KEMENTERIAN PEMBANGUNAN WANITA, KELUARGA DAN MASYARAKAT

LPPKN
LEMBAGA PENDUDUK DAN PEMBANGUNAN KELUARGA NEGARA

Infertility Counselling Module for Primary Care



INFERTILITY COUNSELLING MODULE

for Primary Care

INFERTILITY COUNSELLING MODULE FOR PRIMARY CARE

Published by
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Contact Information:
National Population and Family Development Board (LPPKN)
No. 12B, Bangunan LPPKN, Jalan Raja Laut
50350 Kuala Lumpur,Malaysia
Tel: +603-2613 7555
Email: penduduk@lppkn.gov.my
Website: www.lppkn.gov.my

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Foreword

Minister of Women, Family and Community Development

Infertility is a growing concern affecting many individuals and couples in Malaysia. While often discussed in clinical terms, infertility is also a deeply personal journey that can bring emotional, social, and psychological challenges to couples and families. In a nation that values strong family institutions as the foundation of societal well-being, it is essential that individuals facing fertility difficulties receive compassionate support, reliable information, and accessible healthcare services.

Primary care providers play a crucial role as the first point of contact for individuals seeking advice on fertility and reproductive health concerns. Their ability to provide early guidance, empathetic counselling, and timely referrals to specialised services can make a meaningful difference in helping couples navigate their fertility journey. Integrating patient-centred counselling within primary healthcare strengthens not only clinical outcomes but also the emotional resilience and confidence of patients.

This module is aligned with Malaysia's ongoing commitment to strengthening family well-being and reproductive health through national policies and strategic initiatives. Guided by the National KASIH Family Policy, the Government continues to prioritise programmes that support reproductive health, responsible parenthood and family stability. The Ministry of Women, Family and Community Development (KPWKM) through the National Population and Family Development Board (LPPKN) has implemented various initiatives to enhance reproductive health awareness, counselling services and access to fertility-related care. Moving forward, the strategic direction under the 13th Malaysia Plan further underscores the importance of strengthening family institutions, addressing demographic and fertility challenges, and improving access to quality reproductive healthcare services.

It is my sincere hope that this Infertility Counselling Module for Primary Care will serve as a practical and meaningful resource for healthcare professionals. Our goal is to ensure that no couple feels they are navigating the complexities of infertility alone. I wish to congratulate the development team for their dedication to strengthening the fabric of the Malaysian family.



YB Dato' Sri Hajah Nancy Shukri

Minister of Women, Family and Community Development

Foreword

Secretary-General,
Ministry of Women, Family and Community Development

Infertility is often described as a medical condition; however, for many couples it is much more than that. It is an emotional journey that can bring hope and uncertainty, alongside deep disappointment. Globally, infertility affects millions of individuals and families, making it an important public health and social issue. Behind every statistic are couples striving to build a family, frequently while navigating confusion, stigma and profound emotional strain.

In many communities, infertility has long been misunderstood and frequently associated only with women. Nevertheless, medical evidence unequivocally demonstrates that infertility affects both men and women, and that successful management requires the participation of both partners. Recognising infertility as a shared health concern helps to reduce stigma and encourages couples to seek help earlier, whilst ensuring that men are equally involved in assessment, counselling and treatment processes.

At the community level, healthcare professionals are often the first trusted source of information for couples who begin to experience concern regarding their fertility. Clear explanations, early guidance and supportive conversations can make a meaningful difference during this period of uncertainty. We are actively optimising our national resources to ensure a seamless transition of care from primary to tertiary care. This milestone stands as a testament to the collaborative spirit of our healthcare professionals.

Infertility is a significant global public health challenge. The World Health Organization (WHO) estimates that in 2025 approximately one in six people of reproductive age will experience infertility during their lifetime, representing a lifetime prevalence of 17.5%. Concurrently, National Subfertility Data 2023-2024 indicates that men and women experiencing infertility issues were mostly within the 30-39 years age group. Furthermore, many couples delay seeking treatment, often waiting two to five years or longer before consulting healthcare providers. Such delays can reduce the likelihood of successful outcomes and increase the emotional and financial burden on affected couples. These findings heavily underscore the importance of strengthening early awareness, providing timely counselling and ensuring accessible primary care support.

This Infertility Counselling Module for Primary Care represents a pivotal step towards elevating the quality of care for couples experiencing infertility. It is my earnest hope that this resource will fortify our collective efforts to support Malaysian families and ensure that those facing infertility receive the empathy, understanding and assistance they truly deserve.



YBhg. Datuk Dr. Maziah binti Che Yusoff
Secretary-General, Ministry of Women, Family and Community Development

Foreword

Director General
National Population and Family Development Board



For many individuals and couples, the journey towards parenthood is filled with hope. However, when pregnancy does not occur as expected, the experience can bring uncertainty, stress and many unanswered questions. Infertility is not only a medical issue; it is also an emotional and social experience that requires understanding, accurate information and compassionate support.

In many cases, the first place couples turn to for guidance is the primary care setting. Healthcare providers in primary care therefore play an important role in helping patients understand their fertility concerns, explore possible options and make informed decisions about their reproductive health. Effective counselling—delivered with empathy, clarity and respect—can make a meaningful difference in how patients navigate this journey.

