Annexure 1:

Methodology

The Indian Fertility Society's Executive Committee recognized the need to develop a comprehensive psychosocial consensus statement tailored to the unique social context of India. In response, they commissioned a consensus document to review and adapt the European Society of Human Reproduction and Embryology (ESHRE) psychosocial guidelines. (2015). This initiative aimed to address the specific challenges and considerations pertinent to the Indian population undergoing Assisted Reproductive Techniques (ART).

To initiate this process, the consensus development group was appointed keeping in view their experience in psychosocial care and assisted reproduction. It comprised of eleven core members. For completing the consensus this group met 34 times online and 7 times offline.

The Consensus Development Group (CDG) conducted a survey among experts in the field across India. Utilizing the Delphi technique, a structured method for achieving consensus on statements, the group framed key questions on the basis of PICO (Population, Intervention, Comparison and Outcome) aligning with the ESHRE (2015) guidelines and contextualizing them to the Indian societal setting. The survey identified key areas within the psychosocial domain that required attention. The detailed results of the survey are given in Table 1-125 and chart 1-125

Following the identification of key questions, search string of key words (given at the end of the section) was used to conduct a systematic literature search spanning from April 1, 2014, to January 30, 2024 , as the ESHRE (2015) guideline was based on literature research up to 1 April 2014.The topics which were not covered in the ESHRE guideline i.e. research studies pertaining to Yoga based techniques were searched from the earliest date available . This search encompassed renowned databases including ESHRE guideline (2015) , PubMed, Cochrane, Scopus, Embase, and PsycNET. Additionally, experts in relevant domains conducted secondary literature searches to ensure thorough coverage of the subject matter. The retrieved articles underwent rigorous review to assess their relevance and applicability for the psychosocial care during ART .

Utilizing the Delphi technique, the CDG engaged in structured discussions to arrive at consensus statements. The technique required an 80% concurrence among participants to achieve consensus on each statement. This approach ensured that the resulting consensus statements were robust and reflective of the collective expertise and perspectives of the group. Through these discussions, consensus on good practices was reached, considering cultural, societal, and ethical considerations unique to India. These consensus statements formed the basis of the clinical consensus document.

Once drafted, the document was reviewed for approval by the Indian Fertility Society's Executive Body. Feedback from the committee was incorporated into the final version, ensuring alignment with organizational goals and priorities.

Upon completion, the clinical consensus document will be disseminated widely among fertility specialists, counsellors, and relevant stakeholders across India. Efforts by the IFS are being made to facilitate the seamless integration of the consensus statement into clinical practice, thereby optimizing patient care and outcomes in the realm of assisted reproduction.

Looking ahead, the document will be subject to periodic review and updates to accommodate new evidence and emerging trends in the field. This commitment to ongoing refinement reflects the dedication of the Indian Fertility Society to ensuring the provision of high-quality, evidence-based care to individuals navigating the complexities of assisted reproduction in India.

Detailed Methodology

Step 1: Formation of Consensus Development Group

The group initially had 5 members who decided the objective, scope and target users. To initiate this process, the consensus development group was appointed keeping in view their experience in psychosocial care and assisted reproduction. It comprised of eleven core members. For completing the consensus this group met 34 times online and 7 times offline.

Step 2: PAN–India Survey Based on ESHRE Guidelines

Summary of the Pan-India Survey
A. Areas of Concordance.
B. Areas Requiring Specific Research in India
C. Areas of Potential Discordance

To initiate the process, the CDG conducted a survey among experts in the field across India. The survey identified key areas within the psychosocial domain that required attention. Utilizing the Delphi technique, a structured method for achieving consensus on statements, the group framed key questions aligning with the existing ESHRE guidelines and contextualizing them to the Indian societal setting.

Summary of the Pan-India Survey (Table 1-120 and Chart 1-120)

The consensus development group conducted an online survey among 27 fertility experts and counsellors across India. The survey provided a nuanced understanding of the concordance and divergence between the recommendations outlined in the ESHRE Guidelines on Routine Psychosocial Care In Medically Assisted Reproduction (2015) and the Indian social and cultural context. It elucidated areas of agreement as well as highlighted the need for further specific research to tailor interventions effectively to the Indian population.

A. Areas of Concordance:

1. Patient-Centred Care:

There was unanimous agreement across experts on the importance of patient-centred care, with a focus on understanding patients' emotional needs, involving both partners in the treatment process, and providing clear explanations about treatment options and results. This concordance underscores the universal significance of empathetic communication and personalized care in infertility treatment.

2. Emotional Support:

The survey revealed a strong consensus among experts regarding the need for emotional support, particularly during critical stages such as waiting periods and following unsuccessful treatment outcomes. This alignment emphasizes the universal nature of emotional distress experienced by patients undergoing infertility treatment and the importance of targeted psychosocial interventions.

3. Referral to Specialized Psychosocial Care:

There was widespread acknowledgment across experts on the value of referring patients at risk of experiencing significant psychosocial distress to specialized psychosocial care, such as infertility counselling or psychotherapy. This recognition underscores the importance of a holistic approach to patient care, addressing not only the medical but also the psychological aspects of fertility care.

4. Importance of Information Provision:

Fertility experts and counsellors agreed on the importance of providing preparatory information about medical procedures to alleviate patient anxiety and promote treatment compliance. This consensus highlights the universal need for comprehensive patient education and empowerment throughout the treatment process.

B. Areas Requiring Specific Research in India

1. Psychosocial Distress Screening and Assessment Tools:

The survey underscored the importance of using screening tools to identify patients at risk of psychosocial distress. However, there is a need for research to validate the effectiveness of existing screening tools, such as the SCREENIVF and FERTIQOL in the Indian population and assess their feasibility and acceptability in clinical practice

2. Cultural Adaptation of Interventions:

While certain recommendations from the ESHRE guidelines were deemed relevant, there is a need for specific research to adapt psychosocial interventions to the Indian cultural context. Social and cultural factors may influence patients' coping mechanisms, treatment preferences, and attitudes towards counselling, necessitating tailored approaches to care.

3. Gender Disparities in Psychosocial Impact:

The survey indicated the need for further studies on the gender differences in the experience of psychological distress, depression, and anxiety in Indian population. Further research is warranted to explore the underlying factors contributing to these disparities and develop gender-sensitive interventions to address them effectively.

4. Barriers to Treatment Adherence:

Experts identified the factors impacting treatment adherence, and reasons for discontinuing recommended treatment, including psychological burdens and financial constraints is need further research in India. Specific barriers to treatment adherence may be different in the Indian context and can inform the development of targeted support strategies to enhance patient engagement and persistence with treatment.

5. Cultural Preferences in Decision-Making:

While patient involvement in decision-making was emphasized, cultural preferences and norms may influence the extent to which patients desire autonomy in decision-making processes. Exploring cultural variations in decision-making preferences and developing culturally sensitive decision support tools can facilitate shared decision-making in infertility treatment.

C . Areas of Potential Discordance

One notable finding was regarding patient preferences for consultation. The guideline suggested that IVF patients equally prefer in-person or telephone consultation, but the survey hinted at potential variations in the Indian context, suggesting a need for further research to understand patient preferences regarding communication channels.

Another area of concern was the recommendation to use specific assessment tools for evaluating patients' needs. While these tools were advocated by ESHRE, their applicability and effectiveness in the Indian setting need validation.

Furthermore, the effectiveness of certain interventions, such as interactive complex interventions, in improving patient interpersonal relationships or addressing sexual concerns may need re-evaluation in the Indian context.

Similarly, the impact of internet-based personal health records on patient knowledge about infertility and its treatment may differ in India, requiring assessment before potential adaptation.

The survey also highlighted variations in the psychological impact of IVF/ICSI treatments on patients, such as depression and self-esteem during pregnancy, which may be influenced by cultural factors unique to India.

Moreover, the importance of support networks and the experience of social isolation during treatment cycles may vary among Indian patients, suggesting a need for tailored approaches to address these concerns.

Overall, these findings emphasize the necessity of conducting further research to validate the applicability of existing psychosocial care recommendations in the Indian context. Tailoring interventions and support systems to align with cultural norms and societal dynamics can enhance the effectiveness of fertility care in India and improve patient outcomes.

Step III: Formulation of Key Questions

Utilizing the Delphi technique, a structured method for achieving consensus on statements, the group framed key questions on the basis of PICO (Population, Intervention, Comparison and Outcome) aligning with the ESHRE (2015) guidelines and contextualizing them to the Indian societal setting. The key questions were divided among subgroups of the Consensus group.

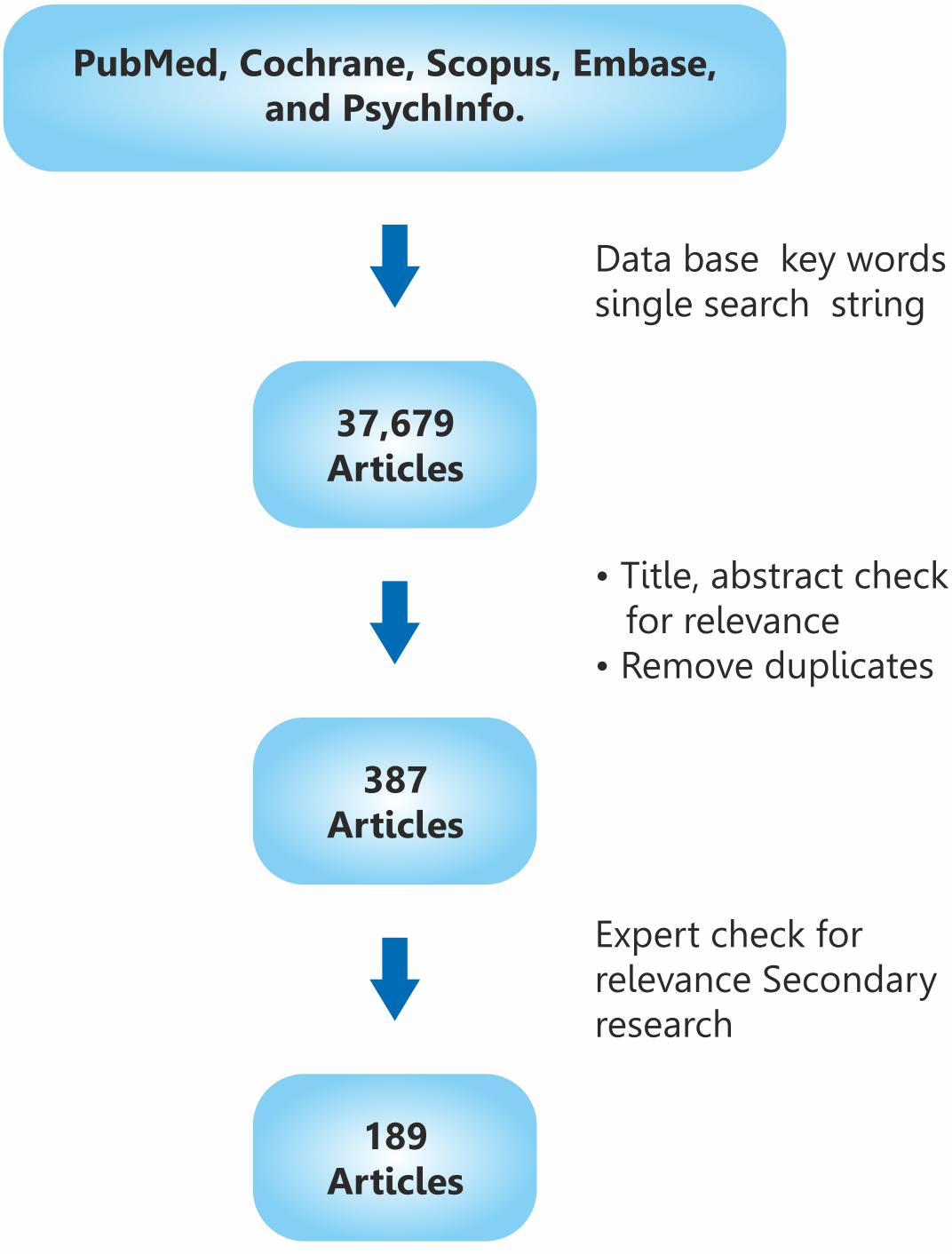
Step IV: Selection of Evidence From The Literature

Following the identification of key questions, keywords** were meticulously chosen to conduct a systematic literature search spanning from January 1, 2015 to November 30, 2023. For questions pertaining to use of mind-body approaches, yoga based techniques (7.6) the studies from the earliest available date were included. This search encompassed databases including PubMed, Cochrane, Scopus, Embase, and PsychInfo. Additionally, experts in relevant domains conducted secondary literature searches to ensure thorough coverage of the subject matter. Metanalysis and systemic reviews followed by randomized controlled trials and prospective studies were taken out. In topics where none of these were present retrospective studies and surveys and questionnaires were selected for review

Step V: The Review Of Research And Relevance Check of Searched Literature

On the basis of title and abstract of retrieved article a relevance check was performed and articles which did not pertain to the PICO of a particular question were removed. (Fig 1). Systematic reviews and met analysis were given maximum weightage followed by RCT. If these were not present for a particular paper prospective studies, retrospective studies, were looked into. Conference abstracts were not included. Through this process, evidence was accumulated, providing a foundation for subsequent consensus-building activities.

Fig 1: Process of selection of evidence to final list of papers examined by the CDG



Step VI: Development of Recommendations Based on Evidence and Consensus

The studies were assessed to determine the quality of evidence. The quality assessment was discussed and finalised by the CDG members. The quantitative studies were scored from 1 to 4. The qualitative studies were included; however they were not given a grading while finalising the draft of the recommendations. (TABLE A)

Meta analysis and Multiple RCT were considered the highest level of evidence (Level I) leading to a grade A or B of recommendation. Single RCT and large non randomized studies or a prospective cohort study were considered Level 2 and any recommendation from then was Grade B or C. Non analytic studies and case reports were Level 3 of evidence and were considered Grade D recommendations. Expert opinion was only considered where nothing else was available and had a level 4of evidence and any recommendation from them was considered a good practice point (GPP)

Based on the collected evidence, the draft of recommendations was written for each question by the CGD members. The discussions were held by the CDG to finalise the recommendations and assign the grade to the recommendation

Table A: LEVEL AND GRADE OF RECOMMENDATION

Study Type	**Level of evidence**	**Study quality**	**Grade of recommendation**
Meta analysis Multiple RCT	1	High ++ Moderate +	A B
Single RCT Large non-randomised trial Case control-cohort study	2	High ++ Moderate +	B C
Non analytical studies, case reports	3	High ++ Moderate +	D
Expert opinion	4	/	Good Practice Points

Utilizing the Delphi technique, the consensus development group engaged in structured discussions to arrive at consensus statements. The technique required an 80% concurrence among participants to achieve consensus on each statement. This approach ensured that the resulting consensus statements were robust and reflective of the collective expertise and perspectives of the group. The questions with evidence summary and the grade of recommendation were noted. Through these discussions, consensus on good practices was reached, The cultural, societal, and ethical considerations unique to India were considered separately . These consensus statements formed the basis of the clinical consensus recommendations .

