Indian Fertility Society

Synapse

4th Edition

Recurrent Implantation Failure (RIF)

Dr Prof (Col) Pankaj Talwar
VSM, MD, PhD.
President

Dr (Prof) Shweta Mittal Gupta
MD, DNB, FNB, MNAMS
Secretary General

Dr Rupali Bassi Goyal
Editor

Dr Nymphaea Walecha
Joint Editor

Dr Garima Kapur
Editorial Board

Dr Niti Vijay
Editorial Board

Dr Shalini Chawla Khanna
Associate Director,
Dept. Of IVF, Laparoscopy &
Reproductive Medicine
Max Hospitals, Delhi & NCR

Dr Akanksha Sharma
Clinical Fellow
Dept. of IVF, laparoscopy &
Reproductive Medicine,
Max Multi-Specialty Centre, New Delhi

Dr Raju Rajasekharan Nair
Consultant,
Reproductive Medicine,
Mitera Hospital,
Kottayam, Kerala

Recurrent implantation failure (RIF) is a clinical concern primarily associated with patients undergoing assisted reproductive technologies (ART). True RIF is relatively uncommon, occurring in less than 5% of couples experiencing infertility. RIF is largely over diagnosed and overtreated, often without sufficient critical evaluation of its underlying etiology.

At present, there is no universally accepted definition of RIF. However, the most widely endorsed criteria stem from the 2022 Lugano RIF Workshop (1), which defines RIF as the failure to achieve a clinical pregnancy following the transfer of at least three euploid blastocysts, or an equivalent number of unscreened embryos adjusted for maternal age and corresponding euploidy rates, as detailed in Table 1 of the consensus report.[1]

Estimation model for of the number of unscreened good-quality embryos needed to be equivalent to 3 successive euploid embryo transfers and achieve a 95% chance of sustained implantation on the basis of the observed aneuploidy rate (20)

Age (y)	Observed aneuploidy rate	No. of untested blastocysts to achieve a 95% chance of sustained implantation
<35	20%	4
35–37	30%	5
38–40	50%	7
41–42	70%	13
≥43	85%	27

Recurrent implantation failure. Fertil Steril 2023.

The failure of embryo implantation is multifactorial in nature and may result from embryonic, uterine, paternal, or procedural factors, including the specific in vitro fertilization (IVF) protocol employed. These contributing factors are explored in detail in the following sections.

- Maternal Age - As maternal age increases aneuploidy increases because of increased chromosomal nondisjunction.[2] There is decrease in mitochondrial membrane potential , increase of mitochondrial DNA damage and higher rates of embryo-endometrial asynchrony with increasing maternal age thus leading to decreased implantation rate and live birth rate after 35 years of age.
- BMI -The oocyte quality and follicular development might be affected by obesity . The implantation rate decreases with increasing BMI (>25 kg/m2) .
- Smoking -Cigarette toxins such as carbon monoxide causes depletion of oxygen to the fetus, and nicotine leads to vasoconstriction and decreased nutrients to the fetus ,thus implantation may be impaired .
- Stress -Elevated levels of cortisol, also known as “the stress hormone,” lead to a 2.7 times greater chance (95% CI=1.2–6.2) of miscarriage within the first 3 weeks after conception in comparison with women with low cortisol levels . However this has been refuted by studies that it is IVF failure that may lead to higher rates of both anxiety and depression in the immediate period after a negative IVF outcome.[3]

Pathophysiological mechanisms of Recurrent Implantation Failure

Based on the definition proposed above, RIF is primarily due to uterine factors. However there will inevitably be a proportion of cases due to gamete or embryo factors.

- **Oocyte Factor:** The response to ovarian stimulation might be poor with fewer numbers of oocytes retrieved, a high proportion of immature oocytes, reduced fertilization rate. High FSH and low anti-Mullerian hormone, points to poor oocyte quality . Age related aneuploidy increases as age advances . Aggressive ovarian stimulation protocols may lead to poor-quality oocytes and a higher rate of fertilization failure.[4]
- **Sperm Factor:** Semen analysis doesn’t reflect sperm quality. Sperm DNA damage (caused by cigarette smoking, genital tract infection and previous chemotherapy or radiotherapy) is associated with poor embryo development.[5]
- **Genetics/ Parental chromosomes anomaly:** Chromosomal abnormalities like translocations, mosaicism, inversions, and deletions(translocation being most common) may lead to RIF though the overall prevalence is only about 2%.[6] Parental karyotyping is recommended in cases of women suffering from RIF and in men with severe oligospermia .
- **Thrombophilia:** Whether hypercoagulable state leads to RIF is still debatable however prothrombotic disorders are more prevalent in RIF patients than in controls . While patients with RIF who have prothrombotic disorder might benefit from heparin treatment, for those without this abnormality empiric treatment with heparin is not justifiable.[7] Altogether, it is recommended that patients diagnosed with RIF be investigated for acquired as well as hereditary thrombophilia disorders, and be treated accordingly.