Addressing the declining Total Fertility Rate (TFR) requires a multifaceted approach, where clinical excellence meets community accessibility. This module was developed to provide practical guidance for healthcare providers to strengthen patient communication and counselling in everyday clinical practice. This module aims to ensure that individuals and couples feel supported from the very first interaction with the healthcare system.

The development of this module also reflects the value of collaboration in advancing reproductive health. Through a strategic public–private partnership aligned with the Sustainable Development Goals (SDGs), LPPKN is pleased to collaborate with Merck and The Malaysian Society of Assisted Reproduction Technology (MSART) in strengthening awareness, knowledge and capacity building in fertility care. Such partnerships enable the sharing of clinical expertise and global experience, while supporting national efforts to improve access to fertility information. This is a landmark achievement for LPPKN and our partners, ensuring that every couple trying to conceive has the best possible start on their journey to parenthood.

Most importantly, this initiative reflects the guiding values of KASIH upheld by LPPKN: Kasih Sayang, Akhlak, Sihat dan Selamat, Ilmu, and Harmoni. These values remind us that healthcare is not only about treatment, but also about caring for people with empathy, respect and professionalism.

It is my hope that this Infertility Counselling Module for Primary Care will serve as a practical reference for healthcare providers across primary care settings, helping them provide supportive counselling and meaningful guidance to individuals and couples seeking help for fertility concerns.

Dato' Abdul Shukur Abdullah
Director General, National Population and Family Development Board

Members of the Expert Panel

Chairperson	
Dr. Wan Hilya Munira Mustapha	Head of the Subfertility Specialist Centre, National Population and Family Development Board (LPPKN)
Co-chairs	
Dr. Eratha Krishnan Gobinadan	Chairman, Private Practitioners Section (PPS), Malaysian Medical Association (MMA)
Dr. Gokilavani Sekar Chandran	Honorary Treasurer, Private Practitioners Section (PPS), Malaysian Medical Association (MMA)
Panellists	
Dato' Dr. Norsiah binti Ali	Director, Family Health Development Division, Ministry of Health Malaysia (MOH)
Dr. Federa Aini binti Hj. Bibit	Deputy Director, Medical Practice Division, Ministry of Health Malaysia (MOH)
Prof. Dr. Abdul Kadir bin Abdul Karim	Head of the Advanced Reproductive Centre, Hospital Canselor Tuanku Muhriz (HCTM), Universiti Kebangsaan Malaysia (UKM)
Dr. Pravin Peraba	President, Malaysian Society for Assisted Reproductive Technology (MSART)
Prof. Dr. Mohd. Faizal bin Ahmad	Chair of the Reproductive Medicine Subcommittee, Obstetrical and Gynaecological Society of Malaysia (OGSM)
Prof. Dr. Kwa Siew Kim	Council Member, Academy of Family Physicians of Malaysia (AFPM)
Dr. Naemah binti Sharifuddin	Representative of the Malaysian Family Medicine Specialists' Association (FMSA), Consultant Family Medicine, Klinik Kesihatan Bandar Seri Putra
Dr. Mohamad Afiq Farhan bin Ahmad Safian	Senior Principal Assistant Director, Medical Development Division, Ministry of Health Malaysia (MOH)
Dr. Tham Seong Wai	Head of Subspecialty Reproductive Medicine, Ministry of Health Malaysia (MOH) and Consultant O&G (Reproductive Medicine), Hospital Raja Permaisuri Bainun

Members of the Expert Panel

Secretarial Affairs	
Dr. Alia binti Zulkifli	Head of the Subfertility Unit, National Population and Family Development Board (LPPKN)
Dr. Nur 'Arifah Mohd Said	Chief Assistant Director, Subfertility Unit, National Population and Family Development Board (LPPKN)
Dr. Ahmad Zaki bin Asraf	Chief Assistant Director, Subfertility Unit, National Population and Family Development Board (LPPKN)
Dr. Ivan Lee Yeh Han	Chief Assistant Director, Subfertility Unit, National Population and Family Development Board (LPPKN)

Objectives of this booklet

1. To raise awareness among primary care doctors of the importance of early and appropriate referral for infertility management.
2. To provide primary care doctors with essential counselling guidance to better support patients and optimise the referral journey.
3. To function as a practical counselling tool for primary care doctors when discussing infertility care with patients.

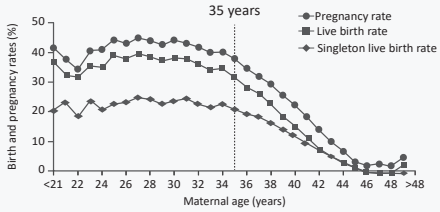
A couple who **has no living child** presents to you. How can you counsel them?

Initial consultation points

Definition of infertility[1]

Wife age <35 years	**Unable to conceive after 12 months of unprotected sex**
Wife age ≥35 years	**Unable to conceive after 6 months of unprotected sex**

Pregnancy and live birth rates following ART



Why was 35 years determined as the cut-off point?