The draft of the consensus document was reviewed for final discussion by the Consensus Statement group members. Feedback from the committee was continuously incorporated into the final version, ensuring alignment with IFS goals and priorities.

STEP VII: REVIEW OF THE CONSENSUS DOCUMENT

The final clinical consensus document was disseminated widely among fertility specialists, counsellors, and relevant stakeholders across India. Nursing, Social Scientist, Embryologist, Lawyer, Gynecologist , Patients Psychiatrist, Fertility specialist and Yoga expert were asked to review document.

STEP VIII: INCORPORATION OF SUGGESTIONS AND FINAL REVIEW BY CDG MEMBERS

The comments of reviewers were discussed with the CDG members and suggestions incorporated. A final review was done by all members.

STEP IX: INCORPORATION OF GUIDELINE INTO CLINICAL PRACTICE

Efforts will be made to facilitate the seamless integration of the guidelines into clinical practice, thereby optimizing patient care and outcomes in the realm of assisted reproduction. The guideline would be available on the IFS website and printed copies would be distributed to members

Looking ahead, the document will be subject to periodic review and updates to accommodate new evidence and emerging trends in the field. This commitment to ongoing refinement reflects the dedication of the Indian Fertility Society to ensuring the provision of high-quality, evidence-based care to individuals navigating the complexities of assisted reproduction in India.

IFS Survey Results

Table: 1

Reccomendations	Valid	Frequency	Percent	Valid Percent	Cumulative Percent
Fertility staff should be aware that patients value how staff relate to them	I believe that this is definitely valid in the Indian context and my practice	27	96.4	96.4	96.4
	I believe that this is possibly valid in the Indian context and my practice	1	3.6	3.6	100
	Total	28	100	100	

Chart: 1

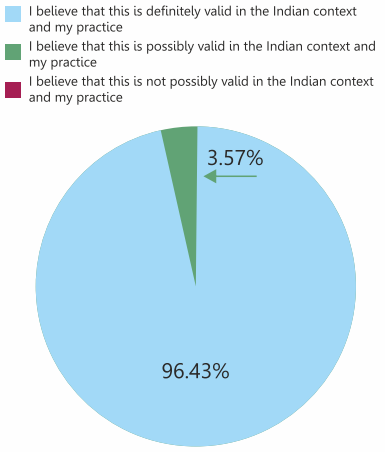


Table: 2

Reccomendations	Valid	Frequency	Percent	Valid Percent	Cumulative Percent
Fertility staff should be aware that patients value staff showing understanding and paying attention to the emotional impact of infertility	I believe that this is definitely valid in the Indian context and my practice	26	92.9	92.9	92.9
	I believe that this is possibly valid in the Indian context and my practice	2	7.1	7.1	100
	Total	28	100	100	

Chart: 2

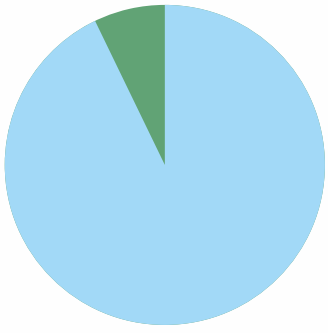


Table: 3

Reccomendations	Valid	Frequency	Percent	Valid Percent	Cumulative Percent
Fertility staff should be aware that patients value that both partners are involved in the treatment process	I believe that this is definitly valid in the Indian context and my practice	25	89.3	89.3	89.3
	I believe that this is possibly valid in the Indian context and my practice	3	10.7	10.7	100
	Total	28	100	100	

Chart: 3

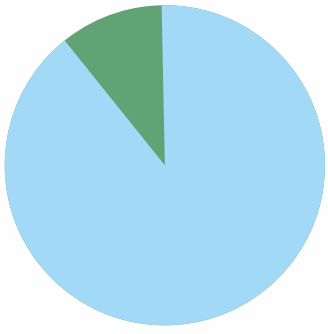


Table: 4

Reccomendations	Valid	Frequency	Percent	Valid Percent	Cumulative Percent
Fertility staff should be aware that patients value being involved in decision-making	I believe that this is definitly valid in the Indian context and my practice	22	78.6	78.6	78.6
	I believe that this is possibly valid in the Indian context and my practice	6	21.4	21.4	100
	Total	28	100	100	

Chart: 4

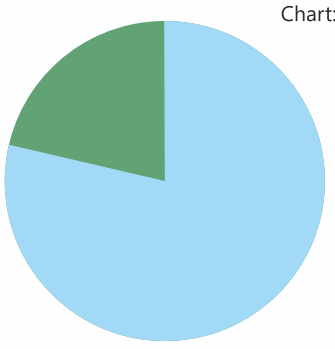


Table: 5

Reccomendations	Valid	Frequency	Percent	Valid Percent	Cumulative Percent
Fertility staff should be aware that patients value receiving psychosocial care from sensitive and trustworthy staff members	I believe that this is definitly valid in the Indian context and my practice	22	78.6	78.6	78.6
	I believe that this is possibly valid in the Indian context and my practice	6	21.4	21.4	100
	Total	28	100	100	

Chart: 5

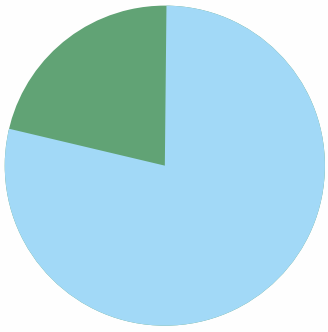


Table: 6

Reccomendations	Valid	Frequency	Percent	Valid Percent	Cumulative Percent
Fertility staff should be aware that patients value receiving attention to their distinct needs related to their medical history	I believe that this is definitely valid in the Indian context and my practice	25	89.3	89.3	89.3
	I believe that this is possibly valid in the Indian context and my practice	3	10.7	10.7	100
	Total	28	100	100	

Chart: 6

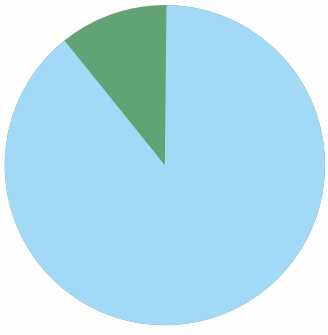


Table: 7

Reccomendations	Valid	Frequency	Percent	Valid Percent	Cumulative Percent
Fertility staff should be aware that patients value minimal waiting times, not being hurried in medical consultations, and continuity of care	I believe that this is definitly valid in the Indian context and my practice	26	92.9	92.9	92.9
	I believe that this is possibly valid in the Indian context and my practice	2	7.1	7.1	100
	Total	28	100	100	

Chart: 7

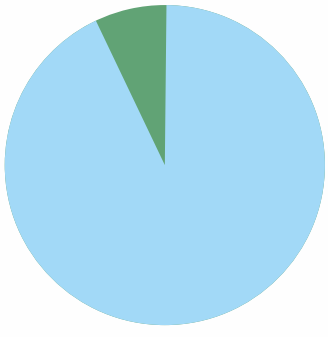


Table: 8

Reccomendations	Valid	Frequency	Percent	Valid Percent	Cumulative Percent
Fertility staff should be aware that patients value the professional competence of fertility staff and receiving personalized care	I believe that this is definitly valid in the Indian context and my practice	23	82.1	82.1	82.1
	I believe that this is possibly valid in the Indian context and my practice	5	17.9	17.9	100
	Total	28	100	100	

Chart: 8

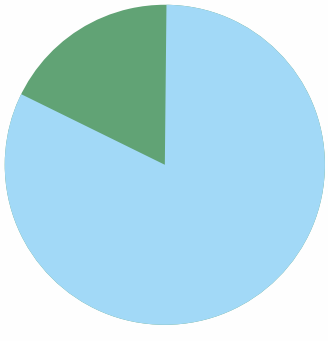


Table: 9

Reccomendations	Valid	Frequency	Percent	Valid Percent	Cumulative Percent
Fertility staff should be aware that patients value the provision of opportunities for contact with other patients	I believe that this is definitly valid in the Indian context and my practice	13	46.4	46.4	46.4
	I believe that this is possibly valid in the Indian context and my practice	11	39.3	39.3	85.7
	I believe that this is not valid in the Indian context and my practice	4	14.3	14.3	100
	Total	28	100	100	

Chart: 9

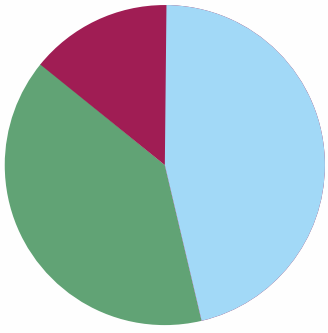


Table: 10

Reccomendations	Valid	Frequency	Percent	Valid Percent	Cumulative Percent
Fertility staff should be aware that patients value being in a clinic dedicated to infertility care	I believe that this is definitly valid in the Indian context and my practice	15	53.6	53.6	53.6
	I believe that this is possibly valid in the Indian context and my practice	9	32.1	32.1	85.7
	I believe that this is not valid in the Indian context and my practice	4	14.3	14.3	100
	Total	28	100	100	

Chart: 10

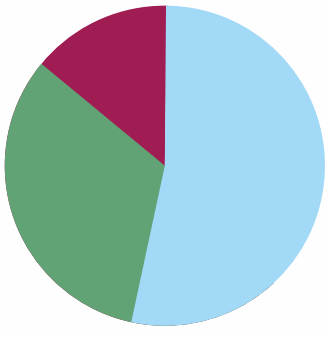


Table: 11

Reccomendations	Valid	Frequency	Percent	Valid Percent	Cumulative Percent
Fertility staff should be aware that patients value the offer of specialized psychosocial care (infertility counselling or psychotherapy) before, during, and after IVF treatment	I believe that this is definitly valid in the Indian context and my practice	20	71.4	71.4	71.4
	I believe that this is possibly valid in the Indian context and my practice	7	25.0	25.0	96.4
	I believe that this is not valid in the Indian context and my practice	1	3.6	3.6	100
	Total	28	100	100	

Chart: 11

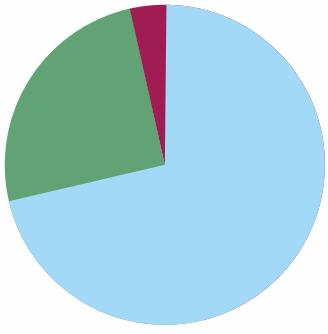


Table: 12

Reccomendations	Valid	Frequency	Percent	Valid Percent	Cumulative Percent
The guideline development group recommends fertility staff to be aware that patients expressing a need for emotional support value the offer of specialized psychosocial care (infertility counselling or psychotherapy)	I believe that this is definitely valid in the Indian context and my practice	21	75.0	75.0	75.0
	I believe that this is possibly valid in the Indian context and my practice	6	21.4	21.4	96.4
	I believe that this is not valid in the Indian context and my practice	1	3.6	3.6	100
	Total	28	100	100	

Chart: 12

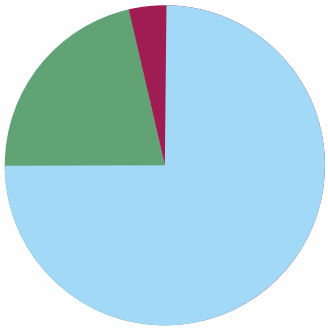


Table: 13

Reccomendations	Valid	Frequency	Percent	Valid Percent	Cumulative Percent
The guideline development group recommends fertility staff to be aware that patients may value the presence of a chaperone during medical examinations	I believe that this is definitely valid in the Indian context and my practice	15	53.6	53.6	53.6
	I believe that this is possibly valid in the Indian context and my practice	8	28.6	28.6	28.6
	I believe that this is not valid in the Indian context and my practice	5	17.9	17.9	100
	Total	28	100	100	

Chart: 13

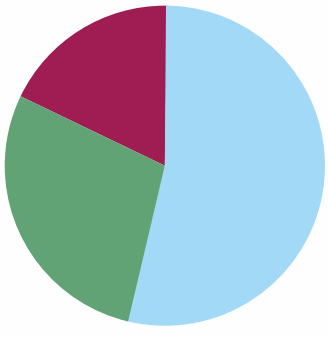


Table: 14

Reccomendations	Valid	Frequency	Percent	Valid Percent	Cumulative Percent
The guideline development group recommends fertility staff to be aware that men value rooms designated for producing sperm samples.	I believe that this is definitely valid in the Indian context and my practice	25	89.3	89.3	89.3
	I believe that this is possibly valid in the Indian context and my practice	3	10.7	10.7	100.0
	Total	28	100	100	

Chart: 14

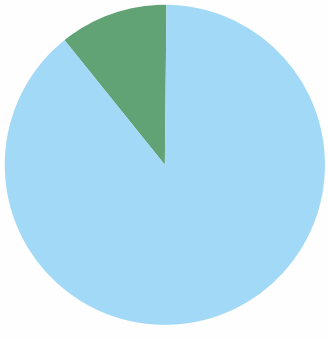


Table: 15

Reccomendations	Valid	Frequency	Percent	Valid Percent	Cumulative Percent
Fertility staff should be aware that patients value written treatment relevant information.	I believe that this is definitely valid in the Indian context and my practice	21	75.0	75.0	75.0
	I believe that this is possibly valid in the Indian context and my practice	6	21.4	21.4	96.4
	I believe that this is not valid in the Indian context and my practice	1	3.6	3.6	100
	Total	28	100	100	