- **Immunological Causes:** Differentiation of endometrial stromal cells(a process called decidualization), is critical for the establishment and maintenance of pregnancy. The decidualized stromal cells acquire the ability to regulate trophoblast invasion and to dampen local maternal immune responses.[8] There is much conflicting evidence in the literature on the role of immunological factors like peripheral and uterine natural killer cells , Th1/Th2 ratio and TNF-α levels in women with RIF . There is no consensus on whether or not immunological investigations are useful and whether immunological treatment is of benefit.
- **Anatomical abnormalities and endometrial thickness:** Uterine pathologies including polyps, myomas, and adhesions can impact implantation rates in patients undergoing IVF. The anomalies can be congenital and acquired.

Congenital Uterine Pathology

- Myomas -can cause distortion of the endometrial cavity
- Septate Uterus – Most common congenital anomaly. The poor outcome is related to the distortion of the uterine cavity and to the inadequate blood supply to the septum
- Bicornuate Uterus – Women with a bicornuate uterus usually have normal implantation, but these patients have a higher risk of mid trimester pregnancy loss . These patients usually don't require surgery
- Hydrosalpinx -The fluid can negatively impact endometrial receptivity, and can also physically flush the embryo out preventing implantation.

Acquired Uterine Pathology

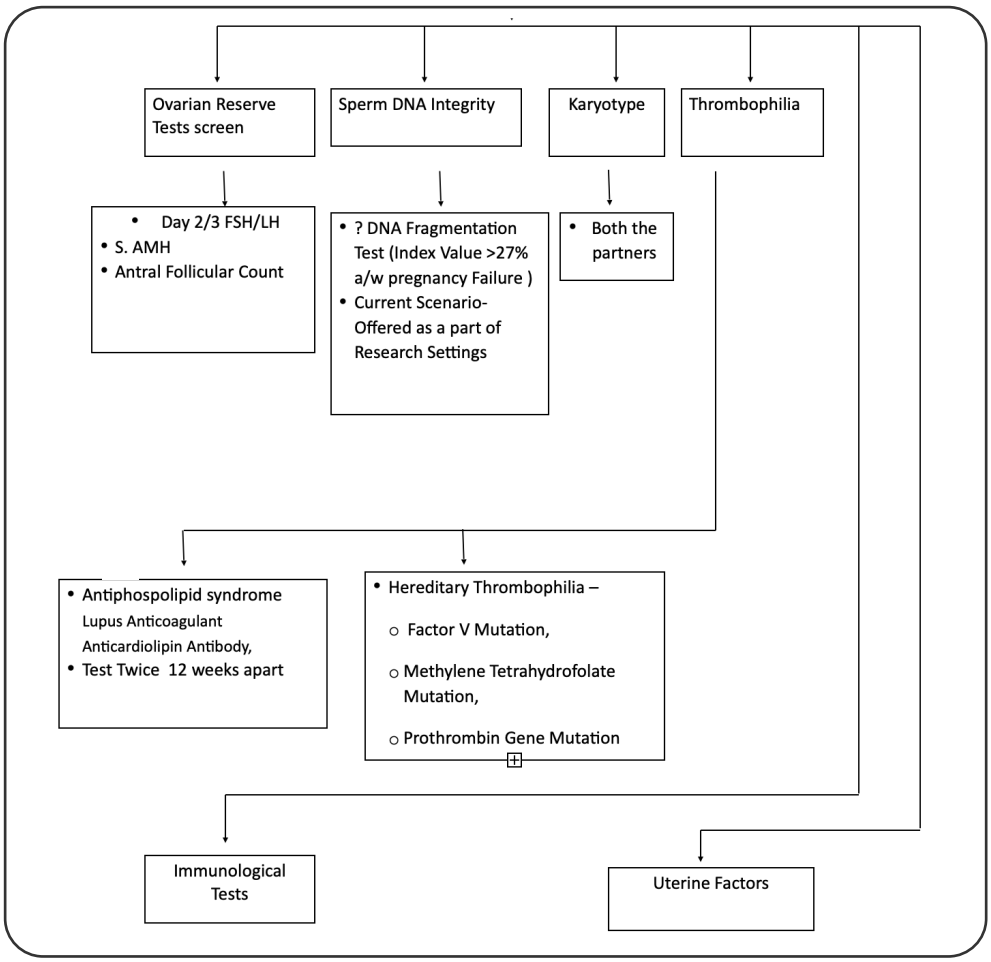
- Frequency of unrecognized intrauterine pathologies in patients with RIF varies between 25% and 50%.9
- Endometrial Polyp : Endometrial polyps may interfere with embryo implantation . The removal of endometrial polyps has been found to result in improved spontaneous pregnancy rates in various studies.
- Intrauterine adhesions. Adhesions within the uterine cavity may prevent the embryos from attaching to the luminal surface of the endometrium. Intrauterine adhesions often occur following curettage of the gravid uterus to terminate an unwanted pregnancy or in cases of retained products of conception after a pregnancy or miscarriage.
- Adenomyosis - Adenomyosis affects the junctional zone of the uterus which is just beneath the endometrium and thus implantation is affected . Unlike intramural fibroids, adenomyosis is not usually amenable to surgical treatment .
- Submucous and Intramural fibroids. The submucous and intramural fibroids of > 4cm may adversely affect implantation by increasing uterine contractility, deranged cytokine profile,abnormal vascularization and chronic endometrial inflammation.