The likelihood of a successful pregnancy following assisted reproductive technology (ART) decreases as a woman's age increases, due to a reduced ovarian response to stimulation and a gradual decline in the chances of embryo implantation and achieving a live birth through *in vitro* fertilisation (IVF), especially in women ≥35 years old.[2]

Primary vs secondary infertility[3]

Primary infertility:
Having never achieved a pregnancy[3]

Secondary infertility:
Inability to achieve a pregnancy despite having a previous pregnancy*[3]

*If couples do not have any living children despite having a previous pregnancy, urgent referrals for infertility management is required.

Evaluating the aetiology of infertility[3]

18.7%	30.6%	26.3%	10.8%
Male factors alone	Female factors alone	Combined factors	Unexplained infertility

Taking a thorough history of the couple[3]

Components of female medical history

- Obstetric history*
- Menstrual history
- Past medical and surgical history
- Gynaecological history
- History of sexually transmitted infections (STIs)
- Sexual history‡
- Childhood and developmental history
- Family history
- Occupational history†
- Lifestyle (including smoking, alcohol and substance use)
- Medication history

*Obstetric history includes pregnancy history and duration of attempting to get pregnant.
‡Sexual history includes sexual dysfunction.
†Occupational history includes history of potential gonadotoxic exposure such as metals, solvents, plasticisers, pesticides, and ionising radiation.

Components of male medical history

- Reproductive history
- Sexual history*
- History of STIs
- Past medical and surgical history†
- Childhood and developmental history
- Family history
- Occupational history‡
- Lifestyle (including smoking, alcohol and substance use)
- Medication history
- Duration of attempting to achieve pregnancy

*Sexual history includes erectile dysfunction, ejaculatory dysfunction and injuries to reproductive organs.
†Past medical and surgical history includes previous investigations or treatment for infertility.
‡Occupational history includes history of potential gonadotoxic exposure such as metals, solvents, plasticisers, pesticides, and ionising radiation.

Initial evaluation for infertility

Infertility investigations for women[3–5]

Physical examination by assessing vital signs and BMI, breast and thyroid examinations and examination of the genital area*

Imaging tests on the uterus and fallopian tubes
Example: Transvaginal ultrasound and tubal patency tests

Lab tests:

- Mid-luteal serum progesterone (approximately 7 days before the expected onset of the next menses)
- Anti-Müllerian Hormone (AMH), thyroid profile and prolactin

Follicle-stimulating hormone (FSH), luteinizing hormone (LH) and oestradiol levels during Days 2 to 4 of the menstrual cycle

STI screening: Serology for hepatitis B, hepatitis C, human immunodeficiency virus (HIV) and syphilis; rubella and varicella titres; and urine or cervical swab for chlamydia and gonorrhoea

*Physical examination for females includes vital signs, body mass index (BMI), breast examination, thyroid examination, examination of the external genitalia, speculum/vaginal examination and a bimanual pelvic examination, which includes an examination of the vaginal, cervical, uterine and pelvic anatomy.

Infertility investigations for men[3–7]

Physical examination by assessing vital signs and BMI, as well as examining the body characteristics and genital areas*

Semen analysis should be obtained after 2–5 days of abstinence.

STI screening: Serology of hepatitis B, hepatitis C, HIV and syphilis

If semen analysis is found to be abnormal, additional investigations may be required:

Penile and testicular assessment

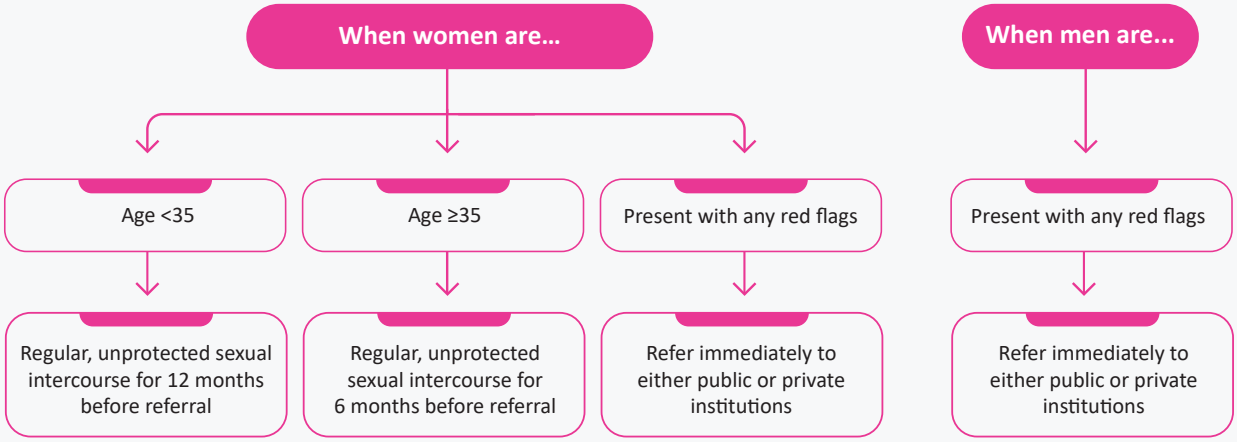
Scrotal ultrasound

Lab tests: FSH, LH, testosterone and prolactin

Genetic testing for karyotyping and/or Y chromosome microdeletion

*Physical examination for males includes assessment of vital signs and BMI, examination of the body characteristics (such as poor virilization, gynaecomastia or obesity), inguinal and genital areas (for scars), external genitalia including the penis (for hypospadias, epispadias, phimosis or curvature), testes (for location, size, texture, consistency, pain, nodules or tenderness), vas deferens and epididymis (if present, absent, inflamed or obstructed), and the spermatic cord and scrotum (for varicocele, hydrocele or cysts).