Chart: 15

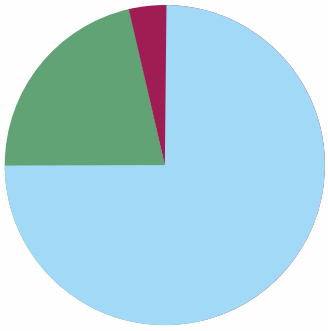


Table: 16

Reccomendations	Valid	Frequency	Percent	Valid Percent	Cumulative Percent
Fertility staff should be aware that patients value explanations about treatment results and treatment options	I believe that this is definitely valid in the Indian context and my practice	26	92.9	92.9	92.9
	I believe that this is possibly valid in the Indian context and my practice	2	7.1	7.1	100.0
	Total	28	100	100	

Chart: 16

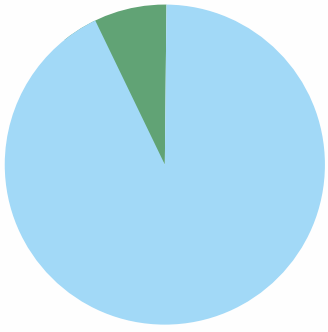


Table: 17

Reccomendations	Valid	Frequency	Percent	Valid Percent	Cumulative Percent
Fertility staff should be aware that patients value understandable and customized (i.e., personally relevant) treatment information	I believe that this is definitely valid in the Indian context and my practice	24	85.7	85.7	85.7
	I believe that this is possibly valid in the Indian context and my practice	4	14.3	14.3	100.0
	Total	28	100	100	

Chart: 17

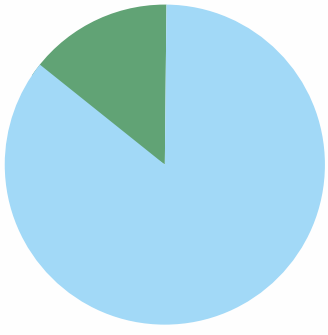


Table: 18

Reccomendations	Valid	Frequency	Percent	Valid Percent	Cumulative Percent
Fertility staff should be aware that patients value the provision of information about psychosocial care options (e.g., contact details of support groups, online support options, access to infertility counselling, or psychotherapy)	I believe that this is definitely valid in the Indian context and my practice	20	71.4	71.4	71.4
	I believe that this is possibly valid in the Indian context and my practice	8	28.6	28.6	100.0
	Total	28	100	100	

Chart: 18

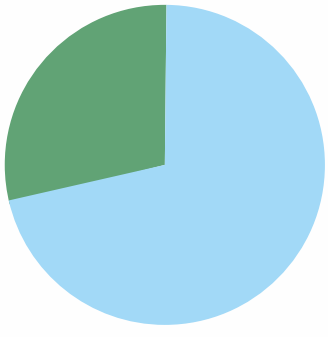


Table: 19

Reccomendations	Valid	Frequency	Percent	Valid Percent	Cumulative Percent
Fertility staff should be aware that IVF patients equally prefer in-person or telephone consultation to discuss their treatment results and future plans	I believe that this is definitly valid in the Indian context and my practice	14	50.0	50.0	50.0
	I believe that this is possibly valid in the Indian context and my practice	7	25.0	25.0	75.0
	I believe that this is not valid in the Indian context and my practice	7	25.0	25.0	100
	Total	28	100	100	

Chart: 19

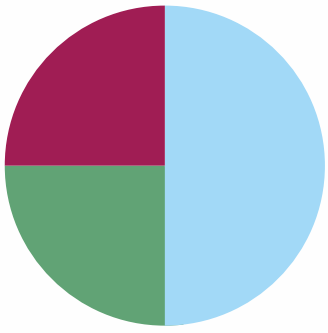


Table: 20

Reccomendations	Valid	Frequency	Percent	Valid Percent	Cumulative Percent
Fertility staff should be aware that receiving patient-centred care is associated with better patient well-being	I believe that this is definitely valid in the Indian context and my practice	24	85.7	85.7	85.7
	I believe that this is possibly valid in the Indian context and my practice	3	10.7	10.7	96.4
	I believe that this is not valid in the Indian context and my practice	1	3.6	3.6	100
	Total	28	100	100	

Chart: 20

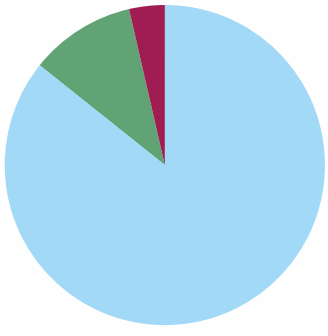


Table: 21

Reccomendations	Valid	Frequency	Percent	Valid Percent	Cumulative Percent
Fertility staff should be aware that positive staff characteristics (communication, respect, competence, involvement, and information) are associated with better patient well-being	I believe that this is definitely valid in the Indian context and my practice	24	85.7	85.7	85.7
	I believe that this is possibly valid in the Indian context and my practice	4	14.3	14.3	100.0
	Total	28	100	100	

Chart: 21

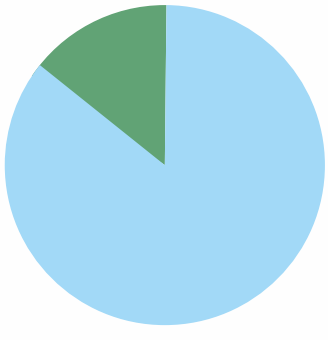


Table: 22

Reccomendations	Valid	Frequency	Percent	Valid Percent	Cumulative Percent
Fertility staff should be aware that positive clinic characteristics (information, competence of clinic and staff, and continuity) are associated with better patient well-being	I believe that this is definitely valid in the Indian context and my practice	24	85.7	85.7	85.7
	I believe that this is possibly valid in the Indian context and my practice	4	14.3	14.3	100.0
	Total	28	100	100	

Chart: 22

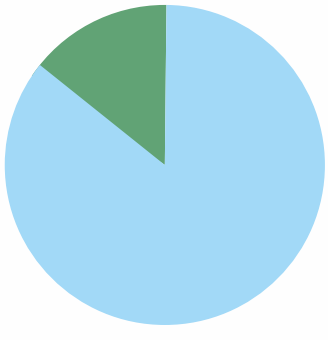


Table: 23

Reccomendations	Valid	Frequency	Percent	Valid Percent	Cumulative Percent
Fertility staff should be aware that offering the currently available interactive complex interventions* is not likely to affect patient individual and relational well-being	I believe that this is definitely valid in the Indian context and my practice	11	39.3	39.3	39.3
	I believe that this is possibly valid in the Indian context and my practice	14	50.0	50.0	89.3
	I believe that this is not valid in the Indian context and my practice	3	10.7	10.7	100
	Total	28	100	100	

Chart: 23

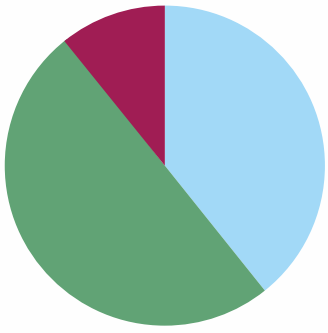


Table: 24

Reccomendations	Valid	Frequency	Percent	Valid Percent	Cumulative Percent
Fertility staff should provide preparatory information about diagnostic procedures because it decreases infertility-specific anxiety and stress	I believe that this is definitely valid in the Indian context and my practice	25	89.3	89.3	89.3
	I believe that this is possibly valid in the Indian context and my practice	3	10.7	10.7	100.0
	Total	28	100	100	

Chart: 24

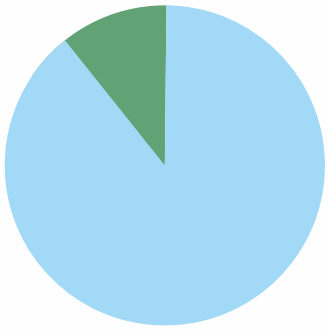


Table: 25

Reccomendations	Valid	Frequency	Percent	Valid Percent	Cumulative Percent
Fertility staff should be aware that tailored online psycho-educational interventions may improve infertility-specific stress and self-efficacy, and the sexual and social concerns of particular groups of patients	I believe that this is definitely valid in the Indian context and my practice	20	71.4	71.4	71.4
	I believe that this is possibly valid in the Indian context and my practice	6	21.4	21.4	92.9
	I believe that this is not valid in the Indian context and my practice	2	7.1	7.1	100.0
	Total	28	100	100	

Chart: 25

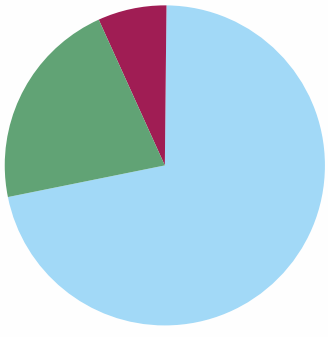


Table: 26

Reccomendations	Valid	Frequency	Percent	Valid Percent	Cumulative Percent
Fertility staff should be aware that a considerable number of patients have lifestyle behaviours that may negatively affect their general and reproductive health	I believe that this is definitely valid in the Indian context and my practice	22	78.6	78.6	78.6
	I believe that this is possibly valid in the Indian context and my practice	6	21.4	21.4	100
	Total	28	100	100	

Chart: 26

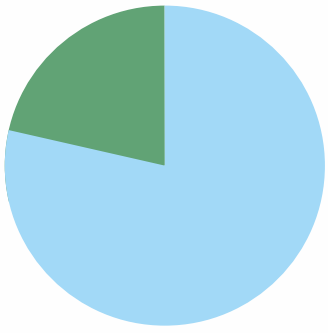


Table: 27

Reccomendations	Valid	Frequency	Percent	Valid Percent	Cumulative Percent
Fertility staff should be aware that patients starting first-line or ART treatments do not have worse marital and sexual relationships than the general population	I believe that this is definitely valid in the Indian context and my practice	13	46.4	46.4	46.4
	I believe that this is possibly valid in the Indian context and my practice	10	35.7	35.7	82.1
	I believe that this is not valid in the Indian context and my practice	5	17.9	17.9	100.0
	Total	28	100	100	

Chart: 27

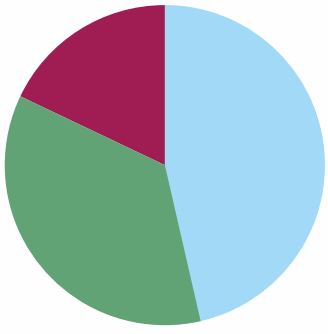


Table: 28

Reccomendations	Valid	Frequency	Percent	Valid Percent	Cumulative Percent
Fertility staff should be aware that patients in fertility workup do not present higher prevalence rates of sexual dysfunctions than the general population	I believe that this is definitely valid in the Indian context and my practice	12	42.9	42.9	42.9
	I believe that this is possibly valid in the Indian context and my practice	10	42.9	42.9	85.7
	I believe that this is not valid in the Indian context and my practice	4	14.3	14.3	100.0
	Total	28	100	100	

Chart: 28

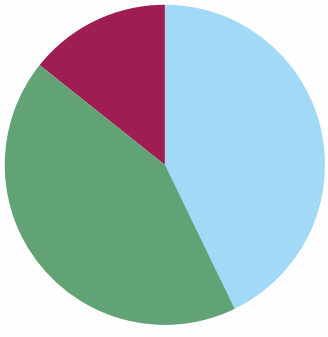


Table: 29

Reccomendations	Valid	Frequency	Percent	Valid Percent	Cumulative Percent
Fertility staff should be aware that before the start of IVF treatment, patients are not more depressed than the general population or matched controls	I believe that this is definitely valid in the Indian context and my practice	10	35.7	35.7	35.7
	I believe that this is possibly valid in the Indian context and my practice	11	39.3	39.3	75.0
	I believe that this is not valid in the Indian context and my practice	7	25.0	25.0	100.0
	Total	28	100	100	

Chart: 29

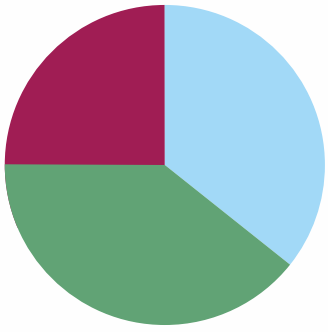


Table: 30

Reccomendations	Valid	Frequency	Percent	Valid Percent	Cumulative Percent
Fertility staff should be aware that evidence about whether before the start of a first IVF cycle patients are more anxious (state and trait anxiety) than the general population is inconsistent	I believe that this is definitely valid in the Indian context and my practice	15	53.6	53.6	53.6
	I believe that this is possibly valid in the Indian context and my practice	9	32.1	32.1	85.7
	I believe that this is not valid in the Indian context and my practice	4	14.3	14.3	100.0
	Total	28	100	100	

Chart: 30

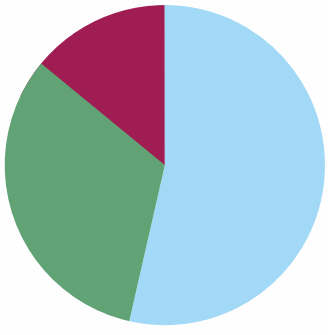


Table: 31

Reccomendations	Valid	Frequency	Percent	Valid Percent	Cumulative Percent
Fertility staff should be aware that before first-line or ART treatment, women do not show more psychiatric disorders or general psychopathology than the general population	I believe that this is definitely valid in the Indian context and my practice	13	46.4	46.4	46.4
	I believe that this is possibly valid in the Indian context and my practice	8	28.6	28.6	75.0
	I believe that this is not valid in the Indian context and my practice	7	25.0	25.0	100.0
	Total	28	100	100	

Chart: 31

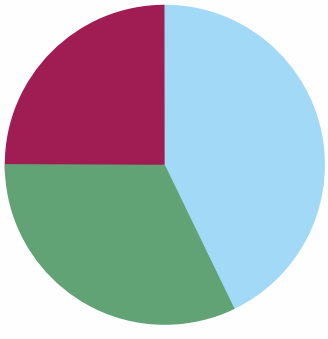


Table: 32

Reccomendations	Valid	Frequency	Percent	Valid Percent	Cumulative Percent
The guideline development group recommends that fertility staff offer patients the opportunity to have their needs assessed and be informed about their emotional adjustment before the start of treatment.	I believe that this is definitely valid in the Indian context and my practice	21	75.0	75.0	75.0
	I believe that this is possibly valid in the Indian context and my practice	7	25.0	25.0	100.0
	Total	28	100	100	

