals of any gender-identity (i.e. non-binary, transgender), older individuals, those who are not in sexual relationships, and people with certain medical conditions, such as HIV and cancer clients/survivors. WHO emphasizes that inequities in access to fertility care disproportionately affect marginalized populations, particularly those with limited education, financial means, or healthcare access, further widening disparities in health.

The underlying causes of infertility can be broadly divided into three categories: i) female factor infertility, and ii) male factor infertility, which contribute to a similar proportion of cases, and iii) unexplained infertility (10-30% of cases) (5, 6).

1.3.2 Barriers to care

A range of barriers may preclude fertility services and care for those unable to achieve pregnancy, some of which vary by setting. Barriers may include:

- Lack of infrastructure
- Lack of support/funding
- Cost/affordability of diagnostic procedures and treatment options
- Socio-cultural and diversity factors, and gender inequality
- Unsuccessful or non-existent educational and/or prevention programs
- Limited knowledge/literature on cost-effective alternative methods
- Lack of educational resources targeting different stakeholders (i.e. policymakers, researchers, healthcare professionals, community leaders, schools)
- Lack of available data to optimize individual rights and societal reproductive goals through public health policies (7)
- Stigmatization of those with infertility

2. Counselling and education

High-quality information is essential for infertility prevention and fertility care, as individuals may need to take many steps beyond clinic attendance to improve their reproductive health. Education should be accessible at both the individual and community levels to enhance health awareness. The WHO conditionally recommends (meaning there is likely more benefit than harm from the intervention) providing information about fertility and infertility using low-cost strategies to the general population of reproductive age whenever there is opportunity (8).

2.1 Counselling/education for clients

Information for clients should include fertility potential, risk factors for infertility, prevention strategies and how to improve healthy lifestyle factors in general. The aim of information provision in a presumably fertile population is to improve fertility awareness and future pregnancy planning. Fertility awareness is the understanding of reproduction, the ability to become pregnant, and related individual risk factors (e.g. advanced age, sexual health factors such as sexually transmitted infections (STIs), and lifestyle factors such as smoking, obesity) and non-individual risk factors (e.g. environmental and workplace factors), including the awareness of societal and cultural factors affecting the ability to meet family planning goals, including family building (8).

2.1.1 Natural conception

Box #1: Counselling points for optimizing natural conception and knowing when to seek care (9)

- Fertility is highest in the first few months of unprotected intercourse.
- More than 70% of couples conceive within 6 months, with the greatest chance in the first 3 months.
- Fertility decreases with age in both men and women but is more pronounced in women (fertility halves by age 40 compared to the late 20s/early 30s; average latest maternal age for live birth is 41). This fertility decline also correlates with a higher miscarriage risk.
- Male fertility remains stable until about age 50, though some semen parameters decline after age 35.
- Menstrual cycle length (cycle days) is calculated by identifying the first day of a cycle as the start of menstrual bleeding and the last day as the day before the next cycle's bleeding begins. A normal ovulatory cycle typically ranges from 24-38 days.
- The fertile window (the time during which conception is possible) comprises 5 days before ovulation and the day of ovulation itself. Once ovulation occurs, the egg survives for only 12-24 hours. Sperm can survive in the female genital tract for up to 5 days.
- Semen analysis provides quantitative data but does not reliably predict functional capacity.
- Intercourse every 1-2 days during the fertile window is recommended for couples seeking pregnancy.

Predicting the fertile window requires using one or more methods to determine the optimal timing for intercourse during the menstrual cycle. The fertile window should be assessed while a woman is not taking hormonal contraception:

- **Calendar-Based Methods:** tracking the menstrual cycle to identify fertile days
  - » **Standard Days Method:** Ideal for those with menstrual cycles between 26 and 32 days. If more than two cycles per year fall outside this range, effectiveness may be reduced.
    - **Ovulation timing:** In a 28-day cycle, ovulation typically occurs around cycle day 14, with cycle day 1 being the first day of menstrual bleeding.
    - **Intercourse timing:** Regular intercourse is recommended between cycle day 8-19, as sperm remain viable in the female reproductive tract up to 5 days.