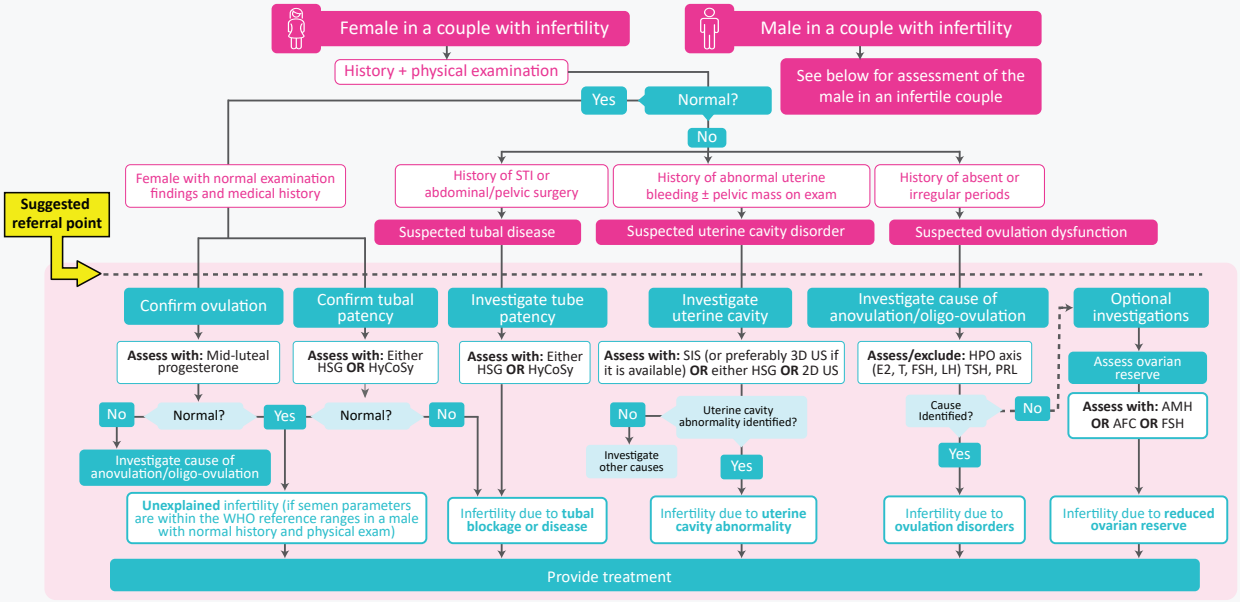
When to refer couples to reproductive specialists?[1,4,5,8]



If patients present with ANY one of the red flags, immediate referral to reproductive specialists in public or private institutions is recommended for further consultation and ART treatments:

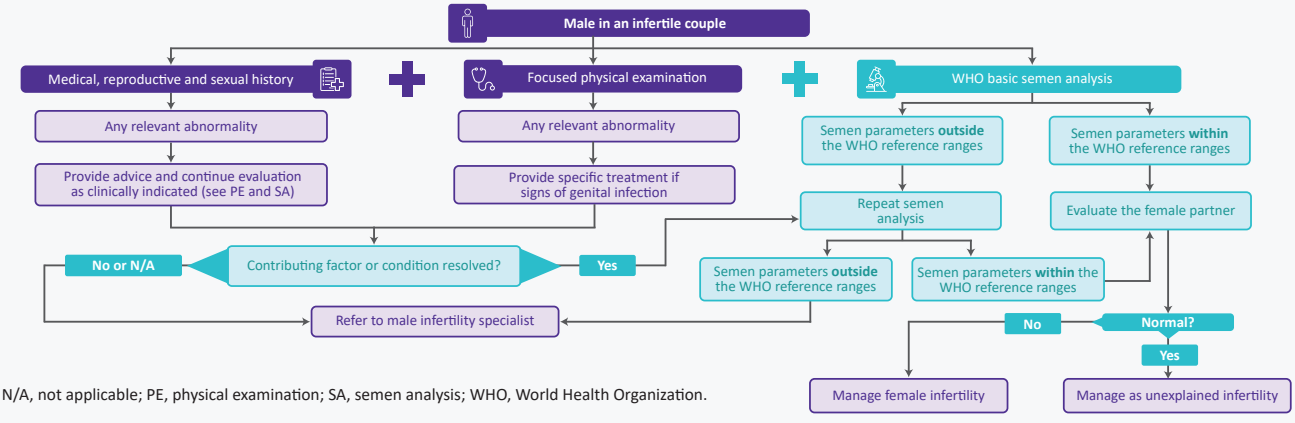
1. Presence of only one ovary
2. Endometriosis (Stage III–IV)
3. Recurrent pregnancy loss (two or more)
4. Known or suspected uterine, tubal or peritoneal disease
5. Pelvic inflammatory disease
6. Previous ectopic pregnancy
7. Premature ovarian insufficiency
8. Repeated abnormal semen analysis, erectile or ejaculatory problems
9. Female older than 40 years old
10. Sexual dysfunction
11. Known or suspected male infertility
12. Irregular menses (intermenstrual bleeding, oligomenorrhoea or amenorrhoea)

Diagnostic algorithm for female factor and unexplained factor infertility, based on the 2025 World Health Organization (WHO) Guidelines[3]



2D US, two-dimensional ultrasound; 3D US, three-dimensional ultrasound; AFC, antral follicle count; AMH, anti-Müllerian hormone; E2, estradiol; FSH, follicle-stimulating hormone; HPO, hypothalamic–pituitary–ovarian; HSG, hysterosalpingogram; HyCoSy, hysterosalpingo contrast sonography; LH, luteinising hormone; PRL, prolactin; SIS, saline infusion sonohysterography; STI, sexually transmitted infection; T, testosterone; TSH, thyroid-stimulating hormone.