Chart: 32

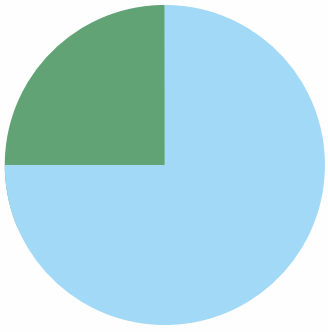


Table: 33

Reccomendations	Valid	Frequency	Percent	Valid Percent	Cumulative Percent
The guideline development group recommends that fertility staff use the tools listed in Appendix 2 (listed below) when assessing patients' needs.	I believe that this is definitely valid in the Indian context and my practice	15	53.6	53.6	53.6
	I believe that this is possibly valid in the Indian context and my practice	11	39.3	39.3	92.9
	I believe that this is not valid in the Indian context and my practice	2	7.1	7.1	100.0
	Total	28	100	100	

Chart: 33

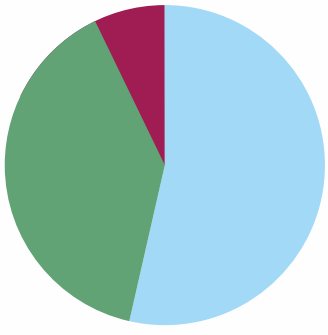


Table: 34

Reccomendations	Valid	Frequency	Percent	Valid Percent	Cumulative Percent
Fertility staff should be aware that currently there are no reliable pre-treatment tools or predictors to identify patients who are not likely to start recommended fertility treatment	I believe that this is definitely valid in the Indian context and my practice	21	75.0	75.0	75.0
	I believe that this is possibly valid in the Indian context and my practice	6	21.4	21.4	96.4
	I believe that this is not valid in the Indian context and my practice	1	3.6	3.6	100.0
	Total	28	100	100	

Chart: 34

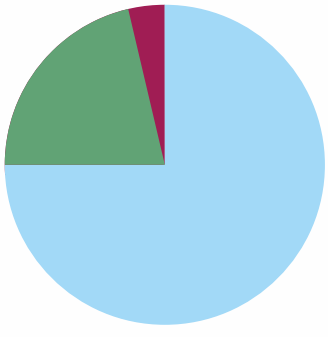


Table: 35

Reccomendations	Valid	Frequency	Percent	Valid Percent	Cumulative Percent
Fertility staff should not assume that patients fully self-report on risk factors for reduced fertility (e.g., eating disorders)	I believe that this is definitely valid in the Indian context and my practice	19	67.9	67.9	67.9
	I believe that this is possibly valid in the Indian context and my practice	7	25.0	25.0	92.9
	I believe that this is not valid in the Indian context and my practice	2	7.1	7.1	100.0
	Total	28	100	100	

Chart: 35

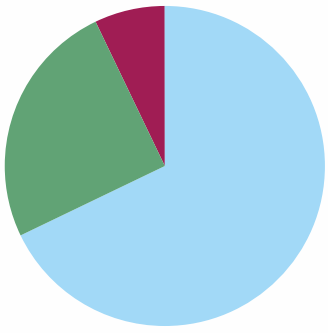


Table: 36

Reccomendations	Valid	Frequency	Percent	Valid Percent	Cumulative Percent
Fertility staff should be aware that risk factors (e.g., smoking, alcohol use, and diet) for reduced fertility can be assessed with self-administered online tools	I believe that this is definitely valid in the Indian context and my practice	12	42.9	42.9	42.9
	I believe that this is possibly valid in the Indian context and my practice	10	35.7	35.7	78.6
	I believe that this is not valid in the Indian context and my practice	6	21.4	21.4	100.0
	Total	28	100	100	

Chart: 36

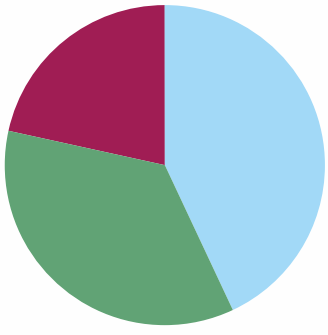


Table: 37

Reccomendations	Valid	Frequency	Percent	Valid Percent	Cumulative Percent
The guideline development group recommends that fertility staff consider explicitly screening risk factors (e.g., drug use, eating disorders) for reduced fertility	I believe that this is definitely valid in the Indian context and my practice	19	67.9	67.9	67.9
	I believe that this is possibly valid in the Indian context and my practice	9	32.1	32.1	100.0
	Total	28	100	100	

Chart: 37

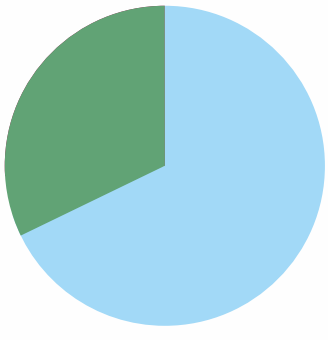


Table: 38

Reccomendations	Valid	Frequency	Percent	Valid Percent	Cumulative Percent
Fertility staff should be aware that women experience higher social and sexual infertility-specific stress than men	I believe that this is definitely valid in the Indian context and my practice	21	75.0	75.0	75.0
	I believe that this is possibly valid in the Indian context and my practice	7	25.0	25.0	100.0
	Total	28	100	100	

Chart: 38

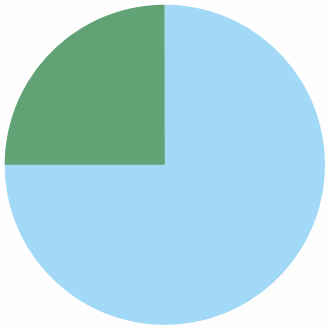


Table: 39

Reccomendations	Valid	Frequency	Percent	Valid Percent	Cumulative Percent
Fertility staff should be aware that the ways patients deal with their fertility problems are associated with infertility-specific relational and social distress. The use of meaning-based coping (e.g., thinking about the fertility problem in a positive light, finding other goals in life) seems to be associated with lower fertility-specific marital and social distress. The use of avoidance coping strategies (e.g., avoiding being among pregnant women) seems to be associated with higher fertility-specific marital and social distress	I believe that this is definitely valid in the Indian context and my practice	21	75.0	75.0	75.0
	I believe that this is possibly valid in the Indian context and my practice	4	14.3	14.3	89.3
	I believe that this is not valid in the Indian context and my practice	3	10.7	10.7	100.0
	Total	28	100	100	

Chart: 39

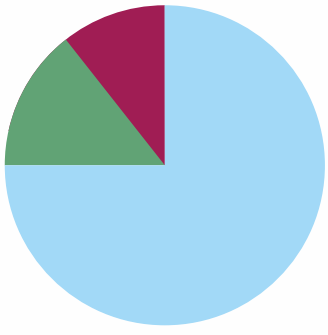


Table: 40

Reccomendations	Valid	Frequency	Percent	Valid Percent	Cumulative Percent
Fertility staff should be aware that, in couples, the way one partner reacts to the infertility condition/diagnos is is associated with how the other partner reacts	I believe that this is definitely valid in the Indian context and my practice	19	67.9	67.9	67.9
	I believe that this is possibly valid in the Indian context and my practice	7	25.0	25.0	92.9
	I believe that this is not valid in the Indian context and my practice	2	7.1	7.1	100.0
	Total	28	100	100	

Chart: 40

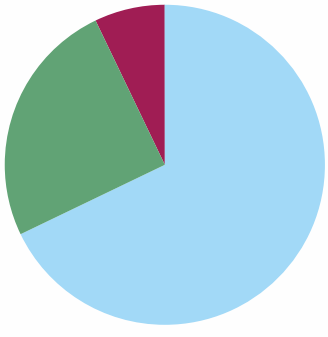


Table: 41

Reccomendations	Valid	Frequency	Percent	Valid Percent	Cumulative Percent
Fertility staff should be aware that couples who have different views on the importance of parenthood and social concerns may show lower relationship satisfaction than those who have similar views	I believe that this is definitely valid in the Indian context and my practice	19	67.9	67.9	67.9
	I believe that this is possibly valid in the Indian context and my practice	7	25.0	25.0	92.9
	I believe that this is not valid in the Indian context and my practice	2	7.1	7.1	100.0
	Total	28	100	100	

Chart: 41

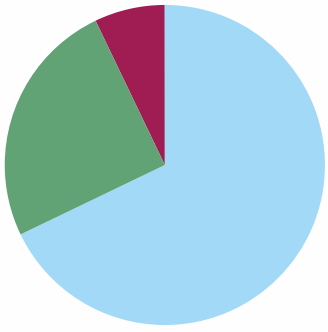


Table: 42

Reccomendations	Valid	Frequency	Percent	Valid Percent	Cumulative Percent
Fertility staff should be aware that women have higher levels of depression and infertility stress than men	I believe that this is definitely valid in the Indian context and my practice	24	85.7	85.7	85.7
	I believe that this is possibly valid in the Indian context and my practice	3	10.7	10.7	96.4
	I believe that this is not valid in the Indian context and my practice	1	3.6	3.6	100.0
	Total	28	100	100	

Chart: 42

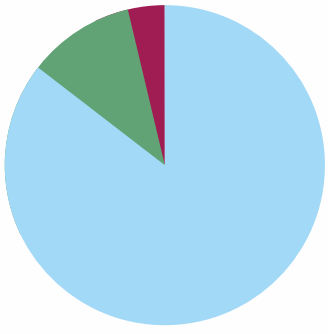


Table: 43

Reccomendations	Valid	Frequency	Percent	Valid Percent	Cumulative Percent
Fertility staff should be aware that patients with a lower occupational status experience higher infertility stress and anxiety than patients with a medium or high occupational status	I believe that this is definitely valid in the Indian context and my practice	15	53.6	53.6	53.6
	I believe that this is possibly valid in the Indian context and my practice	8	28.6	28.6	82.1
	I believe that this is not valid in the Indian context and my practice	5	17.9	17.9	100.0
	Total	28	100	100	

Chart: 43

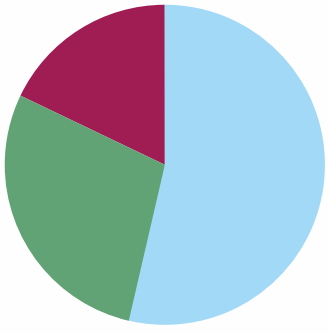


Table: 44

Reccomendations	Valid	Frequency	Percent	Valid Percent	Cumulative Percent
Fertility staff should be aware that women whose partner has male-factor infertility experience higher anxiety than women with female factor, mixed or unexplained infertility, whereas type of infertility diagnosis is not related to depression	I believe that this is definitely valid in the Indian context and my practice	16	57.1	57.1	57.1
	I believe that this is possibly valid in the Indian context and my practice	6	21.4	21.4	78.6
	I believe that this is not valid in the Indian context and my practice	6	21.4	21.4	100.0
	Total	28	100	100	

Chart: 44

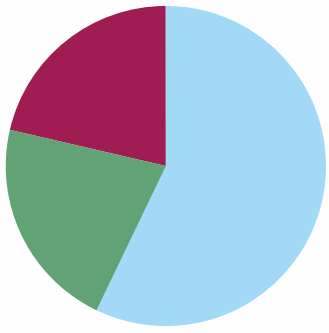


Table: 45

Reccomendations	Valid	Frequency	Percent	Valid Percent	Cumulative Percent
Fertility staff should be aware that the way patients deal with their fertility problems is associated with their infertility distress. The use of passive coping (e.g., rumination, withdrawal) seems to be associated with higher levels of infertility distress. The use of active coping (e.g., goal-oriented problem-solving, thinking rationally about the problem) seems to be associated with lower infertility distress	I believe that this is definitely valid in the Indian context and my practice	19	67.9	67.9	67.9
	I believe that this is possibly valid in the Indian context and my practice	6	21.4	21.4	89.3
	I believe that this is not valid in the Indian context and my practice	3	10.7	10.7	100.0
	Total	28	100	100	

Chart: 45

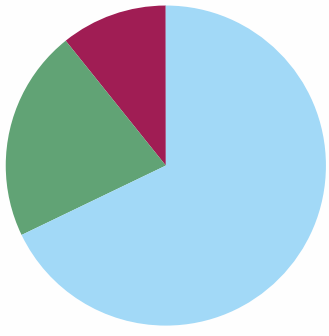


Table: 46

Reccomendations	Valid	Frequency	Percent	Valid Percent	Cumulative Percent
Fertility staff should be aware that individuals who perceive their partner to be available and responsive experience lower infertility stress than individuals who perceive their partner to be avoidant and non-responsive	I believe that this is definitely valid in the Indian context and my practice	23	82.1	82.1	82.1
	I believe that this is possibly valid in the Indian context and my practice	5	17.9	17.9	100
	Total	28	100	100	

Chart: 46

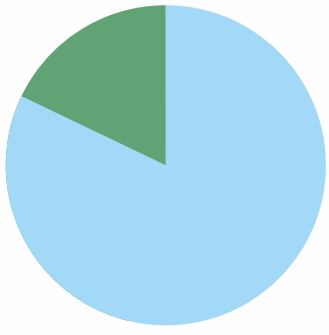


Table: 47

Reccomendations	Valid	Frequency	Percent	Valid Percent	Cumulative Percent
Fertility staff should be aware that, in couples, each partner's depressive symptoms are associated with their own and their partner's infertility-specific distress	I believe that this is definitely valid in the Indian context and my practice	22	78.6	78.6	78.6
	I believe that this is possibly valid in the Indian context and my practice	6	21.4	21.4	100.0
	Total	28	100	100	

Chart: 47

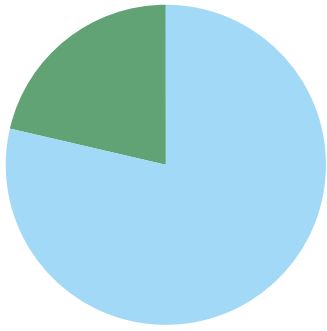


Table: 48

Reccomendations	Valid	Frequency	Percent	Valid Percent	Cumulative Percent
The guideline development group recommends that fertility staff use the SCREEN IVF before the start of each treatment cycle to assess patients' risk factors for emotional problems after the cycle.	I believe that this is definitely valid in the Indian context and my practice	17	60.7	60.7	60.7
	I believe that this is possibly valid in the Indian context and my practice	8	28.6	28.6	89.3
	I believe that this is not valid in the Indian context and my practice	3	10.7	10.7	100.0
	Total	28	100	100	