- **Thin endometrium** - Thin endometrium (<7 mm) may occur following damage to the endometrium following intrauterine surgery or infection and may lead to RIF. Hysteroscopy adhesiolysis is recommended by an experienced reproductive surgeon.

Investigations

The investigations for the RIF need to be individualized after taking a detailed history and checking the previous records . Broad Outline of the investigations is mentioned in the table below.

Flow Chart of Investigations



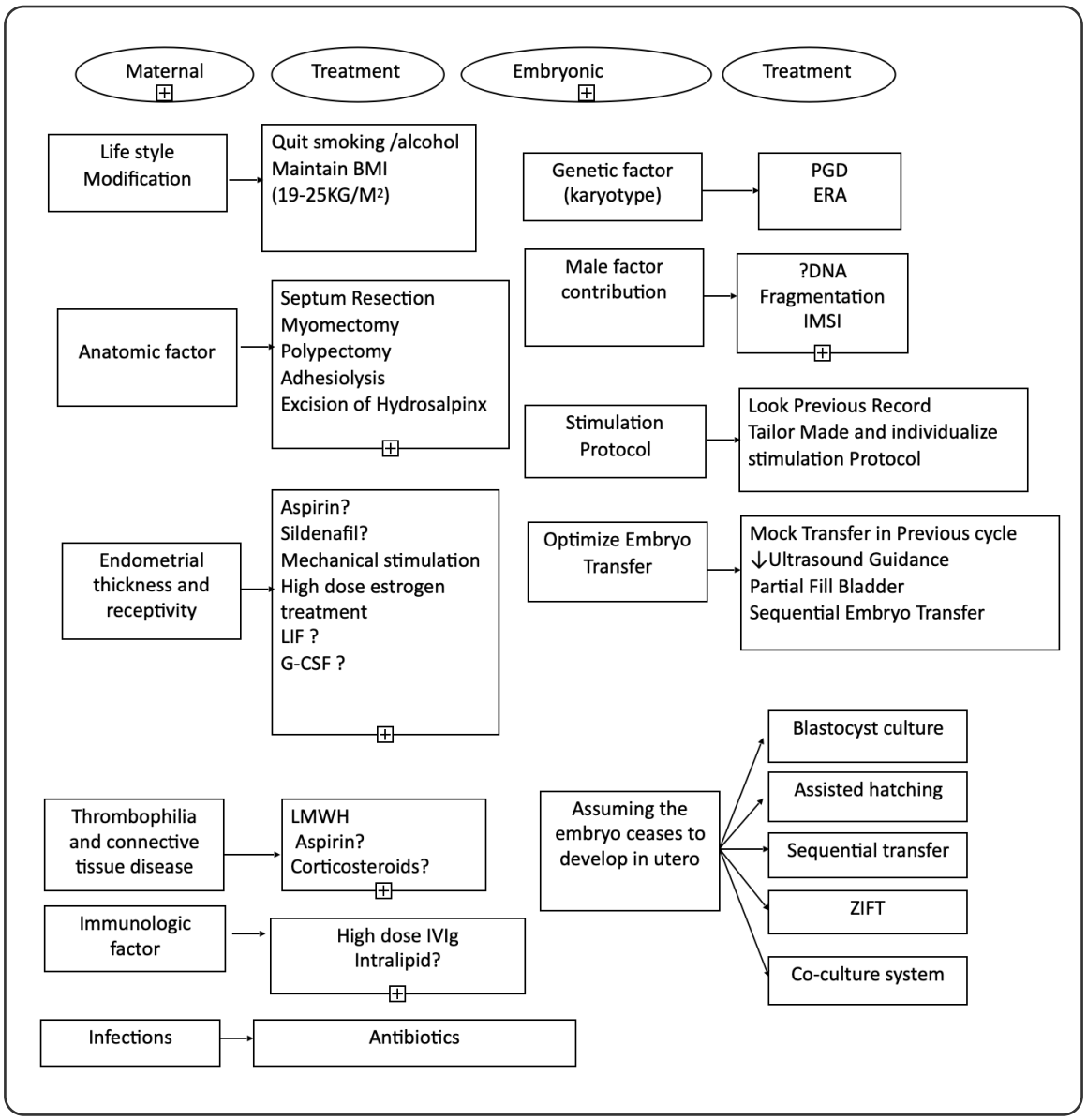
Management

Multidisciplinary approach should be adopted in the management of a couple with RIF.Appropriate counselling and individualized treatment of the couple with RIF is of the utmost importance prior to proceeding with further treatment. A brief overview of current treatment strategies for RIF is outlined below.