Diagnostic algorithm for male factor infertility, based on the 2025 WHO Guidelines[3]



N/A, not applicable; PE, physical examination; SA, semen analysis; WHO, World Health Organization.

Approach to counselling in primary care



Help relieve patients' stress from failed attempts to conceive[9]

Suggest coping strategies:

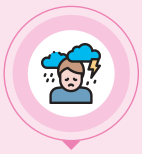
- Meaning-based coping: Thinking about the fertility problem in a positive light, to focus on the end goal without blame.
- Active coping: Goal-oriented problem-solving, thinking rationally about the problem.



Resolve conflict and disagreement between couples and prevent relationship strain[3,9]

Listen to the areas of disagreement and **conduct separate consultations** if required.

Involve both parties in the consultation process and encourage both parties to be **available and responsive.**



Screen for mental health disorders[4,10]

Screening can be done as per established protocols using screening tools such as Generalised Anxiety Disorder-7 (GAD-7) and Patient Health Questionnaire-9 (PHQ-9).

Refer to psychological support (such as counsellors, psychologists and psychiatrists) if patients experience depressive symptoms, severe marital or sexual problems, and/or psychological distress that may directly impact infertility.



Advise and refer patients to a fertility specialist for ART*[11]

Advise patients to consider fertility treatments and refer them to a reproductive medicine specialist.

What you can do:

- Understand why couples hesitate.
- Prepare couples for decision-making by discussing financial, cultural and ethical considerations.

*Assisted Reproductive Technology (ART) includes IVF and intracytoplasmic sperm injection (ICSI).



Address financial considerations

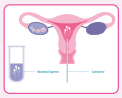
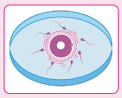
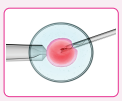
Discuss the different financial initiatives for ART in Malaysia