- **Aids:** Memory aids such as marking days on a calendar or using cycle beads (IPPF Client-Centred Clinical Guidelines, Chapter 4, Section 7.2.2.1, Figure 1, unprotected intercourse on WHITE bead days) can help time intercourse.
- Estimated day of ovulation is calculated by subtracting 14 from the length of the cycle (for a 32-day cycle: 32-14= cycle day 18).

» **Calendar Method:**

- **Preparation:** Record the length of at least six menstrual cycles (from the first day of bleeding in one cycle to the first day of bleeding in the next cycle). Update this record monthly to reference the most recent six cycles.
- **Intercourse timing:** Engage in intercourse during the calculated fertile days.
  - Start of the window: Subtract 18 from the shortest cycle length.
  - End of the window: Subtract 11 from the longest cycle length.

- **Symptom-Based Methods:** observing physical signs of fertile days

» Not recommended for postpartum individuals or those with irregular cycles, breastfeeding, or taking medications/with conditions affecting body temperature or vaginal discharge. After an abortion or miscarriage, three regular cycles should occur before using these methods.

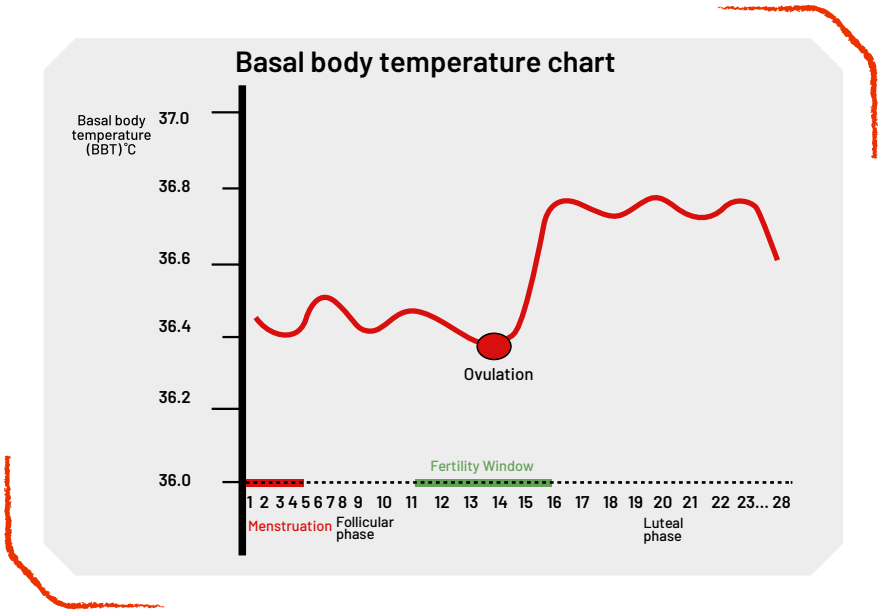
» **Cervical Mucus Method:**

- **Observation:** Check cervical mucus daily after menstruation, preferably in the afternoon or evening for better accuracy.
- **Mucus changes:**
  - Initially thick, sticky, cloudy, and inelastic.
  - Becomes slippery, thin, transparent, white, and elastic (like raw egg whites) near ovulation, signalling the fertile window (~3 days).
    - Test elasticity between fingers or with tissue paper. The mucus during peak fertility stretches 1 to 3 inches (or more) without breaking. It is clear, thin and slippery, like raw egg whites.
- **Important note:** Semen can interfere with observations; avoid checking cervical mucus within two days of intercourse for accuracy.

» **Basal Body Temperature (BBT) Method:**

- **Tracking:** Measure body temperature every morning at the same time before getting out of bed, eating, or drinking.
- **Temperature change:** A 0.2–0.5°C (0.4–1.0°F) rise occurs after ovulation and stays elevated until the next menstrual period.
- **Tools:** An ovulation thermometer or regular thermometer with a suitable scale is recommended.