1. **Lifestyle modifications:** The European Society of Human Reproduction and Embryology (ESHRE) recommends several lifestyle interventions that may positively influence outcomes in individuals experiencing recurrent implantation failure (RIF). These include smoking cessation support, adoption of a balanced and nutritious diet, engagement in regular physical activity, and prioritization of mental health and psychological well-being. Such modifications, while not specific to RIF, may contribute to improved reproductive outcomes and overall health.
2. **Optimal IVF-ET Protocols:** An appropriate controlled ovarian hyperstimulation (COH) protocol is essential, especially in patients with a history of suboptimal response. It's important to review prior cycle outcomes and adjust the stimulation protocol and gonadotropin dosage accordingly. In a study by Barmat et al[10] no significant difference in implantation rates was observed between the long GnRH agonist and antagonist protocols. However, the antagonist protocol was found to be more convenient for patients, primarily due to the shorter duration of the treatment cycle and timing of oocyte retrieval.
3. **Embryo transfer**
   - A. **Cleavage vs Blastocyst Transfer:** With advances in culture media and lab techniques, blastocyst transfer has become the preferred approach over cleavage-stage transfer, showing higher implantation rates,irrespective of embryo quality. However, this strategy may not benefit all patients equally.Some studies have overgeneralized their findings to broader populations and are not restricted to RIF. Factors such as age, ovarian reserve, lab conditions, and sperm quality should guide the decision. A 2016 Cochrane review[11] found only low- to moderate-quality evidence supporting blastocyst transfer over cleavage-stage transfer for improving live birth and clinical pregnancy rates.
   - B. **Frozen embryo transfer vs Fresh embryo transfer:** While frozen embryo transfer (FET) is gaining popularity—partly due to concerns about the altered hormonal environment and impaired endometrial receptivity in stimulated cycles—it's still a topic of ongoing debate. FET has been linked to lower risks of preterm birth, low birthweight, and OHSS. However, evidence on its superiority remains mixed.A large meta-analysis by Roque et al[12] reported no significant benefit in live birth or cumulative live birth rates among normo-responders. These findings suggest that a "freeze-all" approach may not be appropriate for every IVF patient.
   - C. **Embryo transfer Method:** Ultrasound-guided embryo transfer improves clinical pregnancy and live birth rates. The choice between a soft or rigid catheter often depends on the shape of the cervix. In some cases, gently removing cervical mucus by aspiration can also boost the chances of pregnancy.
4. **Progesterone support:** Progesterone support is important in improving birth rates for patients with repeated implantation failure (RIF). A systematic review by Saccone et al[13] confirmed that progesterone in early pregnancy benefits women with recurrent pregnancy loss. Vaginal, intramuscular, and subcutaneous routes are all effective. Additionally, oral dydrogesterone is found to be as effective as vaginal progesterone for luteal support in IVF patients.
5. **Immunotherapy:** Maternal-fetal immune tolerance is a necessary condition for successful implantation. Several immunological therapies have been explored to increase implantation rates. Endometrial biopsies and peripheral blood sampling for NK cell type and count or Th cell proportion offer a method to assess maternal immune status and a rationale for immune-modulating therapies
   - A. **Glucocorticoids** act as immunomodulators by binding to receptors on uterine natural killer (uNK) cells and reducing their numbers. They may improve implantation rates in patients with elevated peripheral CD69+ NK cells. However, while prednisolone can lower uNK cell levels, it has not shown a clear benefit on pregnancy outcomes. Therefore, glucocorticoids should be used cautiously, tailored to specific cases, as optimal dosage and timing remain uncertain
   - B. **Intravenous immunoglobulin** IVIG therapy is considered for women with repeated implantation failure who show immune imbalances like elevated Th1/Th2 ratio, increased NK cells, abnormal TNF-α/IL-10 ratio, or autoantibodies. It helps normalize the Th1/Th2 balance, increases regulatory T cells , and reduces NK cell numbers and activity.[14] IVIG is typically given at 200–500 mg/kg (usually 400 mg/kg) about 7 days to 24 hours before embryo transfer and continued either until fetal heartbeat is detected or every three weeks during pregnancy.
   - C. **Tacrolimus,** an immunosuppressant approved for transplant rejection, has been explored as a treatment for RIF patients with elevated Th1/Th2 ratios. It works by inhibiting cytotoxic T cell activity, lymphocyte proliferation, and the production of IL-2 and IFN-γ[15] However, more research is needed to confirm its effectiveness and to establish safe dosing for RIF patients.
   - D. **Intralipid Therapy:** Intralipids are fat emulsions that can modulate natural killer (NK) cell activity and reduce inflammation. However, a study using 20% intralipid infusion on embryo transfer day showed no improvement in pregnancy or live birth rates. Coulam[16] suggested intralipids may benefit only RIF patients with specific immune abnormalities, highlighting the need to identify these cases. Overall, evidence is insufficient to recommend routine intralipid use, and no standardized treatment protocol exists.
   - E. **Lymphocyte immunization therapy:** Lymphocyte Immunotherapy (LIT) involves administering partner-derived lymphocytes to modulate the maternal-fetal immune balance. However, the 2017 ESHRE guidelines do not recommend LIT for patients with recurrent pregnancy loss due to limited evidence and potential risks, including infections, autoimmune reactions, and irregular antibody formation.