Financial initiatives

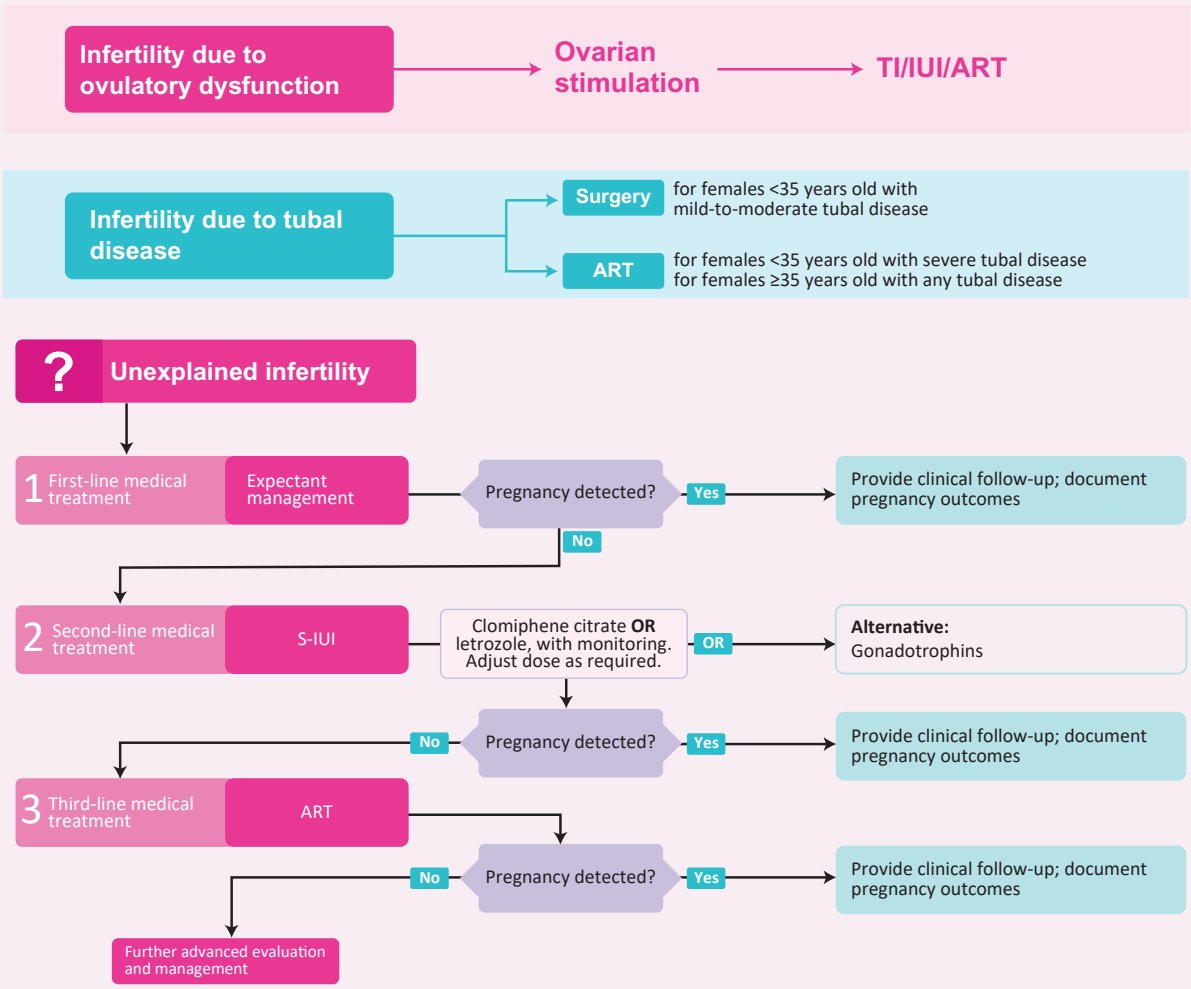
Financial initiative options	Eligibility	Amount	Fertility treatments covered
Employees Provident Fund (EPF)[12]	Malaysian citizens or non-Malaysians who are below 55 years old and have savings in Account 2	Allowed to make withdrawals from their Account 2	Intrauterine insemination (IUI), IVF, ICSI
Tunku Azizah Fertility Foundation (TAFF)[13]	• Registered as a married couple • Both husband and wife are Malaysians • Wife is not more than 43 years old • Not a sperm/ovum donor • Maximum monthly joint income of not more than RM5000.00 • More than 5 years of marriage	*Not specified*	IVF and ICSI in approved centres
Program Bantuan Rawatan Kesuburan dan Advokasi Infertiliti (BuAI) LPPKN[14]	• Household income of less than RM10,000 per month • Legally married couples • Both husband and wife are Malaysians • Primary or secondary infertility • Wife is below 37 years of age • Not received any financial assistance for infertility treatment from any other agency while undergoing this programme • At least one patent fallopian tube • Normal semen analysis parameters (sperm count and motility) • Passed clinical assessment by the treating physician	Maximum RM2,000	IUI in approved centres
Insurance coverage[15]	Covers infertility treatments and all significant congenital defects	*Not specified, based on individual providers*	IUI, IVF, ICSI
Tax relief for individual income tax*[16]	Couples undergoing fertility treatments	Claimable amount is RM10,000 *Based on the year of assessment of 2025	Fertility treatment for self or spouse

The cost of ART treatments varies between public and private healthcare settings, as well as among individual private centres. In addition, treatment plans and associated costs may differ depending on each individual's clinical assessment and needs.

The patient journey in overcoming infertility: Available options

Treatment options	Indications	Process	Clinical pregnancy rates	Risks and limitations
Ovulation induction (OI) with timed intercourse (TI) 	Patients with anovulation[3]	Ovarian stimulation followed by follicular/ovulation tracking and advice on optimal days for intercourse[3]	Around 10%[17]	Multiple pregnancies[3] Ovarian hyperstimulation syndrome (OHSS)[3]
OI with IUI 	• Patients with unexplained infertility[3] • Patients who failed OI with timed intercourse for 2–3 times	Ovarian stimulation followed by a procedure where sperm are placed directly inside the woman's uterus[19]	15%–20%[20,21]	Multiple pregnancies[3] Infection[22] OHSS[3]
Conventional IVF 	• Patients with unexplained infertility[3] • Patients with anovulatory conditions after failure with OI[3] • Patients who failed OI with IUI for 3– 4 times	Involves an egg that is fertilised outside the body in a lab[3]	30%–40%[23,24]	High costs[3] OHSS[3] Multiple pregnancies[3]
ICSI 	• Patients with male factor infertility as an additional procedure to conventional IVF[3]	A single sperm is directly injected into an egg to fertilise it[3]	Not significantly different from IVF[3]	High costs[3] OHSS[3] Multiple pregnancies[3]

The patient journey in overcoming infertility: Treatment algorithm[3]



ART, assisted reproductive technology; ICSI, intracytoplasmic sperm injection; S-IUI, stimulated intrauterine insemination; TI, timed intercourse.

The patient journey in overcoming infertility: The OI/IUI pathway[3]

