Primary Care
Women's Health Society

Top tips

Things you should know about fertility

Dr. Steph Cook.
GPwER in women's health.
PCWHS director.

This resource has been produced on behalf of the PCWHS. It is for guidance only; healthcare professionals should use their own judgment when applying it to patient care.

For more resources, visit www.pcwhs.co.uk. Date of publication: August 2025. Date of next review: August 2028.
The PCWHS aims to educate primary care clinicians about women's health, i.e. the health of those who were registered female at birth. Our resources therefore all use the words woman/women and the pronouns she/her. Where patients have a gender identity which is different from their sex registered at birth, communication should be sensitive and respectful of the patient's pronouns.
For further information, or to leave any feedback, please contact admin@pcwhs.co.uk

Fertility consultations can be emotive and sometimes challenging. As clinicians we should take care to avoid wording or phrases that can convey a sense of blame or guilt -- these conversations should be approached with empathy and sensitivity.

It is also important that we educate patients on the factors affecting fertility, especially modifiable or varying factors such as age, weight, diabetic control and smoking. Contraception consultations and pill checks are a great opportunity to discuss these modifiable risk factors and to encourage patients to be proactive about considering their future fertility plans.

1) Weight is important – not too high or too low.

- Female obesity reduces the likelihood of both natural conception and successful fertility treatment. It is also associated with an increased risk of miscarriage, congenital abnormalities and pregnancy complications for mother and child[1,2].
- Women should be told about the impact of obesity on fertility and receive support to lose weight. Advise women with a BMI of <19 who are struggling to conceive that gaining weight is likely to improve their chances of natural conception.

2) You can't stop the biological clock.

- Age really matters, especially for women.
- Average female fertility declines from 30, with a faster decline from 35. Girls are born with ~2,000,000 immature eggs in their ovaries, falling to ~400,000 during adolescence and to ~25,000 by their late 30s, 1-2% of the number present at birth[3].
- Age is also important for eligibility for NHS funded in-vitro fertilisation (IVF), discussed in more detail later.

3) Lifestyle is important for both prospective parents.

- Smoking (and probably vaping, though more research is needed), drinking more than 1-2 units of alcohol/day or becoming intoxicated are all likely to negatively impact female fertility.
- Excessive alcohol consumption, smoking and vaping have a negative effect on semen quality[4,5,6].

4) Take a good gynaecological history in a woman with fertility problems

- Endometriosis:
  - Endometriosis negatively impacts on fertility[7]; a multidisciplinary approach may include medical/surgical treatment of endometriosis and assisted reproduction.
  - Excision/ablation of endometriosis lesions, adhesiolysis and laparoscopic cystectomy for endometriomas all improve fertility.
- Fibroids:
  - Fibroids are very common - the impact on fertility depends on size and location, with submucosal/intramural fibroids having more impact than subserosal fibroids.
  - Fibroids can also increase the chances of miscarriage or preterm labour. The impact of existing fibroids on a patient's fertility, and the best management, will vary and should be discussed with a fertility specialist.

For more resources, visit www.pcwhs.co.uk. Date of publication: August 2025. Date of next review: August 2028.
The PCWHS aims to educate primary care clinicians about women's health, i.e. the health of those who were registered female at birth. Our resources therefore all use the words woman/women and the pronouns she/her. Where patients have a gender identity which is different from their sex registered at birth, communication should be sensitive and respectful of the patient's pronouns.
For further information, or to leave any feedback, please contact admin@pcwhs.co.uk

5) Everyone is eligible for baseline investigations

- As a general rule, all patients referred to a fertility centre are entitled to NHS funded fertility investigations; restrictions to NHS funding only apply to treatment itself.
- In this situation, patients may still attend their GP to request baseline fertility investigations. These commonly include semen analysis for the man and a pelvic ultrasound and chlamydia swab for the woman, as well as blood tests for the woman (e.g. FSH, LH, oestradiol, prolactin, testosterone, rubella immunity, HIV, hepatitis B and C). To avoid duplication, refer to the guidance on baseline tests from your local fertility department.
- More specialised tests are done once patients have been seen by a specialist. For example, anti-Müllerian hormone (AMH) is not usually available in primary care but can be requested by fertility specialists.
- If you know that a couple are likely to be entitled to investigations but not fertility treatment, it can be useful to mention this at an early stage, so that their expectations of what they will receive in secondary care are realistic.