6. **Anticoagulants:** Aspirin, by inhibiting cyclooxygenase, acts as an antithrombotic and may reduce uterine inflammation and improve blood flow, potentially enhancing endometrial receptivity. However, studies in RIF patients have shown no significant improvement in implantation or pregnancy rates compared to controls.[17]A. LMWH Low molecular weight heparin
   A. (LMWH) has anticoagulant effects that may help prevent placental thrombosis and support endometrial function. In patients with multiple unexplained failed embryo transfers, LMWH (40 mg/day) started after oocyte retrieval showed a trend toward higher live birth rates but no significant difference in implantation or pregnancy outcomes.[18]
7. **Intrauterine infusion**
   A. A.Platelet-rich plasma: Platelet-rich plasma (PRP) is an autologous blood product rich in growth factors that promote angiogenesis, cell growth, and immune modulation. In patients with repeated implantation failure (RIF), PRP has shown promise in improving endometrial thickness and clinical pregnancy rates. However, larger, high-quality studies are needed to confirm its effectiveness and safety.[19]
   B. Granulocyte colony-stimulating factor-Granulocyte-colony stimulating factor (G-CSF) is a cytokine produced by various cells, including endothelial and immune cells. However, randomized controlled trials and meta-analyses have shown that intrauterine G-CSF infusion does not improve implantation or pregnancy rates in patients with repeated implantation failure.[19]
8. **Endometrial scratching:** Endometrial scratching, which intentionally injures the lining to release cytokines like LIF and IL-11 important for implantation, has been proposed as a treatment but currently lacks proven effectiveness.
9. **Endometrial receptivity assay:** The Endometrial Receptivity Assay (ERA) aims to personalize embryo transfer timing in patients with repeated implantation failure (RIF). While some recent studies report improved pregnancy and live birth rates with ERA-guided transfers, evidence remains inconsistent. Multiple randomized trials and meta-analyses show no significant benefit, and current guidelines (e.g., ESHRE)[20] (do not support its routine use. ERA may be considered in selected cases, but broader RIF management should prioritize embryo quality, endometrial optimization, and treatment of underlying pathology. Further research is needed to clarify ERA's clinical value.[21]
10. **Preimplantation Genetic Testing for Aneuploidy (PGT-A):** Preimplantation Genetic Testing for Aneuploidy (PGT-A) is used to identify chromosomally normal (euploid) embryos prior to transfer, with the goal of improving implantation and live birth rates. In patients with repeated implantation failure (RIF), PGT-A may help distinguish between embryonic and endometrial causes of failure.
    Several studies support the use of PGT-A in RIF, especially in women of advanced maternal age or those with multiple failed IVF cycles. A meta-analysis by Chen et al.[22] found that PGT-A significantly increased clinical pregnancy and live birth rates in RIF patients.
    However, some randomized controlled trials (RCTs), including the STAR trial(23) have shown mixed results in the general IVF population, with limited benefit from PGT-A in younger women or those with good prognosis. As such, current guidelines recommend PGT-A selectively for RIF patients, particularly when aneuploidy risk is high
    While PGT-A does not address endometrial or immunological causes of RIF, it is considered a valuable tool for optimizing embryo selection and reducing time to pregnancy in appropriate cases.
11. **Antibiotics:** Studies show that treating chronic endometritis with oral antibiotics significantly improves pregnancy and live birth rates compared to untreated cases. A recent meta-analysis also confirmed higher implantation and clinical pregnancy rates in patients whose infection was cured. However, combining oral antibiotics with intrauterine infusion of antibiotics did not improve outcomes and may disrupt the intrauterine environment.[24]
12. **Hysteroscopy:** Polyps, myomas, adhesions, and septa can all affect implantation, and the gold standard for evaluation is hysteroscopy. The previously reported prevalence of undetected anomalies was between 20 and 45%, however, Fatemi et al. found the prevalence in their study population to be only 11%, identifying polyps as the most common pathology (41%).[25] Hysteroscopy might serve as a useful diagnostic tool in many RIF patients, as some literature suggests that with this. intervention there can be major changes in pregnancy outcome.
13. **Male factor:** Sperm morphology may influence repeated implantation failure (RIF). Intracytoplasmic morphologically selected sperm injection (IMSI), which uses high magnification to select sperm before injection, showed higher implantation 19.2% vs. 7.8%, P = 0.042, pregnancy 43.1% vs. 10.5%, P = 0.02, and live birth rates 43.1% vs. 10.5%, P = 0.02 in one retrospective study by Shalom-Paz et al.[26] However, other studies have not confirmed these benefits. More research is needed before IMSI can be recommended as a standard procedure.

Table 2: A summary of the management is highlighted



Summary

Recurrent Implantation Failure (RIF) is a multifactorial condition with diverse etiologies and treatment options. The most effective approach appears to be personalized medicine, tailored to each patient's unique profile. While no single treatment fits all, standardized preliminary testing could guide individualized management. Future well-designed studies are essential to develop evidence-based protocols and improve outcomes.

References:

1. (The writing group) for the participants to the 2022 Lugano RIF Workshop; Pirtea P, Cedars MI, Devine K, Ata B, Franasiak J, Racowsky C, Toner J, Scott RT, de Ziegler D, Barnhart KT. Recurrent implantation failure: reality or a statistical mirage?: Consensus statement from the July 1, 2022 Lugano Workshop on recurrent implantation failure. Fertil Steril. 2023 Jul;120(1):45-59. doi: 10.1016/j.fertnstert.2023.02.014. Epub 2023 Feb 22. PMID: 36822566.
2. Zeyneloglu HB, Onalan G. Remedies for recurrent implantation failure. Semin Reprod Med. 2014;32(4):297–305.
3. Pasch LA, et al. Psychological distress and in vitro fertilization outcome. Fertil Steril. 2012;98(2):459–64.
4. Collins, J., 2009. Mild stimulation for in vitro fertilization: making progress downward. Hum. Reprod. Update 15, 1–3.
5. Fernandez, J.L., Muriel, L., Rivero, M.T., Goyanes, V., Vazquez,R., Alvarez, J.G., 2003. The sperm chromatin dispersion test: a simple method for the determination of sperm DNA fragmentation. J. Androl. 24, 59–66.
6. De Sutter P, et al. Prevalence of chromosomal abnormalities and timing of karyotype analysis in patients with recurrent implantation failure (RIF) following assisted reproduction. Facts Views Vis Obgyn. 2012;4(1):59–65.
7. Seshadri S, Sunkara SK. Low-molecular-weight-heparin in recurrent implantation failure. Fertil Steril. 2011;95:e29.
8. Blois, S.M., Klapp, B.F., Barrientos, G., 2011. Decidualisation and angiogenesis in early pregnancy: unravelling the functions of DC and NK cells. J. Reprod. Immunol. 88, 86–92.
9. Fatemi HM, et al. Prevalence of unsuspected uterine cavity abnormalities diagnosed by office hysteroscopy prior to in vitro fertilization. Hum Reprod. 2010;25(8):1959–65.
10. Barmat LI, et al. A randomized prospective trial comparing gonadotropinreleasing hormone (GnRH) antagonist/recombinant follicle-stimulating hormone (rFSH) versus GnRH-agonist/rFSH in women pretreated with oral contraceptives before in vitro fertilization. Fertil Steril. 2005;83(2):321–30.

11. Glujovsky D, Farquhar C, Quinteiro Retamar A, Alvarez Sedo C, Blake D. Cleavage stage versus blastocyst stage embryo transfer in assisted reproductive technology. Cochrane Database Syst Rev. 2016;(6):CD002118. https://doi.org/10.1002/14651858.CD002118.pub5
12. Roque M, Valle M, Guimarães F, Sampaio M, Geber S. Freeze-all policy: fresh vs. frozen-thawed embryo transfer. Fertil Steril. 2015 May;103(5):1190-3. doi: 10.1016/j.fertnstert.2015.01.045. Epub 2015 Mar 4. PMID: 25747130.
13. Gabriele Saccone, Corina Schoen, Jason M. Franasiak, Richard T. Scott, Vincenzo Berghella. Supplementation with progestogens in the first trimester of pregnancy to prevent miscarriage in women with unexplained recurrent miscarriage: a systematic review and meta-analysis.