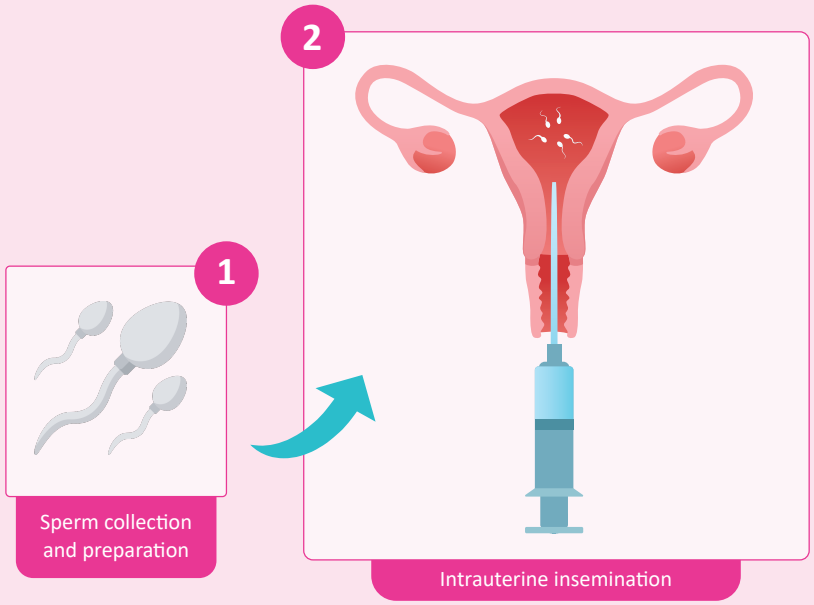


Ovarian stimulation

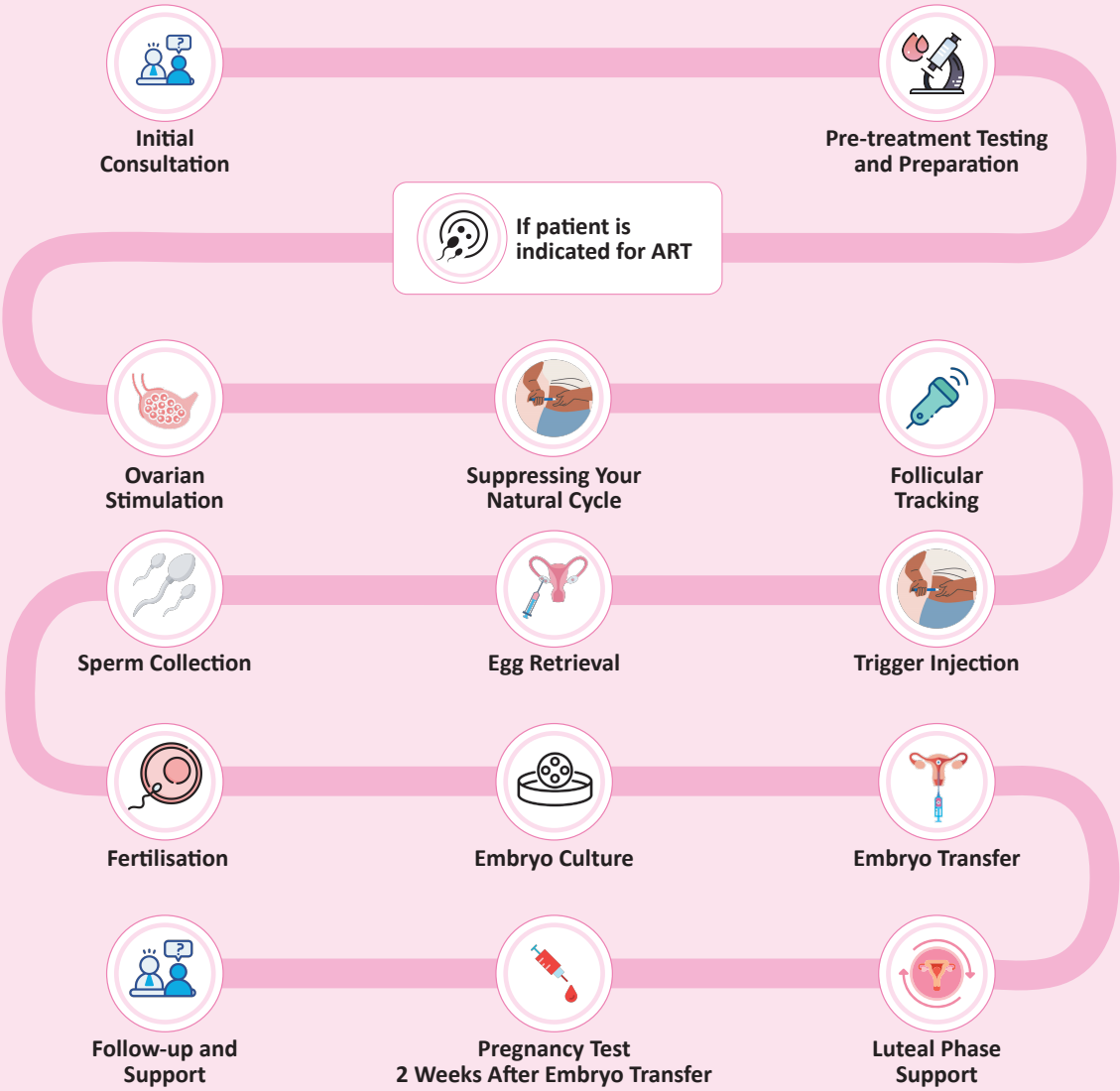
Follicular tracking

Close monitoring is required between cycles with OI agents to watch out for OHSS and ovarian cyst retention.

The IUI procedure is mostly done a day or two after the trigger injection or after tests show signs of imminent ovulation[22]



The patient journey in overcoming infertility: The ART pathway[3,25,26]



The IVF process explained[5]



Ovarian Stimulation
Take hormonal medications to stimulate the ovaries to produce multiple eggs, and regular monitoring to track egg development.