- **Fertile window:** Spans 7 days before the midcycle BBT rises. Optimal intercourse timing begins 7 days before the earliest observed rise and ends on the observed rise (1).
- This method is not reliable among women taking exogenous progesterone.



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» **Combination methods:** Using both cervical mucus observations and BBT tracking improves accuracy in determining the fertile window. The calendar method can support fertility awareness by tracking menstrual cycles to estimate fertile days.

- **Ovulation predictor kits:** If available, ovulation predictor kits are an easy-to-use alternative or in addition to these methods for timing intercourse. The best products predict ovulation within the subsequent 24–48 hours, with greater than 90% probability.

2.1.2 Lifestyle interventions

Several lifestyle interventions are recommended for both partners, as they enhance fertility at little to no cost while also improving overall health:

- Cessation of tobacco and marijuana smoking (10-12).
- Limiting caffeine intake to <200 mg (about 3 cups of coffee) /day (13, 14)(1).
- Limiting alcohol consumption to ≤4 drinks per week (14)(1).

- Weight loss over 3-6 months if: anovulatory, having irregular menstrual cycles or diagnosed with polycystic ovulation syndrome (PCOS) with a body mass index (BMI) of 25 kg/m2 or higher. Even a 5-10% reduction in body weight in individuals with anovulation and an average BMI of 35 kg/m2 can improve ovulation by more than 50% (15).

- Ensuring adequate folic acid intake; increasing from 400 mcg to >800 mcg/day has been associated with a 1.5-fold increase in live birth rates in in-vitro fertilization (IVF) patients and decreases the risk of neural tube defects in the fetus (16).

- Evaluate ongoing medicines (anti-androgens such as finasteride or steroids for men, etc.) or environmental exposures that may decrease fertility.

2.2 Community awareness

Effective public awareness efforts may require collaboration with community groups/ organizations, governments, health ministries, schools, and traditional healers (17). Outreach should include media campaigns and educational materials tailored to diverse populations to increase knowledge about infertility as well as to combat social stigma.

Key messages for community education:

- **Infertility is common**, affecting 1 in 6 reproductive-aged individuals, making it one of the most prevalent chronic conditions (18).

- **Infertility is not just a concern for women**. Male factor infertility is almost equally common as female factor infertility (1). Fertility issues are often multifactorial and may remain unexplained. However, some treatments can help couples with unexplained infertility achieve pregnancy.

- **Hormonal contraceptives and intrauterine devices (IUDs) do not cause infertility.** However, the use of some contraceptives may temporarily delay fertility return. In most individuals, ovulation returns to normal cycles immediately following discontinuation; however, there may be a delay after discontinuation of long-term contraceptives, implants and injectables, with return to ovulation taking between 3 and 10 months (1, 19).

- **Previous abortion(s) does not cause infertility**. Safely performed, uncomplicated abortions do not cause infertility or affect future pregnancy, according to WHO. Risks to future fertility are extremely low, and linked only to rare, severe, untreated infections or surgical complications.

- **Prevention and treatment of sexually transmitted infections are crucial**. Consistent condom use helps prevent gonorrhoea and chlamydia (GC/CT), which, if untreated, can cause fallopian tube adhesion with occlusion and infertility (20). Testing or syndromic treatment for GC/CT is recommended to prevent irreversible tubal damage, especially for sexually active individuals at risk, with prompt treatment for both partners.

3. Assessment and diagnosis

3.1 Initiating the conversation

When initiating conversations about fertility with clients of reproductive age, it is important to emphasize that one in six individuals worldwide will experience infertility at some point in their lifetime. Primary care providers play a key role in discussing fertility concerns, offering psychological support and guidance on lifestyle modifications, and advising on potential next steps in a confidential, nonjudgmental environment. Referrals for infertility services should be facilitated quickly for those needing specialist care. As not all couples or individuals seeking fertility services will ultimately become pregnant, ongoing psychological/mental health support is an important part of the care continuum.

For basic universal questions to assess infertility, refer to the IPPF Client-Centred Clinical Guidelines (Chapter 8, Section 6.2). While additional questions may be needed, a rigid list is not included here to ensure a people-centred, culturally sensitive approach.