6) Those with risk factors for infertility should be referred early.

- NICE recommends referral to a fertility clinic when a couple has failed to conceive after one year[4], but an earlier referral should also be considered in certain situations. For women, these include age ≥36, ovulatory disorders, peritoneal disorders (e.g. endometriosis and fibroids[8]) and previous abdominal or pelvic surgery[4].
- For men, conditions such as previous genital pathology, urogenital surgery, previous varicocele and abnormal semen analysis should prompt an early referral[9].

7) Access to fertility treatment varies by area.

- NICE recommend that women under 40 who have not conceived after two years of regular unprotected intercourse should be offered three full cycles of NHS funded IVF[4], but many areas limit this to one or two funded cycles, and in some areas a previous cycle of IVF done privately removes NHS eligibility[10].
- It is important to be aware of the criteria in your area; common restrictions include:
    - An upper and lower BMI limit and an age limit for the woman (usually <43 when the IVF starts).
    - No IVF if either person smokes, has had a previous sterilisation reversed, or has existing children. In some areas the restriction is only for children from the existing partnership.
    - A minimum time of residency in the area where the IVF will be done.

8) Same sex couples are eligible for some NHS funded treatment

- For same sex couples, IUI and IVF can sometimes be done on the NHS. In these circumstances donor sperm is used (via donor insemination). Eligibility for these treatments depends on various factors (such as age, BMI etc) and will vary by area. There may be a requirement for the couple to self-fund a certain number of cycles of IUI before having any on the NHS[11,12].
- Surrogacy is not available on the NHS[12].
- Fertility treatment for single women must also be self-funded.

For more resources, visit www.pcwhs.co.uk. Date of publication: August 2025. Date of next review: August 2028.
The PCWHS aims to educate primary care clinicians about women's health, i.e. the health of those who were registered female at birth. Our resources therefore all use the words woman/women and the pronouns she/her. Where patients have a gender identity which is different from their sex registered at birth, communication should be sensitive and respectful of the patient's pronouns.
For further information, or to leave any feedback, please contact admin@pcwhs.co.uk

9) Patients undergoing private fertility treatment may need to self-fund certain additional tests and medications.

- Patients undergoing private fertility treatments may attend their GP to ask for additional tests or medications (for example an AMH test, or a prescription for pessaries to be given following embryo transfer).
- The BMA advise that NHS and private treatment should be 'kept as clearly separate as possible'[13], however in the real world boundaries can be unclear, particularly where the tests being requested are ones which would probably be offered on demand on the NHS (such as a blood test for HIV or rubella status).
- GPs should use their clinical judgement and remember that they carry full medicolegal responsibility for prescriptions that they write.
- A common pragmatic approach is to offer the couple the same initial investigations as would be done if referring on the NHS, but not subsequent tests needed during fertility treatment. A similar policy would see prescriptions usually available on the NHS in primary care (for example high dose folic acid for those with obesity) offered, whereas those which are done by specialists in the NHS (such as the hormones involved in IVF) must remain private.
- Those accessing fertility treatment abroad who need to access prescriptions which the GP does not feel comfortable to provide should be signposted to a private fertility specialist in the UK.

10) Gamete freezing may be done for social or medical reasons.