14. Abdolmohammadi-Vahid S, Pashazadeh F, Pourmoghaddam Z, AghebatiMaleki L, Abdollahi-Fard S, Yousefi M. The effectiveness of IVIG therapy in pregnancy and live birth rate of women with recurrent implantation failure (RIF): A systematic review and meta-analysis. J Reprod Immunol (2019) 134-135:28–33. doi: 10.1016/j.jri.2019.07.006
15. Nakagawa K, Kuroda K, Sugiyama R, Yamaguchi K. After 12 consecutive miscarriages, a patient received immunosuppressive treatment and delivered an intact baby. Reprod Med Biol (2017) 16:297–301. doi: 10.1002/rmb2.12040
16. Coulam CB. Intralipid treatment for women with reproductive failures. Am J Reprod Immunol (2021) 85:e13290. doi: 10.1111/aji.13290.
17. Zhang X, Guo F, Wang Q, Bai W, Zhao A. Low-dose aspirin treatment improves endometrial receptivity in the midluteal phase in unexplained recurrent implantation failure. Int J Gynaecol Obstet (2022) 156:225–30. doi: 10.1002/ ijgo.13699
18. Potdar N, Gelbaya TA, Konje JC, Nardo LG. Adjunct low-molecularweight heparin to improve live birth rate after recurrent implantation failure: a systematic review and meta-analysis. Hum Reprod Update (2013) 19:674–84. doi: 10.1093/humupd/dmt032
19. Kalem Z, Namli Kalem M, Bakirarar B, Kent E, Makrigiannakis A, Gurgan T. Intrauterine G-CSF administration in recurrent implantation failure (RIF): An rct. Sci Rep (2020) 10:5139. doi: 10.1038/s41598-020-61955-7
20. ESHRE Guideline Group on RIF. Evidence-based recommendations for the management of repeated implantation failure. ESHRE Guidelines. 2023.
21. García-Velasco JA, Acevedo B, Alvarez C, et al. Personalized embryo transfer in the era of precision medicine: a critical review. Hum Reprod. 2024;39(1):12–20.
22. Chen X, Liu Y, Liu L, et al. The impact of PGT-A on reproductive outcomes in patients with repeated implantation failure: A meta-analysis. Reprod Biol Endocrinol. 2023;21(1):45.
23. Munné S, Kaplan B, Frattarelli JL, et al. STAR trial: A prospective, multicenter randomized controlled trial of PGT-A in IVF. Fertil Steril. 2019;112(6):1071–1078.e7.
24. Vitagliano A, Saccardi C, Noventa M, Di Spiezio Sardo A, Saccone G, Cicinelli E, et al. Effects of chronic endometritis therapy on in vitro fertilization outcome in women with repeated implantation failure: a systematic review and meta-analysis. Fertil Steril (2018) 110:103–112.e1. doi: 10.1016/ j.fertnstert.2018.03.017
25. Fatemi HM, et al. Prevalence of unsuspected uterine cavity abnormalities diagnosed by office hysteroscopy prior to in vitro fertilization. Hum Reprod. 2010;25(8):1959–65.
26. Shalom-Paz E, et al. Can intra cytoplasmatic morphologically selected sperm injection (IMSI) technique improve outcome in patients with repeated IVFICSI failure? A comparative study. Gynecol Endocrinol. 2015;31(3):247–51.