3.2 Fertility workup

A stepwise approach to fertility evaluations – when time is not a critical factor, such as in younger clients - can enhance cost-effectiveness while maintaining comprehensive care. Box #2 summarizes this framework and key considerations.

Box #2: Fertility workup

Female factor workup:

1. Ovulation evaluation:

- **Progesterone level <3 ng/mL** ~1 week before expected menses (based on the woman's typical cycle) suggests anovulation. If no menses after 7 days, repeat test. Further evaluation includes:
  - TSH & prolactin: Identify and treat thyroid or prolactin abnormalities.
  - Cycle day 3 FSH & estradiol (cycle day 1 being the first day of menstrual bleeding): Rule out primary ovarian insufficiency or menopause; if confirmed, referral to a specialist is recommended.
  - If all other results are normal (including male-factor analysis and, if indicated*, uterine/tubal assessment in time-sensitive cases): Offer ovulation induction (see Section 4.1).
- **Progesterone level ≥3 ng/mL** indicates ovulation; further assessment for other infertility causes is needed (below).

Box #2: Fertility workup

2. Assessment of tubal patency and uterine factors:

- **Tubal patency:** Evaluated via hysterosalpingogram (HSG), hysterosalpingo-contrast sonography or laparoscopy and chromopertubation (if there is another indication for surgery).
- **Uterine evaluation:** HSG, saline sonohysterography (preferred if no tubal concerns), or diagnostic hysteroscopy (more costly and invasive).
- **Additional considerations:** If fibroids (not affecting the uterine cavity), adenomyosis, or endometriosis are suspected, ultrasound or saline sonohysterography may be used. Management of these conditions is beyond this statement's scope.

* Uterine and tubal assessment is essential in females with a history of pelvic infection or surgery, ectopic pregnancy, inflammatory bowel disease, pelvic pain/endometriosis, or an abnormal pelvic examination (1)

Male factor workup:

1. Physical exam:

Male genitalia should be evaluated.

- Palpable varicoceles may benefit from surgical repair. Although the results from varicocele repair have varied widely in the literature, repair is recommended if semen parameters are outside of the normal range. Decisions for fertility treatment include considering female factors and using intrauterine insemination (IUI), or advanced reproductive technologies such as intracytoplasmic sperm injection (ICSI) and in-vitro fertilization (IVF).

2. Semen analysis: (sperm number, concentration, morphology and motility; performed after minimum 2 days to maximum 5 days of abstinence (8):

a) If Normal and the female factor workup is also normal, the diagnosis is unexplained infertility.

b) If Abnormal: Repeat in ~3 months (consider implementing lifestyle interventions during this time). If abnormalities persist, refer to a male fertility specialist or urologist.

Recurrent pregnancy loss workup (defined as ≥2 pregnancy losses)(21):

- **Overlapping tests with female factor workup:** TSH, prolactin, HSG and/or saline sonohysterography (to evaluate for uterine causes)
- **Additional considerations:** hemoglobin A1c, parental karyotypes, antiphospholipid syndrome (APS) testing (lupus anticoagulant, anticardiolipin IgG/IgM, anti-β_2 glycoprotein I IgG/IgM)
- The diagnosis of APS should follow the most up-to-date international consensus classification criteria. In addition to bloodwork – which must be repeated at least 12 weeks apart - APS diagnosis requires clinical history. Management of recurrent pregnancy loss focuses on addressing underlying causes and may require referral (22, 23).

Andrology testing facilities may be limited due to funding, equipment, and expertise constraints, making semen analysis challenging. Simplified sperm testing assays offer a practical, cost-effective solution while enhancing privacy (24). One such assay can analyse unwashed, unprocessed semen in under five seconds, providing 98% accuracy based on WHO guidelines (25). Box 3 summarizes the steps for using this assay, which can serve as a point-of-care tool for both patients and clinic staff.

Box #3: Simplified sperm testing

- A small semen sample is drawn into a slide-like microfluidic device by dipping the disposable tip into the sample.
- Once the device pulls the sample into its built-in microchannel; the disposable tip is removed and discarded.
- The microfluidic device is placed into a smartphone optical attachment.
- The smartphone application runs the test, delivering the results in under five seconds.