- Medical:
  - Fertility preservation is sometimes available on the NHS to patients whose ongoing medical condition or treatment is likely to cause permanent harmful effects on sperm or egg production (e.g. cancer treatment).
  - It may also be offered for individuals with gender dysphoria[9].
  - Eligibility varies by area.
- Social:
  - People may choose to privately freeze their gametes and embryos for social reasons, such as increasing age and not feeling ready to start a family.
  - Following a 2022 law change, patients can now store their eggs, sperm and embryos (for their own treatment) for up to 55 years. As part of this process, patients must reconsent every 10 years.
  - In addition, patients can also choose for their eggs, sperm and embryos to remain in storage for up to 10 years after their death (if they have given specific consent for this). The HFEA website is a good source of information for those who would like to consider this option[13,14,15].

Resources

- NICE guidance on fertility.
- Human fertility and embryology authority.
- Fertility Network.
- NHS patient information on infertility.
- Association of UK dieticians update on diet and fertility.
- Patient information on smoking and fertility.

For more resources, visit www.pcwhs.co.uk. Date of publication: August 2025. Date of next review: August 2028. This guidance was correct at the time of publication. Healthcare professionals are responsible for their own actions and the PCWHS can take no responsibility for decisions made due to the use of this guidance. The PCWHS aims to educate primary care clinicians about women's health, i.e. the health of those who were registered female at birth. Our resources therefore all use the words woman/women and the pronouns she/her. Where patients have a gender identity which is different from their sex registered at birth, communication should be sensitive and respectful of the patient's pronouns.
For further information, or to leave any feedback, please contact admin@pcwhs.co.uk

References

1) Balen AH, Anderson RA; Policy & Practice Committee of the BFS. Impact of obesity on female reproductive health: British Fertility Society, Policy and Practice Guidelines. Hum Fertil (Camb). 2007 Dec;10(4):195-206.
2) Turner F, Powell SG, Al-Lamee H et al. Impact of BMI on fertility in an otherwise healthy population: a systematic review and meta-analysis. BMJ Open. 2024 Nov 1;14(10):e082123.
3) British Fertility Society. At what age does fertility begin to decrease?
4) NICE. CG156. Fertility problems: assessment and treatment. Sept 2017.
5) Montjean D, Godin Pagé MH, Bélanger MC et al. An Overview of E-Cigarette Impact on Reproductive Health. Life (Basel). 2023 Mar 18;13(3):827.
6) Holmboe SA, Priskorn L, Jensen TK et al. Use of e-cigarettes associated with lower sperm counts in a cross-sectional study of young men from the general population. Hum Reprod. 2020 Jul 1;35(7):1693-1701.
7) Filip L, Duică F, Prădatu A et al. Endometriosis Associated Infertility: A Critical Review and Analysis on Etiopathogenesis and Therapeutic Approaches. Medicina (Kaunas). 2020 Sep 9;56(9):460
8) American Society for Reproductive Medicine. Fibroids and fertility. 2023.
9) Farber NJ, Madhusoodanan VK, Gerkowicz SA et al. Reasons that should prompt a referral to a reproductive urologist: guidelines for the gynecologist and reproductive endocrinologist. Gynecol Pelvic Med. 2019 Oct;2:20.
10) East and North Hertfordshire NHS Trust. Patient Information – IVF eligibility criteria for NHS funded IVF treatment for Hertfordshire and West Essex. June 2022.
11) North West London ICS. IVF treatment policy update statement. May 2024.
12) NHS. Ways to become a parent if you're LGBT+. June 2023.
13) BMA. General practice responsibility in responding to private healthcare. August 2023.
14) HFEA. Egg freezing.
15) HFEA. Sperm freezing.
16) HFEA. Embry freezing.

For more resources, visit www.pcwhs.co.uk. Date of publication: August 2025. Date of next review: August 2028.
The PCWHS aims to educate primary care clinicians about women's health, i.e. the health of those who were registered female at birth. Our resources therefore all use the words woman/women and the pronouns she/her. Where patients have a gender identity which is different from their sex registered at birth, communication should be sensitive and respectful of the patient's pronouns.
For further information, or to leave any feedback, please contact admin@pcwhs.co.uk