Suppressing the Natural Ovulation Cycle
Take injections to suppress ovulation depending on the type of protocol use.



Follicular Tracking
Regular ultrasounds are performed to monitor the growing eggs and adjust medication if necessary.



Trigger Injection
Trigger shot is administered to complete maturation and prepare eggs for retrieval.



Egg Retrieval
Eggs are collected from the ovaries using a fine needle, under sedation, once the eggs are matured.



Sperm Collection
On the day of egg retrieval, a sperm sample is collected from the male partner to be processed and prepared for fertilisation.



Fertilisation
The collected eggs and sperm are combined in a laboratory by IVF or ICSI for fertilisation.



Embryo Culture
Embryos are cultured in a controlled environment for several days. Their development are monitored and the healthiest embryos are selected for transfer.



Embryo Transfer
One or more healthy embryos are transferred into the patient's uterus through a thin catheter. It is usually painless and does not require anaesthesia.



Luteal Phase Support
After the embryo transfer, the patient takes hormonal medications to support the uterine lining and enhance the chances of implantation.

A couple who is indicated for ART decides to go through the process. How can you help set their expectations?

Setting expectations for ART in the initial consultation

Explain that the success rate of ART is not 100%, which may be contributed to by these factors:[26,27]

- Patient age
- Unsuccessful fertilisation
- Poor embryo, egg or sperm quality
- Too few eggs
- Implantation failure
- Chromosomal abnormalities
- Miscarriage
- Lifestyle factors

Explain the possible physical and mental changes during ART:[26,28]

- Physical changes
- Emotional changes
- Changes in appetite
- Fatigue
- Increased sick leave/ long medical certificates

Explain the injections required for women during the ART process[26,29]

The patient will have to self-administer hormone injections at home if she is undergoing ovulation stimulation.



Assure patients that although injections can feel intimidating at first, most patients adapt quickly with practice.



Inform patients that injections need to be administered around the same time each day.



Advise patients that they can opt to perform injections independently for scheduling flexibility, or ask a partner, friend, or family member for help.

Explain the possible adjuncts for ART



Preimplantation genetic testing[30]

- To exclude embryos that are affected with genetic anomalies to improve clinical outcomes.

Indications include:

- Single gene disorders
- Chromosomal abnormalities
- Gender selection in non-Mendelian disorders with unequal gender distribution
- Aneuploidy screening
- Preconceptually identified genetic abnormalities in prospective parents



Freezing of embryos, sperm and oocytes[31,32]

- Embryo freezing can maximise the effectiveness of the ART cycle.
- It plays an important role when embryo transfer is cancelled due to unforeseen circumstances.
- Freezing of oocytes and sperm can preserve the fertility of the couple.

Advice on preparation before ART for couples

Encourage a balanced diet[33]

Advise patients to consume foods low in saturated fat and red meat, and high in vegetables, legumes, and antioxidants.

Encourage intake of prenatal supplements[4]

Encourage female patients to take prenatal vitamins with folic acid (400 to 800 mcg daily) to limit the risk of neural tube defects.

Encourage weight loss in obese patients[5]

A weight loss (5%–10%) has been shown to improve the rate of spontaneous ovulation and the response to ovulation induction.

Advise to quit smoking and avoid passive smoking[3,34]

There is a significant impact of smoking on reproductive outcomes.

Advise to abstain from alcohol consumption[3,5,34]

A high alcohol intake can adversely affect fertility.

Advise to avoid anxiety and emotional stress[33]

Encourage patients to undergo relaxation programmes to reduce other sources of stress and improve fertility.

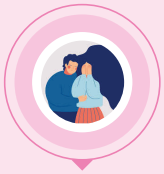
Educate to avoid occupational exposure[34]

Reproductive risk factors include metals, solvents, plasticisers, pesticides, and ionising radiation.

A couple who **experienced repeated failure with ART** presents to you. How can you counsel them?



Counselling patients with repeated failures: What to advise patients who experienced repeated failures of ART?[26]



Dealing with grief

- Encourage patients to take time to grieve and process their loss.
- Acknowledge that partners may grieve differently, and both ways are valid.
- Suggest healthy coping strategies:
  - Talking or sharing feelings
  - Expressing through art, music, or journalling
  - Spending time in nature
  - Physical activity
  - Allowing themselves to express their emotions



Alternative options

- Acknowledge patients' hesitancy about trying again.
- Highlight that alternative fertility treatments may also be considered.
- Recommend referral to a reproductive medicine specialist to discuss the next best step.
- Highlight that there are alternative pathways depending on cultural and religious beliefs, such as adoption.



Treatment break

- Encourage patients to consider taking a short break from fertility treatment.
- Emphasise that time off can help them:
  - Reflect on next steps, and/or
  - Rest from the physical and emotional toll of treatment.

When counselling a couple with infertility issues, you should emphasize:



Empathy and validation

Initiating the conversation by understanding their worries and dilemma, while covering talking points tailored to the problems faced by them.



Shared decision-making

Encourage the active involvement of both partners in the decision-making process.



Setting realistic expectations

Setting expectations for the couple who would like to undergo ART by covering points about the side effects, success rates, treatment risks, and the costs involved.

Scan here to find out which centres provide infertility management services in Malaysia.

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