3.3 Unexplained-factor infertility

Unexplained infertility is a diagnosis of exclusion; it requires all the following:

- failure to achieve a pregnancy after 12 months of regular unprotected sexual intercourse;
- normal physical examination and medical history in both the male and female;
- presumptive confirmation of ovulation and patent tubes in the female partner; and
- semen parameters that are within the WHO reference ranges in the male partner **(8)**.

4. Interventions and treatments

4.1 Expectant management

Expectant management refers to monitoring the couple with the expectation that pregnancy will be achieved without medical intervention. It includes providing advice on lifestyle, timing intercourse to the most fertile days of the menstrual cycle and monitoring for pregnancy. The WHO recommends expectant management for couples with unexplained infertility for 3-6 months before initiating treatment (ovulation induction and IUI, detailed below) (8).

4.2 Ovulation induction/ovarian stimulation with intrauterine insemination (IUI) or timed intercourse

4.2.1 Indications for ovulation induction/ovarian stimulation

- **Anovulatory/oligoovulatory individuals:** Ovulatory dysfunction is the underlying cause of infertility in up to 40% of female factor infertility. The relative contribution of anovulation and tubal factors differ by setting and country, for example, due to differences in the background prevalence of STIs, or differing ages of populations studied (26).

    - If a specific cause, such as thyroid or prolactin abnormalities, is identified, treating the underlying condition should restore ovulation and fertility, provided no other underlying causes exist. However, when no specific cause is found, as is the case for most who are anovulatory, ovulation induction/ovarian stimulation is indicated. Even with ovulation, pregnancy may still not occur due to chance or other coexisting factors. The chance of pregnancy each month for normal fertile couples is 20-30%, meaning that the benchmark for comparison is 20-30% rather than 100% each cycle. After repeated treatment cycles failing to achieve pregnancy, advanced reproductive technologies, such as in-vitro fertilization (IVF), may provide a solution (1).

    - Ovulatory dysfunction can be diagnosed by not meeting the criteria described for ovulation in Section 2.1.1. Ovulatory dysfunction can also be diagnosed in clients who report irregular, unpredictable, or infrequent menstrual cycles.

- **Unexplained infertility:** Although studies show only a modest improvement in pregnancy rates with ovarian stimulation plus IUI, its low cost and complexity make it a reasonable treatment (1). For those who have not conceived with ovarian stimulation and IUI after more than 3-6 cycles, the WHO recommends using IVF.

    - With ovarian stimulation, multiple follicular recruitment is thought to be beneficial. However, in younger clients, there is a risk of multiple gestation, which should be carefully discussed (1).

- **IUI:** If IUI is indicated, ovulation induction/stimulation is recommended to aid in timing and potentially address unknown underlying causes of infertility. See Section 4.3 for IUI indications.

- **Endometriosis should be considered in cases of unexplained infertility, and further investigations or surgery undertaken if conception doesn't occur.**

4.2.2 Overview of ovulation induction/stimulation cycles

1. Cycle and medication start:

- Letrozole (2.5 mg/day) or clomiphene citrate (50 mg/day) for 5 days, starting cycle day 3- 5.

    - Letrozole is preferred, if it is available, for patients with anovulation or polycystic ovarian syndrome. If letrozole is not available for use in polycystic ovarian syndrome (PCOS) patients, clomiphene citrate should be administered in combination with metformin.

    - Either letrozole or clomiphene citrate may be used for couples with unexplained infertility.

2. Ovulation monitoring:

- Start daily cycle day 9-11 (cycle day 1 being the first day of menstrual bleeding) to detect luteinizing hormone (LH) surge in clomiphene/letrozole cycles. LH starts to rise about 36 hours before ovulation, peaking about 10-12 hours before ovulation.

- Bloodwork and ultrasound:

    - LH: Can be measured as needed, typically beginning cycle day 9-11; follicle growth signals that ovulation will take place soon (when follicles are around 14 mm in size).