Chart: 48

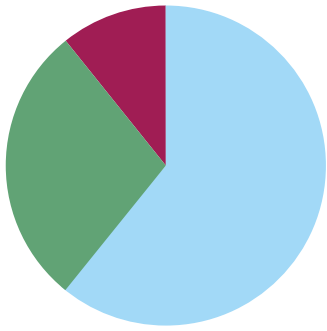


Table: 49

Reccomendations	Valid	Frequency	Percent	Valid Percent	Cumulative Percent
Fertility staff should be aware that the SCREEN IVF is an infertility-specific validated tool designed to be used before the start of treatment, to assess risk factors for emotional problems after a treatment cycle	I believe that this is definitely valid in the Indian context and my practice	18	64.3	64.3	64.3
	I believe that this is possibly valid in the Indian context and my practice	7	25.0	25.0	89.3
	I believe that this is not valid in the Indian context and my practice	3	10.7	10.7	100.0
	Total	28	100	100	

Chart: 49

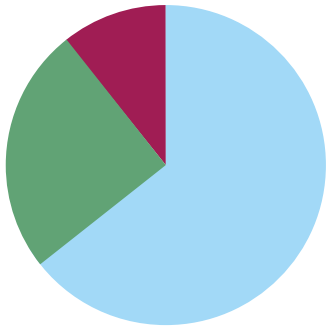


Table: 50

Reccomendations	Valid	Frequency	Percent	Valid Percent	Cumulative Percent
The guideline development groups recommends that fertility staff refer patients at risk of experiencing clinically significant psychosocial problems to specialized psychosocial care (infertility counselling or psychotherapy)	I believe that this is definitely valid in the Indian context and my practice	21	75.0	75.0	75.0
	I believe that this is possibly valid in the Indian context and my practice	7	25.0	25.0	100.0
	Total	28	100	100	

Chart: 50

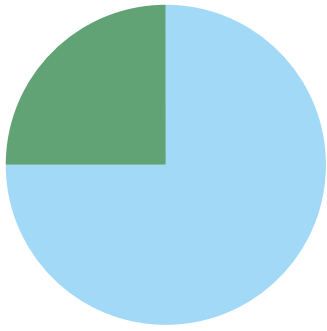


Table: 51

Reccomendations	Valid	Frequency	Percent	Valid Percent	Cumulative Percent
Fertility staff should provide preparatory information about medical procedures because it promotes compliance	I believe that this is definitely valid in the Indian context and my practice	24	85.7	85.7	85.7
	I believe that this is possibly valid in the Indian context and my practice	3	10.7	10.7	96.4
	I believe that this is not valid in the Indian context and my practice	1	3.6	3.6	100.0
	Total	28	100	100	

Chart: 51

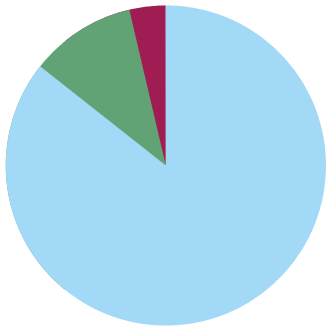


Table: 52

Reccomendations	Valid	Frequency	Percent	Valid Percent	Cumulative Percent
Fertility staff should be aware that weight-loss programmes based on diet and exercise offered pre-ART treatment may be effective in reducing weight and body mass index (BMI)	I believe that this is definitely valid in the Indian context and my practice	24	85.7	85.7	85.7
	I believe that this is possibly valid in the Indian context and my practice	4	14.3	14.3	100.0
	Total	28	100	100	

Chart: 52

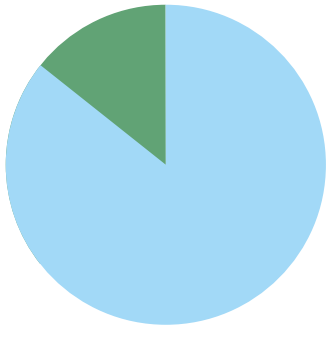


Table: 53

Reccomendations	Valid	Frequency	Percent	Valid Percent	Cumulative Percent
The guideline development group recommends that fertility staff consider providing patients with information about lifestyle behaviours that may negatively affect their general and reproductive health.	I believe that this is definitely valid in the Indian context and my practice	23	82.1	82.1	82.1
	I believe that this is possibly valid in the Indian context and my practice	4	14.3	14.3	96.4
	I believe that this is not valid in the Indian context and my practice	1	3.6	3.6	100.0
	Total	28	100	100	

Chart: 53

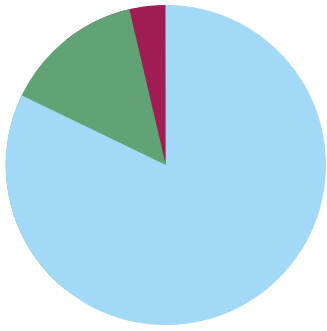


Table: 54

Reccomendations	Valid	Frequency	Percent	Valid Percent	Cumulative Percent
The guideline development group recommends that fertility staff support patients in changing lifestyle behaviours that negatively affect their general and reproductive health, as well as their chances of treatment success.	I believe that this is definitely valid in the Indian context and my practice	23	82.1	82.1	82.1
	I believe that this is possibly valid in the Indian context and my practice	5	17.9	17.9	100.0
	Total	28	100	100	

Chart: 54

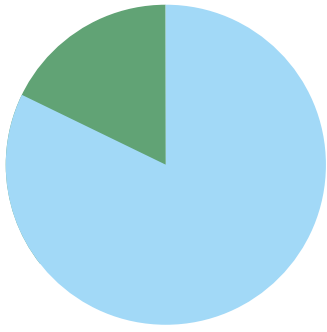


Table: 55

Reccomendations	Valid	Frequency	Percent	Valid Percent	Cumulative Percent
The guideline development group recommends that fertility staff offer additional psychosocial care to patients at risk of experiencing increased infertility-specific relational and social distress.	I believe that this is definitely valid in the Indian context and my practice	24	85.7	85.7	85.7
	I believe that this is possibly valid in the Indian context and my practice	3	10.7	10.7	96.4
	I believe that this is not valid in the Indian context and my practice	1	3.6	3.6	100.0
	Total	28	100	100	

Chart: 55

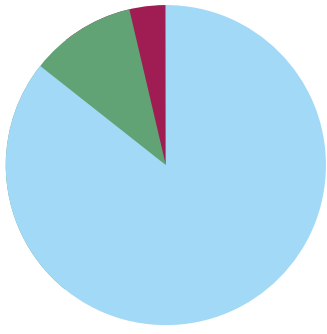


Table: 56

Reccomendations	Valid	Frequency	Percent	Valid Percent	Cumulative Percent
The guideline development group recommends that fertility staff actively involve both partners of the couple in the diagnosis and treatment process.	I believe that this is definitely valid in the Indian context and my practice	26	92.9	92.9	92.9
	I believe that this is possibly valid in the Indian context and my practice	2	7.1	7.1	100.0
	Total	28	100	100	

Chart: 56

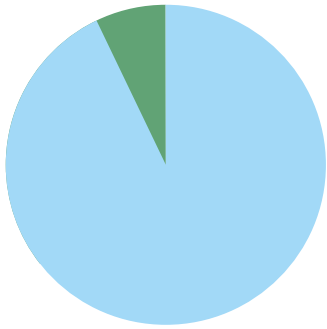


Table: 57

Reccomendations	Valid	Frequency	Percent	Valid Percent	Cumulative Percent
Fertility staff should provide preparatory information about medical procedures because it decreases infertility-specific anxiety and stress	I believe that this is definitely valid in the Indian context and my practice	25	89.3	89.3	89.3
	I believe that this is possibly valid in the Indian context and my practice	3	10.7	10.7	100.0
	Total	28	100	100	

Chart: 57

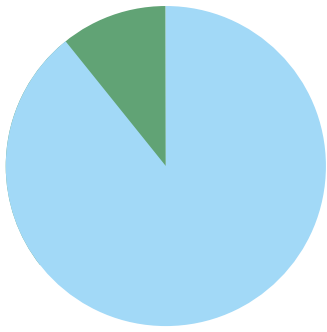


Table: 58

Reccomendations	Valid	Frequency	Percent	Valid Percent	Cumulative Percent
The guideline development group recommends that fertility staff refer patients identified by the SCREEN IVF as being at risk of emotional problems to specialized psychosocial care (infertility counselling or psychotherapy)	I believe that this is definitely valid in the Indian context and my practice	22	78.6	78.6	78.6
	I believe that this is possibly valid in the Indian context and my practice	3	17.9	17.9	96.4
	I believe that this is not valid in the Indian context and my practice	1	3.6	3.6	100.0
	Total	28	100	100	

Chart: 58

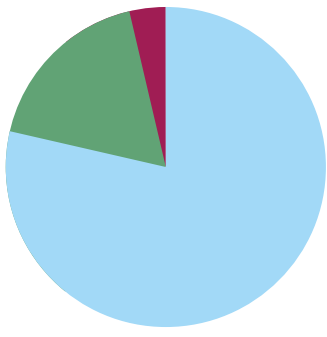


Table: 59

Reccomendations	Valid	Frequency	Percent	Valid Percent	Cumulative Percent
The guideline development group recommends that fertility staff actively involve both partners of the couple in the diagnosis and treatment process.	I believe that this is definitely valid in the Indian context and my practice	26	92.9	92.9	92.9
	I believe that this is possibly valid in the Indian context and my practice	2	7.1	7.1	100.0
	Total	28	100	100	

Chart: 59

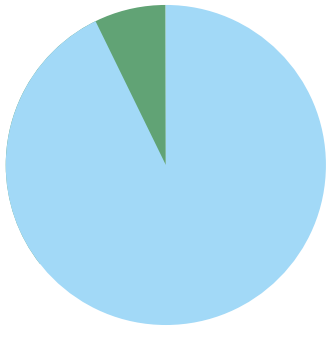


Table: 60

Reccomendations	Valid	Frequency	Percent	Valid Percent	Cumulative Percent
Fertility staff should be aware that around 1 in 12 patients and 1 in 5 patients do not comply with first-line and ART treatment, respectively	I believe that this is definitely valid in the Indian context and my practice	17	60.7	60.7	60.7
	I believe that this is possibly valid in the Indian context and my practice	9	32.1	32.1	92.9
	I believe that this is not valid in the Indian context and my practice	2	7.1	7.1	100.0
	Total	28	100	100	

Chart: 60

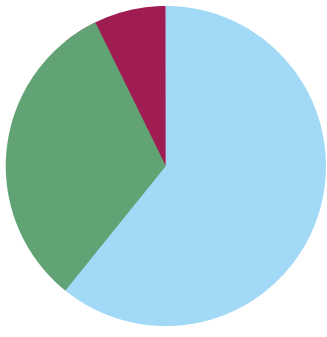


Table: 61

Reccomendations	Valid	Frequency	Percent	Valid Percent	Cumulative Percent
Fertility staff should be aware that the reasons patients state for discontinuing recommended first-line treatment are: postponement of treatment (i.e., stopping treatment for at least 1 year) logistics and practical reasons rejection of treatment perception of poor prognosis psychological burden of treatment	I believe that this is definitely valid in the Indian context and my practice	18	64.3	64.3	64.3
	I believe that this is possibly valid in the Indian context and my practice	9	32.1	32.1	96.9
	I believe that this is not valid in the Indian context and my practice	2	3.6	3.6	100.0
	Total	28	100	100	

Chart: 61

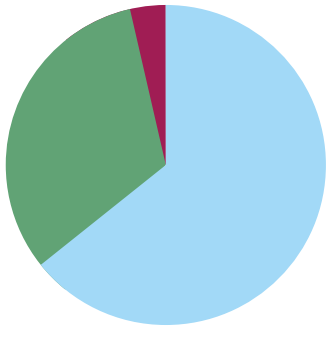


Table: 62

Reccomendations	Valid	Frequency	Percent	Valid Percent	Cumulative Percent
Fertility staff should be aware that the reasons patients state for discontinuing recommended treatment after one failed IVF/ICSI cycle are: financial issues the psychological and physical burdens of treatment clinic-related reasons and organizational problems postponement of treatment (or unknown) relational problems	I believe that this is definitely valid in the Indian context and my practice	20	71.4	71.4	71.4
	I believe that this is possibly valid in the Indian context and my practice	7	25.0	25.0	96.4
	I believe that this is not valid in the Indian context and my practice	1	3.6	3.6	100.0
	Total	28	100	100	

Chart: 62

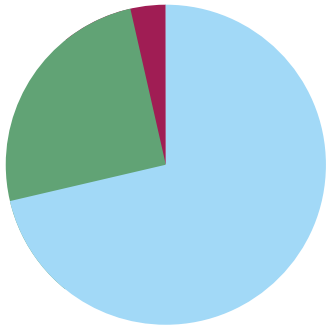


Table: 63

Reccomendations	Valid	Frequency	Percent	Valid Percent	Cumulative Percent
Fertility staff should be aware that the reasons patients state for discontinuing a recommended standard ART treatment programme of three consecutive cycles are: postponement of treatment psychological burden of treatment physical and psychological burdens of treatment personal problems	I believe that this is definitely valid in the Indian context and my practice	21	75.0	75.0	75.0
	I believe that this is possibly valid in the Indian context and my practice	6	21.4	21.4	96.4
	I believe that this is not valid in the Indian context and my practice	1	3.6	3.6	100.0
	Total	28	100	100	

Chart: 63

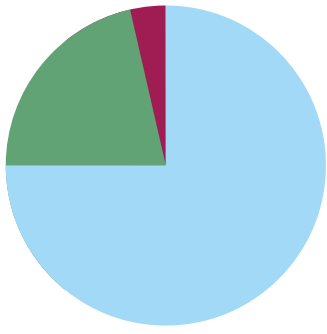


Table: 64

Reccomendations	Valid	Frequency	Percent	Valid Percent	Cumulative Percent
Fertility staff should be aware that the relational satisfaction of patients does not change from before they start an IVF/ICSI cycle to after the pregnancy test	I believe that this is definitely valid in the Indian context and my practice	10	35.7	35.7	35.7
	I believe that this is possibly valid in the Indian context and my practice	12	42.9	42.9	78.6
	I believe that this is not valid in the Indian context and my practice	6	21.4	21.4	100.0
	Total	28	100	100	