INDIAN FERTILITY SOCIETY

How to Become an IFS Member

Dr. Prof (Col) Pankaj Talwar, VSM
President, IFS

Dr. (Prof) Shweta Mittal Gupta
Secretary General, IFS

01 Scan QR Code

02 REGISTRATION *2 Min*

03 UPI / Online Payments are made in Jiffy *3 Min*

04 *E-Mail Notification* *4 Min*

05 *Download E Certificate & Membership Number* *7 Min*

For any Information, Contact

+91 9899308083

indianfertilitysocietydelhi@gmail.com

INDIAN FERTILITY SOCIETY

INDIAN FERTILITY SOCIETY

Free access to

- IFS Genius Junction Quiz
- Patient Empowerment Program (PEP)
- Intelligence Empowerment Program (IEP)
- Young Empowerment Program (YEP)
- Counsellor Empowerment Program (CEP)
- Nurses Empowerment Program (NEP)
- Self Empowerment Program (SEP)

Why Become An IFS Member?

Scan QR code

CALL NOW!

9899308083

Become a Member in ***3 Min***

Notification in ***4 Min***

Download E Certificate & Membership Number in ***7 Min***

indianfertilitysocietydelhi@gmail.com

21st Annual National Conference of the Indian Fertility Society

FERTIVISION 2025

Theme:
Green ART - Global Sustainability Initiative

INDIAN FERTILITY SOCIETY

Dr Prof (Col) Pankaj Talwar, VSM
President IFS
Organizing Chair

Dr (Prof) Shweta Mittal Gupta
Secretary General IFS
Organizing Secretary

Dr (Prof) Neena Malhotra
President Elect, IFS
Scientific Committee Chair

Block Your Dates

12th to 14th DECEMBER

The Leela Ambience Hotel & Residences, Gurugram, Delhi NCR

www.fertivision2025.com

Conferences International

Digital IFS

Unlock Fertility Wisdom in Every Upload

Dr. Prof (Col) Pankaj Talwar, VSM
President, IFS

Dr. (Prof) Shweta Mittal Gupta
Secretary General, IFS

Dr. Rashmi Sharma
Web Editor

Dr. Shalini Khanna
Joint Web Editor

Scan QR Codes

(CEP) Counsellor Empowerment Program

(IEP) Intelligence Empowerment Program

NEP) Nurses Empowerment Program

(PEP) Patient Empowerment Program

(SEP) Self Empowerment Program

(YEP) Young Empowerment Program

Green IVF

IFS Genius Junction

SIG

Become An IFS Member

Scan QR Code

IFS SECRETARIAT

Flat No. 302, 3rd Floor, Kailash Building
26, Kasturba Gandhi Marg, C.P. New Delhi - 110001
+91 9899308083 (Ms Farha Khan)
☎ +91 11 40018184

@ www.indianfertilitysociety.org
indianfertilitysocietydelhi@gmail.com
indianfertilitysociety