    - Estradiol:
        - Measured alongside LH levels for confirmatory monitoring if using clomiphene or gonadotrophins
        - Should be monitored alongside LH levels in gonadotrophin stimulation cycles, first prior to starting stimulation, then on day 5 of medication, and subsequently as needed, in conjunction with ultrasound monitoring

- Progesterone: Should be measured if the ovulation status is unclear

- Ultrasound is essential for patients:
  - Diagnosed with PCOS, as high baseline LH levels make ovulation predictor kits unreliable
  - At risk for multifollicular recruitment, to assess the risk of multiple gestation.

- Cost- saving adaptations: Prefer ovulation predictor kits when possible; minimize bloodwork and ultrasounds, relying on follicular growth rate (2 mm/day) for ovulation estimation.

3. Detecting/triggering ovulation for timed intercourse or IUI:

- If the ovulation predictor kit is positive and the baseline LH is low, timed intercourse or IUI for the day after positive kit result.

- With bloodwork and ultrasound:

  - **Clomiphene or letrozole cycles:** If dominant follicle >17 mm, appropriate estradiol rise (if using clomiphene) and,
    - If LH is low (less than 14-20) then administer human chorionic gonadotropin (hCG) and follow with timed intercourse or IUI within 36-40 hours after trigger administration.
    - If LH is elevated (more than or equal to 14-20) timed intercourse or IUI - the next day (no hCG needed).

- **Cost saving adaptations:** Prefer timed intercourse over IUI, no need to use hCG if LH surge occurs naturally, especially if LH greater than 20-40.

4. If no dominant follicle:

- Ensure that ovulation was not missed: Check LH, estradiol, and progesterone for luteal phase assessment.

- **Clomiphene or letrozole cycles:**

  - If no ovulation occurs, the medication dose can be increased either within the same cycle (on the last day of evaluation) or during the next cycle.

  - If the dose is increased within the current cycle, the day of evaluation or the start of the increased dose becomes the new cycle day 3, with continued monitoring starting on the new cycle day 9.
    - Clomiphene: Increase to 100 mg, then 150 mg if needed.
    - Letrozole: Increase to 5 mg, then 7.5 mg if needed.

- If early ovulation is detected: Adjust monitoring for earlier detection in future cycles. Clomiphene citrate at doses of more than 150 will cause thinning of endometrium and have a negative impact on implantation.

- **Cost- saving adaptations:** Limit bloodwork to progesterone for detecting early ovulation.

4.3 Intrauterine insemination (IUI)

IUI is a quick, straightforward procedure where a thin, flexible catheter attached to a syringe containing prepared semen is passed through the cervix into the uterus, where it is used to deposit sperm (after sperm is washed to separate from seminal fluid and other debris in semen) ~1 cm from the uterine fundus.

Indications for IUI:

- Unexplained infertility
- Mild male factor infertility
- Therapeutic donor insemination:
    - » Same-sex couples, both partners assigned female at birth
    - » Severe, uncorrectable male factor infertility
    - » Inherited genetic disorders in the male partner
    - » Women seeking pregnancy without a partner

Ethical, legal, and psychosocial complexities may arise for same-sex couples and single parents, often influenced by social and cultural factors.

IUI can slightly improve success rates over timed intercourse when combined with ovarian induction/stimulation.

Cost- saving considerations:

- Sperm prep: Conventional sperm washing is generally sufficient over a gradient wash (1).
- Insemination catheter: Choose the most cost-effective catheter suitable for IUI.

4.3 Overview of IVF and adaptations

IVF involves controlled ovarian stimulation using exogenous gonadotrophin administration - followed by ovulation triggering, oocyte retrieval, fertilization, and embryo transfer.

IVF is an advanced assisted reproductive technology technique that requires the expertise of trained professionals. Where official training programs for gynecologists do not exist, structured

training should be made available for both physicians and paramedical staff. The Walking Egg Project is a non-profit organisation dedicated to establishing affordable, high-quality infertility centres in low-middle-income countries, serving as a valuable resource for expanding access to fertility care (17).