Chart: 64

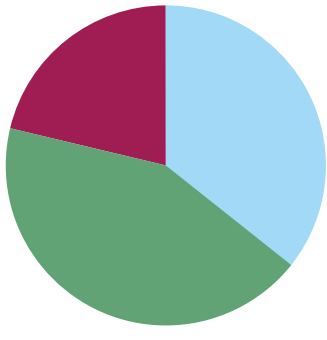


Table: 65

Reccomendations	Valid	Frequency	Percent	Valid Percent	Cumulative Percent
Fertility staff should be aware that women report more intimacy with their partner during an IVF/ICSI cycle than during a normal menstrual cycle, in particular at the retrieval and transfer days of the cycle	I believe that this is definitely valid in the Indian context and my practice	12	42.9	429	42.9
	I believe that this is possibly valid in the Indian context and my practice	10	35.7	35.7	78.6
	I believe that this is not valid in the Indian context and my practice	6	21.4	21.4	100.0
	Total	28	100	100	

Chart: 65

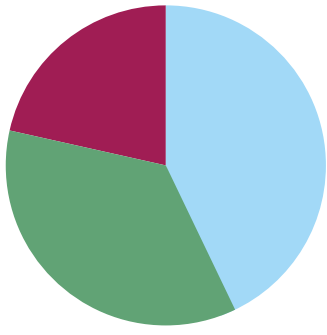


Table: 66

Reccomendations	Valid	Frequency	Percent	Valid Percent	Cumulative Percent
Fertility staff should be aware that women experience lower sexual satisfaction after the pregnancy test than before the start of an IVF/ICSI cycle	I believe that this is definitely valid in the Indian context and my practice	14	50.0	50.0	50.0
	I believe that this is possibly valid in the Indian context and my practice	12	42.9	42.9	92.9
	I believe that this is not valid in the Indian context and my practice	2	7.1	7.1	100.0
	Total	28	100	100	

Chart: 66

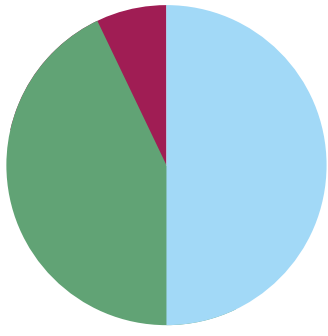


Table: 67

Reccomendations	Valid	Frequency	Percent	Valid Percent	Cumulative Percent
Fertility staff should be aware that women report lower social support from significant others in the period between the oocyte retrieval and the embryo transfer of an IVF/ICSI cycle than during the equivalent period in a normal menstrual cycle	I believe that this is definitely valid in the Indian context and my practice	12	42.9	42.9	42.9
	I believe that this is possibly valid in the Indian context and my practice	11	39.3	39.3	82.1
	I believe that this is not valid in the Indian context and my practice	5	17.9	17.9	100.0
	Total	28	100	100	

Chart: 67

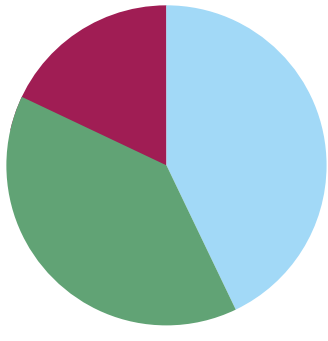


Table: 68

Reccomendations	Valid	Frequency	Percent	Valid Percent	Cumulative Percent
Fertility staff should be aware that during an IVF/ICSI cycle, 6 in 10 patients report treatment-related absences from work and, on average, patients miss 23 h of work	I believe that this is definitely valid in the Indian context and my practice	18	64.3	64.3	64.3
	I believe that this is possibly valid in the Indian context and my practice	8	28.6	28.6	92.9
	I believe that this is not valid in the Indian context and my practice	2	7.1	7.1	100.0
	Total	28	100	100	

Chart: 68

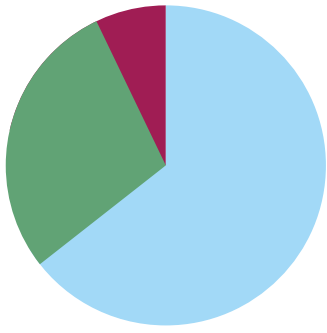


Table: 69

Reccomendations	Valid	Frequency	Percent	Valid Percent	Cumulative Percent
Fertility staff should be aware that patients' emotional stress fluctuates during an IVF/ICSI cycle, with peaks at the oocyte retrieval, the embryo transfer, and the waiting period before the pregnancy test	I believe that this is definitely valid in the Indian context and my practice	24	85.7	85.7	85.7
	I believe that this is possibly valid in the Indian context and my practice	4	14.3	14.3	100.0
	Total	28	100	100	

Chart: 69

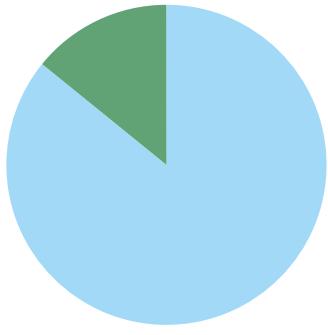


Table: 70

Reccomendations	Valid	Frequency	Percent	Valid Percent	Cumulative Percent
Fertility staff should be aware that women's positive affect decreases during an IVF/ICSI cycle	I believe that this is definitely valid in the Indian context and my practice	19	67.9	67.9	67.9
	I believe that this is possibly valid in the Indian context and my practice	8	28.6	28.6	96.4
	I believe that this is not valid in the Indian context and my practice	1	3.6	3.6	100.0
	Total	28	100	100	

Chart: 70

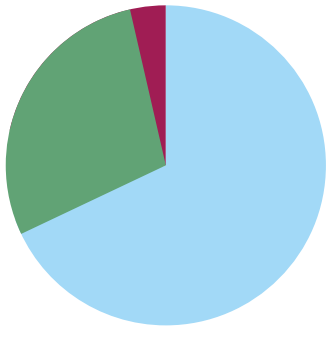


Table: 71

Reccomendations	Valid	Frequency	Percent	Valid Percent	Cumulative Percent
Fertility staff should be aware that anxiety and stress are higher when patients are anticipating results (e.g., in the waiting period before the pregnancy test, between oocyte retrieval and embryo transfer)	I believe that this is definitely valid in the Indian context and my practice	26	92.9	92.9	92.9
	I believe that this is possibly valid in the Indian context and my practice	2	7.1	7.1	100.0
	Total	28	100	100	

Chart: 71

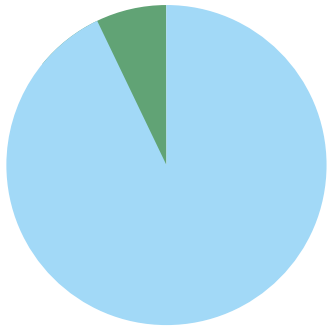


Table: 72

Reccomendations	Valid	Frequency	Percent	Valid Percent	Cumulative Percent
Fertility staff should be aware that patients experience high emotional distress when they are informed that the treatment was unsuccessful	I believe that this is definitely valid in the Indian context and my practice	27	96.4	96.4	96.4
	I believe that this is possibly valid in the Indian context and my practice	1	3.6	3.6	100.0
	Total	28	100	100	

Chart: 72

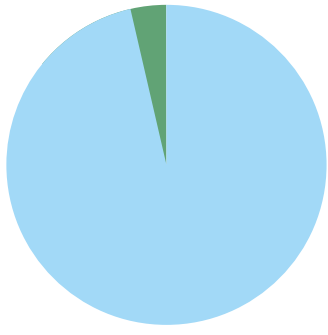


Table: 73

Reccomendations	Valid	Frequency	Percent	Valid Percent	Cumulative Percent
Fertility staff should be aware that, when they are informed that the treatment was unsuccessful, 1 to 2 in 10 women experience clinically significant levels of depressive symptoms	I believe that this is definitely valid in the Indian context and my practice	23	82.1	82.1	82.1
	I believe that this is possibly valid in the Indian context and my practice	5	17.9	17.9	100.0
	Total	28	100	100	

Chart: 73

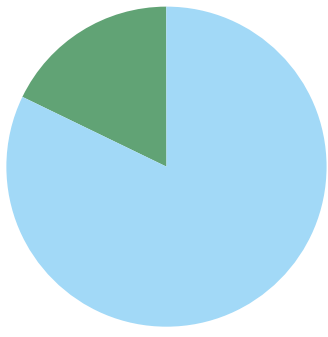


Table: 74

Reccomendations	Valid	Frequency	Percent	Valid Percent	Cumulative Percent
Fertility staff should be aware that after receiving the pregnancy test for their IVF/ICSI treatment, 1 in 4 women and 1 in 10 men have a depressive disorder. One in 7 women and 1 in 20 men have an anxiety disorder	I believe that this is definitely valid in the Indian context and my practice	20	71.4	71.4	71.4
	I believe that this is possibly valid in the Indian context and my practice	7	25.0	25.0	96.4
	I believe that this is not valid in the Indian context and my practice	1	3.6	3.6	100.0
	Total	28	100	100	

Chart: 74

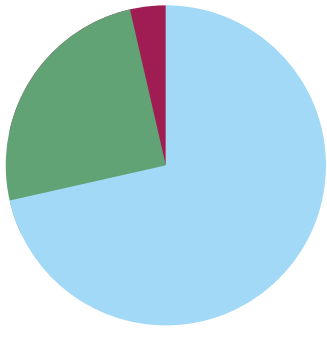


Table: 75

Reccomendations	Valid	Frequency	Percent	Valid Percent	Cumulative Percent
Fertility staff should be aware that patients report moderate to high concerns about achieving pregnancy with a healthy live birth, that do not decrease across treatment	I believe that this is definitely valid in the Indian context and my practice	18	64.3	64.3	64.3
	I believe that this is possibly valid in the Indian context and my practice	10	35.7	35.7	100.0
	Total	28	100	100	

Chart: 75

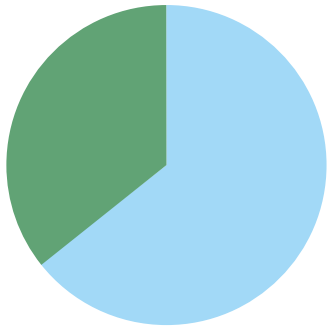


Table: 76

Reccomendations	Valid	Frequency	Percent	Valid Percent	Cumulative Percent
The guideline development group recommends that fertility staff use the tools recommended by ESHRE 2015 when assessing patients' needs.	I believe that this is definitely valid in the Indian context and my practice	13	46.4	46.4	46.4
	I believe that this is possibly valid in the Indian context and my practice	11	39.3	39.3	85.7
	I believe that this is not valid in the Indian context and my practice	4	14.3	14.3	100.0
	Total	28	100	100	

Chart: 76

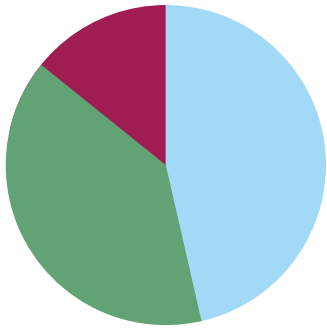


Table: 77

Reccomendations	Valid	Frequency	Percent	Valid Percent	Cumulative Percent
Fertility staff should be aware that currently there are no reliable tools or predictors to identify patients not likely to comply with recommended treatment	I believe that this is definitely valid in the Indian context and my practice	20	71.4	71.4	71.4
	I believe that this is possibly valid in the Indian context and my practice	6	21.4	21.4	92.9
	I believe that this is not valid in the Indian context and my practice	2	7.1	7.1	100.0
	Total	28	100	100	

Chart: 77

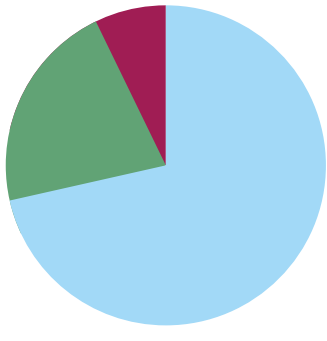


Table: 78

Reccomendations	Valid	Frequency	Percent	Valid Percent	Cumulative Percent
Fertility staff should be aware that at the start of ovarian stimulation, at oocyte retrieval, and after the pregnancy test, men report lower perceived support than women	I believe that this is definitely valid in the Indian context and my practice	16	57.1	57.1	57.1
	I believe that this is possibly valid in the Indian context and my practice	8	28.6	28.6	85.7
	I believe that this is not valid in the Indian context and my practice	4	14.3	14.3	100.0
	Total	28	100	100	

Chart: 78

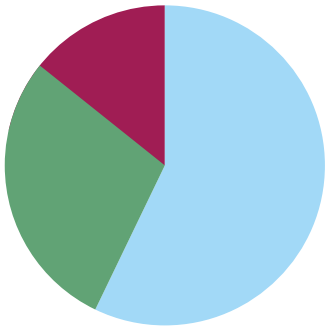


Table: 79

Reccomendations	Valid	Frequency	Percent	Valid Percent	Cumulative Percent
Fertility staff should be aware that men report higher social isolation than women during an IVF/ICSI treatment cycle	I believe that this is definitely valid in the Indian context and my practice	12	42.9	42.9	42.9
	I believe that this is possibly valid in the Indian context and my practice	6	21.4	21.4	64.3
	I believe that this is not valid in the Indian context and my practice	10	35.7	35.7	100.0
	Total	28	100	100	

Chart: 79

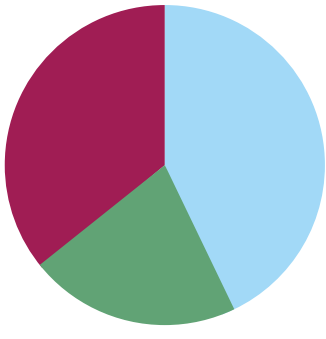


Table: 80

Reccomendations	Valid	Frequency	Percent	Valid Percent	Cumulative Percent
Fertility staff should be aware that patients with lower education level or with physical or emotional complaints due to IVF/ICSI may take more treatment-related hours off work	I believe that this is definitely valid in the Indian context and my practice	17	60.7	60.7	60.7
	I believe that this is possibly valid in the Indian context and my practice	7	25.0	25.0	85.7
	I believe that this is not valid in the Indian context and my practice	4	14.3	14.3	100.0
	Total	28	100	100	