4.4 Surgical management

A range of surgical procedures may be indicated for physical causes or contributors to subfertility. Uterine abnormalities are an uncommon cause of infertility. While there are some surgical interventions to correct conditions of the testes (surgical correction of varicocele) that may lead to slight improvements in semen parameters, they do not reliably predict fertilization capacity and generally IVF with intracytoplasmic sperm injection (ICSI) is recommended.

The key considerations for surgical management can be summarized as follows:

- If both fallopian tubes are blocked, after ruling out proximal tube spasm with a repeat HSG using pain/anxiety control, then IVF is preferred over surgical management.

- For uterine pathology, operative hysteroscopy followed by postoperative intrauterine balloon placement with estrogen and progesterone supplementation—or another barrier to prevent adhesions—is highly recommended. Office hysteroscopy can be performed without anesthesia or with low dose/cost anesthesia.

5. Recommendations for IPPF MAs on delivering rights-based care for people experiencing infertility:

Helping people meet their fertility intentions, whether to space, limit or have children, is intrinsic to the values of IPPF. Expanding fertility care is critical to increasing equitable access to services and includes interventions from the simple to the complex. To further implement fertility care services, IPPF MAs should:

- Advocate for the incorporation of full-range fertility care in their public health systems, through a rights-based approach, with a focus on reproductive autonomy, dignity and equality, in alignment with IPPF values.

- Organize specialized training to recognize and address the unique barriers to fertility care in their settings. Providers should be equipped to navigate economic constraints, gender norms and other sociocultural challenges that affect access to care. They should also be proficient in delivering fertility-related education in a culturally sensitive manner, ensuring that individuals understand that basic reproductive physiology can significantly impact fertility outcomes.

- Increase awareness and education about the global incidence and multifactorial nature of infertility. Clinics should collaborate with community groups, community-based health agents, government agencies, schools, to disseminate accurate information and reduce stigma surrounding infertility. Messaging should also include information about maximizing fertility, including that fertility decreases significantly with age after 35 for women, and the importance of seeking fertility services if pregnancy does not occur after one year of unprotected intercourse.

- Offer appropriate diagnostic workups to guide treatment strategies. Providers should understand key laboratory tests (including semen analysis and hormonal panels) and imaging modalities (such as pelvic ultrasound and HSG) to assess the underlying causes of infertility accurately.

- Promote evidence-based lifestyle interventions that can enhance fertility. These include weight management, folic acid supplementation, and reducing exposure to known reproductive toxins such as smoking, excessive alcohol consumption, and high caffeine intake.

- Recognize when advanced treatment is necessary and provide appropriate work-up, guidance and referrals. This may involve assisting clients with ovulation induction/ stimulation with timed intercourse/IUI or referring for IVF or surgical interventions. If IVF or necessary surgical treatments are unavailable within the MA's facilities, structured referral pathways should be in place to ensure access to care.

- Include psychological and mental health support in the fertility care continuum. Infertility diagnoses and treatments can be difficult and stressful for clients, and even with treatment, some will still not achieve pregnancy. Providing psychologic support is a key service to ensure the well-being of clients receiving fertility services.

- Expand expertise and capacity to meet increasing demand for fertility care. As delayed childbearing becomes more common worldwide, fertility services play an increasingly important role in realizing people's reproductive health and rights. MAs should work towards enhancing their capabilities, infrastructure and referral pathways to address this growing need effectively.

- Establish formal referral mechanisms for individuals with significantly abnormal fertility test results that may suggest an underlying health condition (e.g., those diagnosed with primary ovarian insufficiency or azoospermia). These clients require specialized evaluation and management that extends beyond the scope of local healthcare settings.

- MAs who are skilled at ovulation induction and IUI treatment and wish to introduce IVF into their services will need to pursue structured training and acquire appropriate facilities to conduct oocyte retrieval, fertilization, assessment of embryo quality (usually performed

by an embryologist) and embryo transfer. MAs may reach out to the Walking Egg Project (https://thewalkingegg.com/the-project) for assistance with training and capacity building with laboratory aspects of IVF treatment.

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