Chart: 80

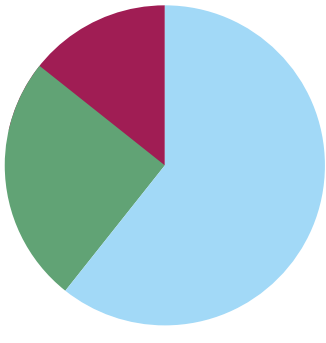


Table: 81

Reccomendations	Valid	Frequency	Percent	Valid Percent	Cumulative Percent
Fertility staff should be aware that women are more likely to experience anxiety, depression, stress, and/or psychiatric morbidity than men	I believe that this is definitely valid in the Indian context and my practice	23	82.1	82.1	82.1
	I believe that this is possibly valid in the Indian context and my practice	4	14.3	14.3	96.4
	I believe that this is not valid in the Indian context and my practice	1	3.6	3.6	100.0
	Total	28	100	100	

Chart: 81

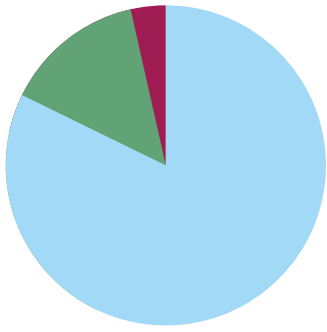


Table: 82

Reccomendations	Valid	Frequency	Percent	Valid Percent	Cumulative Percent
Fertility staff should be aware that the number of previous treatment cycles is not associated with depression, anxiety, or incidence of psychiatric disorders for men and women undergoing treatment	I believe that this is definitely valid in the Indian context and my practice	10	35.7	35.7	35.7
	I believe that this is possibly valid in the Indian context and my practice	4	14.3	14.3	50.0
	I believe that this is not valid in the Indian context and my practice	14	50.0	50.0	100.0
	Total	28	100	100	

Chart: 82

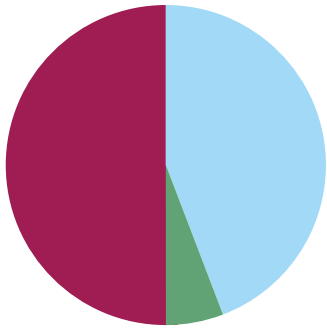


Table: 83

Reccomendations	Valid	Frequency	Percent	Valid Percent	Cumulative Percent
Fertility staff should be aware that patients undergoing mild stimulation IVF/ICSI (as opposed to standard stimulation) are more likely to experience negative emotional reactions at oocyte retrieval but less likely to experience these reactions during hormonal stimulation and after a treatment cycle cancellation or failure	I believe that this is definitely valid in the Indian context and my practice	12	42.9	42.9	42.9
	I believe that this is possibly valid in the Indian context and my practice	11	39.3	39.3	82.1
	I believe that this is not valid in the Indian context and my practice	5	17.9	17.9	100.0
	Total	28	100	100	

Chart: 83

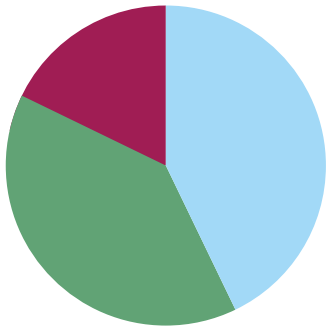


Table: 84

Reccomendations	Valid	Frequency	Percent	Valid Percent	Cumulative Percent
Fertility staff should be aware that patients with a previous history of vulnerability to mental health disorders are more likely to experience depression, anxiety, and/or psychiatric morbidity during treatment	I believe that this is definitely valid in the Indian context and my practice	25	89.3	89.3	89.3
	I believe that this is possibly valid in the Indian context and my practice	3	10.7	10.7	100.0
	Total	28	100	100	

Chart: 84

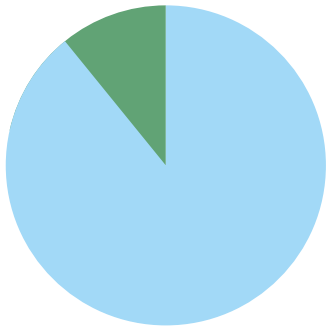


Table: 85

Reccomendations	Valid	Frequency	Percent	Valid Percent	Cumulative Percent
Fertility staff should be aware that the ways women deal with their fertility problems are associated with infertility-specific distress. The use of avoidant coping (e.g., avoiding being amongst pregnant women) is associated with higher infertility-specific distress. The use of emotional expressive coping (e.g., expressing feelings to significant others) is associated with lower infertility-specific distress	I believe that this is definitely valid in the Indian context and my practice	21	75.0	75.0	75.0
	I believe that this is possibly valid in the Indian context and my practice	3	10.7	10.7	85.7
	I believe that this is not valid in the Indian context and my practice	4	14.3	14.3	100.0
	Total	28	100	100	

Chart: 85

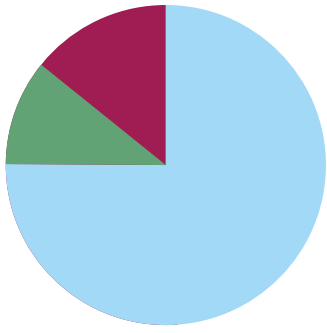


Table: 86

Reccomendations	Valid	Frequency	Percent	Valid Percent	Cumulative Percent
Fertility staff should be aware that patients with low acceptance of infertility and childlessness are more likely to experience anxiety and depression when they are informed that the treatment was unsuccessful	I believe that this is definitely valid in the Indian context and my practice	24	85.7	85.7	85.7
	I believe that this is possibly valid in the Indian context and my practice	2	7.1	7.1	92.9
	I believe that this is not valid in the Indian context and my practice	2	7.1	7.1	100.0
	Total	28	100	100	

Chart: 86

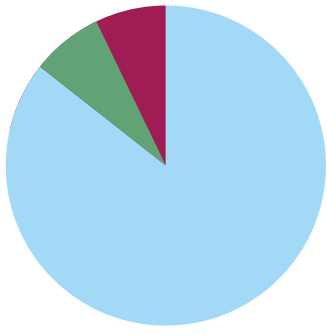


Table: 87

Reccomendations	Valid	Frequency	Percent	Valid Percent	Cumulative Percent
Fertility staff should be aware that patients who experience high helplessness regarding infertility and its treatment are more likely to experience anxiety and depression when they are informed that the treatment was unsuccessful	I believe that this is definitely valid in the Indian context and my practice	24	85.7	85.7	85.7
	I believe that this is possibly valid in the Indian context and my practice	3	10.7	10.7	96.4
	I believe that this is not valid in the Indian context and my practice	1	3.6	3.6	100.0
	Total	28	100	100	

Chart: 87

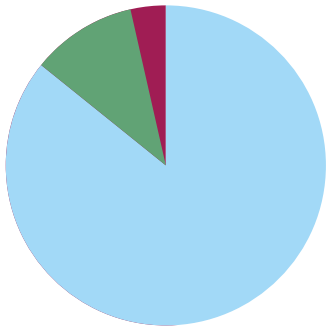


Table: 88

Reccomendations	Valid	Frequency	Percent	Valid Percent	Cumulative Percent
Fertility staff should be aware that in couples, the way one partner reacts to infertility and its treatment is associated with how the other partner reacts	I believe that this is definitely valid in the Indian context and my practice	19	67.9	67.9	67.9
	I believe that this is possibly valid in the Indian context and my practice	7	25.0	25.0	92.9
	I believe that this is not valid in the Indian context and my practice	2	7.1	7.1	100.0
	Total	28	100	100	

Chart: 88

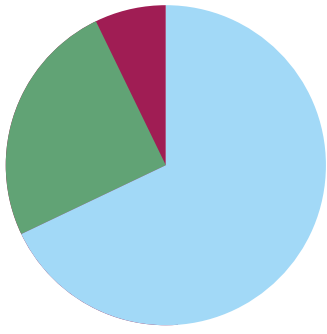


Table: 89

Reccomendations	Valid	Frequency	Percent	Valid Percent	Cumulative Percent
Fertility staff should be aware that currently there are no reliable methods or information about predictors of the concerns patients have about treatment	I believe that this is definitely valid in the Indian context and my practice	17	60.7	60.7	60.7
	I believe that this is possibly valid in the Indian context and my practice	9	32.1	32.1	32.1
	I believe that this is not valid in the Indian context and my practice	2	7.1	7.1	100.0
	Total	28	100	100	

Chart: 89

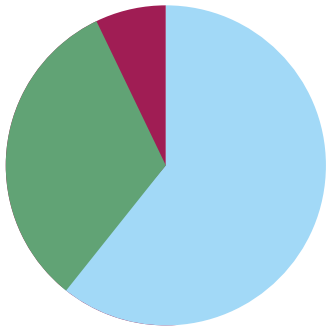


Table: 90

Reccomendations	Valid	Frequency	Percent	Valid Percent	Cumulative Percent
The guideline development group recommends that fertility staff refer patients at risk of experiencing clinically significant psychosocial problems to specialized psychosocial care (infertility counselling or psychotherapy)	I believe that this is definitely valid in the Indian context and my practice	23	82.1	82.1	82.1
	I believe that this is possibly valid in the Indian context and my practice	4	14.3	14.3	96.4
	I believe that this is not valid in the Indian context and my practice	1	3.6	3.6	100.0
	Total	28	100	100	

Chart: 90

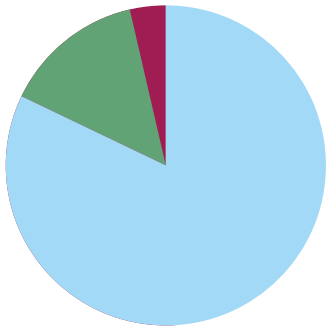


Table: 91

Reccomendations	Valid	Frequency	Percent	Valid Percent	Cumulative Percent
The guideline development group recommends that fertility staff offer patients the opportunity to discuss uptake or not of recommended treatment and receive decisional support to deliberate their choice.	I believe that this is definitely valid in the Indian context and my practice	22	78.6	78.6	78.6
	I believe that this is possibly valid in the Indian context and my practice	6	21.4	21.4	100.0
	Total	28	100	100	

Chart: 91

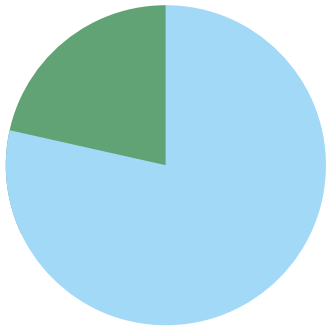


Table: 92

Reccomendations	Valid	Frequency	Percent	Valid Percent	Cumulative Percent
Fertility staff should be aware that offering the currently available interactive complex interventions* is not likely to improve patient interpersonal relationships or sexual concerns	I believe that this is definitely valid in the Indian context and my practice	14	50.0	50.0	50.0
	I believe that this is possibly valid in the Indian context and my practice	8	28.6	28.6	78.6
	I believe that this is not valid in the Indian context and my practice	6	21.4	21.4	100.0
	Total	28	100	100	

Chart: 92

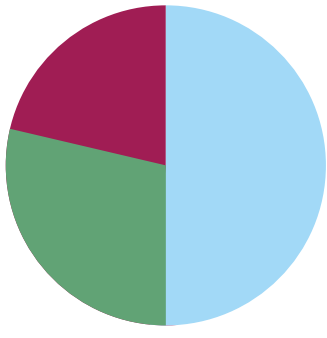


Table: 93

Reccomendations	Valid	Frequency	Percent	Valid Percent	Cumulative Percent
Fertility staff should be aware that providing IVF/ICSI-patients with access to an internet-based personal health record is not likely to improve their social support	I believe that this is definitely valid in the Indian context and my practice	15	53.6	53.6	53.6
	I believe that this is possibly valid in the Indian context and my practice	9	32.1	32.1	85.7
	I believe that this is not valid in the Indian context and my practice	4	14.3	14.3	100.0
	Total	28	100	100	

Chart: 93

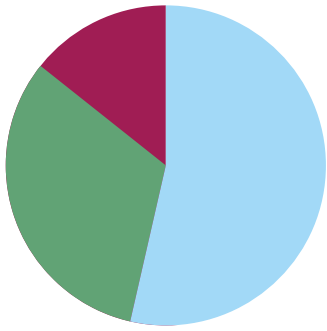


Table: 94

Reccomendations	Valid	Frequency	Percent	Valid Percent	Cumulative Percent
The guideline development group recommends that fertility staff offer additional psychosocial care to patients with specific characteristics associated with social isolation or absence from work.	I believe that this is definitely valid in the Indian context and my practice	21	75.0	75.0	75.0
	I believe that this is possibly valid in the Indian context and my practice	5	17.9	17.9	92.9
	I believe that this is not valid in the Indian context and my practice	2	7.1	7.1	100.0
	Total	28	100	100	

Chart: 94

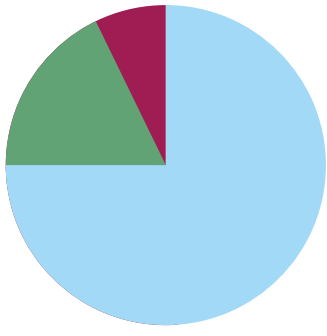


Table: 95

Reccomendations	Valid	Frequency	Percent	Valid Percent	Cumulative Percent
The guideline development group recommends that fertility staff actively involve both partners of the couple in the treatment process.	I believe that this is definitely valid in the Indian context and my practice	27	96.4	96.4	50.0
	I believe that this is possibly valid in the Indian context and my practice	1	3.6	3.6	100.0
	Total	28	100	100	

Chart: 95

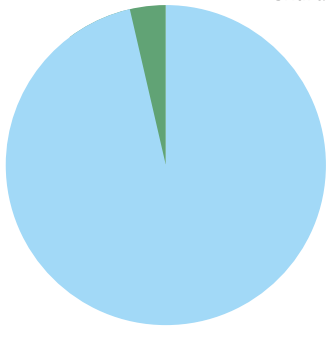


Table: 96

Reccomendations	Valid	Frequency	Percent	Valid Percent	Cumulative Percent
Fertility staff should be aware that offering the currently available complex interventions* is not likely to improve patients' depression levels	I believe that this is definitely valid in the Indian context and my practice	16	57.1	57.1	57.1
	I believe that this is possibly valid in the Indian context and my practice	7	25.0	25.0	82.1
	I believe that this is not valid in the Indian context and my practice	5	17.9	17.9	100.0
	Total	28	100	100	

Chart: 96

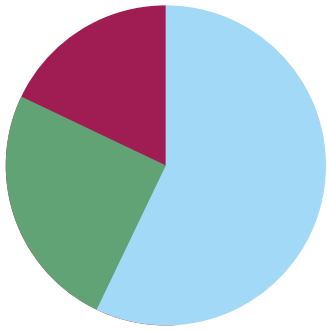


Table: 97

Reccomendations	Valid	Frequency	Percent	Valid Percent	Cumulative Percent
Fertility staff should be aware that providing IVF/ICSI-patients with access to an internet-based personal health record is not likely to improve their emotional well-being (anxiety, depression, and self-efficacy)	I believe that this is definitely valid in the Indian context and my practice	17	60.7	60.7	60.7
	I believe that this is possibly valid in the Indian context and my practice	7	25.0	25.0	85.7
	I believe that this is not valid in the Indian context and my practice	4	14.3	14.3	100.0
	Total	28	100	100	

Chart: 97

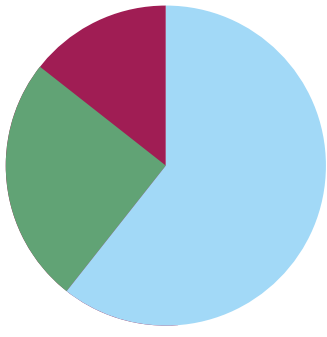


Table: 98

Reccomendations	Valid	Frequency	Percent	Valid Percent	Cumulative Percent
The guideline development group recommends that fertility staff offer additional psychosocial care to patients with specific characteristics associated with negative emotional reactions.	I believe that this is definitely valid in the Indian context and my practice	21	75.0	75.0	75.0
	I believe that this is possibly valid in the Indian context and my practice	5	17.9	17.9	92.9
	I believe that this is not valid in the Indian context and my practice	2	7.1	7.1	100.0
	Total	28	100	100	

Chart: 98

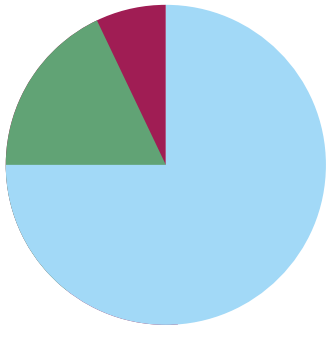


Table: 99

Reccomendations	Valid	Frequency	Percent	Valid Percent	Cumulative Percent
Fertility staff should be aware that providing IVF/ICSI-patients with access to an internet-based personal health record is not likely to increase their knowledge about infertility and its treatment	I believe that this is definitely valid in the Indian context and my practice	14	50.0	50.0	50.0
	I believe that this is possibly valid in the Indian context and my practice	8	28.6	28.6	78.6
	I believe that this is not valid in the Indian context and my practice	6	21.4	21.4	100.0
	Total	28	100	100	

Chart: 99

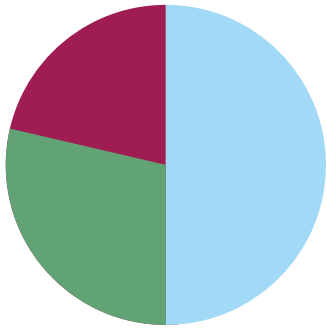


Table: 100

Reccomendations	Valid	Frequency	Percent	Valid Percent	Cumulative Percent
The guideline development group recommends that fertility staff offer patients the opportunity to discuss and clarify their treatment related concerns.	I believe that this is definitely valid in the Indian context and my practice	26	92.9	92.9	92.9
	I believe that this is possibly valid in the Indian context and my practice	1	3.6	3.6	96.4
	I believe that this is not valid in the Indian context and my practice	1	3.6	3.6	100.0
	Total	28	100	100	

Chart: 100

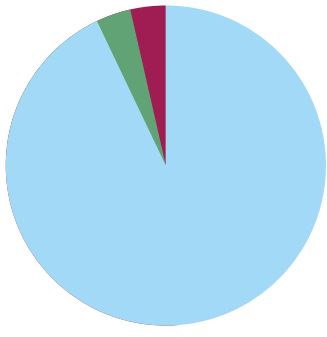


Table: 101

Reccomendations	Valid	Frequency	Percent	Valid Percent	Cumulative Percent
Fertility staff should be aware that about 2 years after unsuccessful IVF/ICSI treatment patients are generally satisfied with their marital relationship	I believe that this is definitely valid in the Indian context and my practice	12	42.9	42.9	42.9
	I believe that this is possibly valid in the Indian context and my practice	7	25.0	25.0	67.9
	I believe that this is not valid in the Indian context and my practice	9	32.1	32.1	100.0
	Total	28	100	100	

Chart: 101

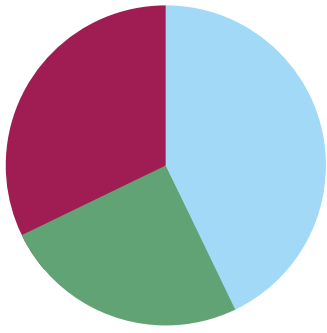


Table: 102

Reccomendations	Valid	Frequency	Percent	Valid Percent	Cumulative Percent
Fertility staff should be aware that women who achieve pregnancy with fertility treatment practice lifestyle behaviours that are similar to women who conceive spontaneously	I believe that this is definitely valid in the Indian context and my practice	14	50.0	50.0	50.0
	I believe that this is possibly valid in the Indian context and my practice	8	28.6	28.6	78.6
	I believe that this is not valid in the Indian context and my practice	6	21.4	21.4	100.0
	Total	28	100	100	

Chart: 102

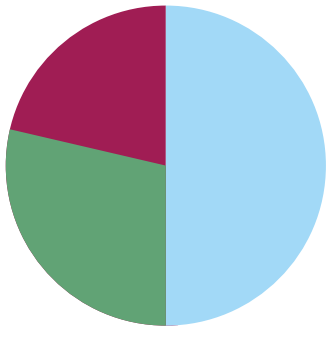


Table: 103

Reccomendations	Valid	Frequency	Percent	Valid Percent	Cumulative Percent
Fertility staff should be aware that the way patients relate to their foetus is similar whether the foetus is conceived with ART treatment or spontaneously	I believe that this is definitely valid in the Indian context and my practice	21	75.0	75.0	75.0
	I believe that this is possibly valid in the Indian context and my practice	3	10.7	10.7	85.7
	I believe that this is not valid in the Indian context and my practice	4	14.3	14.3	100.0
	Total	28	100	100	

Chart: 103

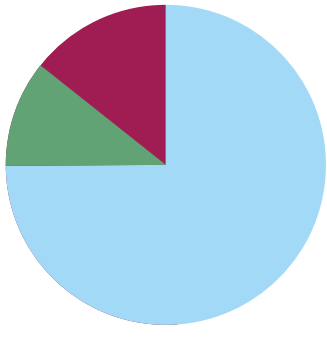


Table: 104

Reccomendations	Valid	Frequency	Percent	Valid Percent	Cumulative Percent
Fertility staff should be aware that women who conceived with IVF/ICSI do not experience more symptoms of depression, worse self esteem or worse mental health during pregnancy than women who conceive spontaneously	I believe that this is definitely valid in the Indian context and my practice	14	50.0	50.0	50.0
	I believe that this is possibly valid in the Indian context and my practice	5	17.9	17.9	67.9
	I believe that this is not valid in the Indian context and my practice	9	32.1	32.1	100.0
	Total	28	100	100	

Chart: 104

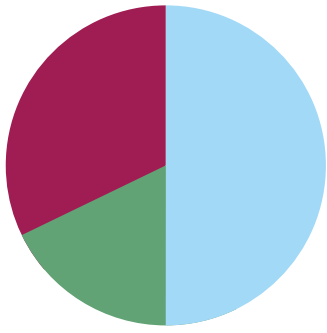


Table: 105

Reccomendations	Valid	Frequency	Percent	Valid Percent	Cumulative Percent
Fertility staff should be aware that women who conceived with IVF/ICSI may experience more pregnancy-specific anxiety than women who conceived spontaneously	I believe that this is definitely valid in the Indian context and my practice	22	78.6	78.6	78.6
	I believe that this is possibly valid in the Indian context and my practice	6	21.4	21.4	100.0
	Total	28	100	100	

Chart: 105

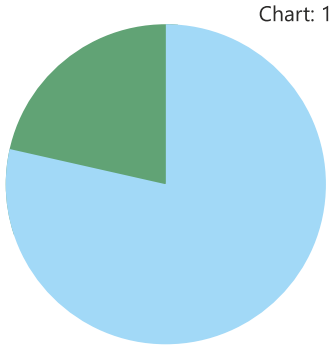


Table: 106

Reccomendations	Valid	Frequency	Percent	Valid Percent	Cumulative Percent
Fertility staff should be aware that women with multiple pregnancies after IVF/ICSI may have higher maternal expectations than women with spontaneous multiple pregnancies	I believe that this is definitely valid in the Indian context and my practice	20	71.4	71.4	71.4
	I believe that this is possibly valid in the Indian context and my practice	7	25.0	25.0	96.4
	I believe that this is not valid in the Indian context and my practice	1	3.6	3.6	100.0
	Total	28	100	100	

Chart: 106

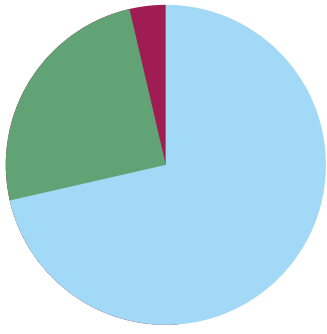


Table: 107

Reccomendations	Valid	Frequency	Percent	Valid Percent	Cumulative Percent
Fertility staff should be aware that women who conceived with IVF/ICSI do not experience more symptoms of depression, worse self esteem or worse mental health during pregnancy than women who conceive spontaneously	I believe that this is definitely valid in the Indian context and my practice	14	50.0	50.0	50.0
	I believe that this is possibly valid in the Indian context and my practice	5	17.9	17.9	67.9
	I believe that this is not valid in the Indian context and my practice	9	32.1	32.1	100.0
	Total	28	100	100	

Chart: 107

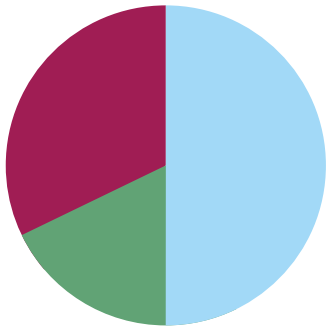


Table: 108

Reccomendations	Valid	Frequency	Percent	Valid Percent	Cumulative Percent
Fertility staff should be aware that women who conceived with IVF/ICSI may experience more pregnancy-specific anxiety than women who conceived spontaneously	I believe that this is definitely valid in the Indian context and my practice	22	78.6	78.6	78.6
	I believe that this is possibly valid in the Indian context and my practice	6	21.4	21.4	100.0
	Total	28	100	100	

Chart: 108

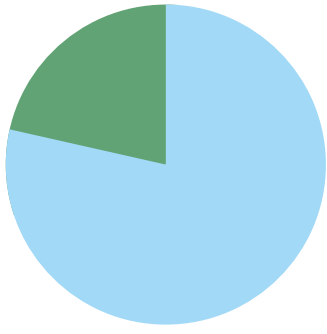


Table: 109

Reccomendations	Valid	Frequency	Percent	Valid Percent	Cumulative Percent
Fertility staff should be aware that women with multiple pregnancies after IVF/ICSI may have higher maternal expectations than women with spontaneous multiple pregnancies	I believe that this is definitely valid in the Indian context and my practice	20	71.4	71.4	71.4
	I believe that this is possibly valid in the Indian context and my practice	7	25.0	25.0	96.4
	I believe that this is not valid in the Indian context and my practice	1	3.6	3.6	100.0
	Total	28	100	100	

Chart: 109

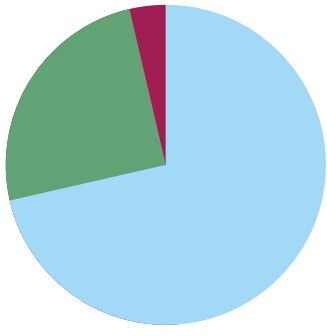


Table: 110

Reccomendations	Valid	Frequency	Percent	Valid Percent	Cumulative Percent
Fertility staff should be aware that former patients who remain childless 5 years after unsuccessful IVF/ICSI treatment may use more sleeping pills, smoke more often, and consume more alcohol than former patients that become parents via adoption, or spontaneously	I believe that this is definitely valid in the Indian context and my practice	17	60.7	607	60.7
	I believe that this is possibly valid in the Indian context and my practice	6	21.4	21.4	82.1
	I believe that this is not valid in the Indian context and my practice	5	17.9	17.9	100.0
	Total	28	100	100	

Chart: 110

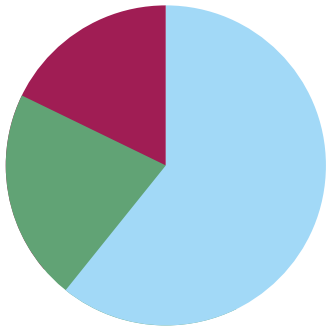


Table: 111

Reccomendations	Valid	Frequency	Percent	Valid Percent	Cumulative Percent
Fertility staff should be aware that former patients that remain childless 5 years after unsuccessful IVF/ICSI treatment are three times more likely to separate than former patients that become parents via adoption, or spontaneously	I believe that this is definitely valid in the Indian context and my practice	16	57.1	57.1	57.1
	I believe that this is possibly valid in the Indian context and my practice	10	35.7	35.7	92.9
	I believe that this is not valid in the Indian context and my practice	2	7.1	7.1	100.0
	Total	28	100	100	

Chart: 111

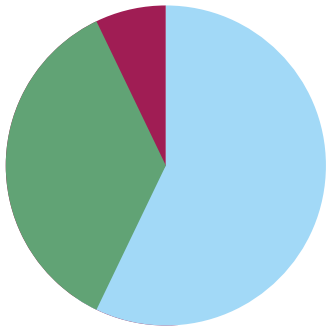


Table: 112

Reccomendations	Valid	Frequency	Percent	Valid Percent	Cumulative Percent
Fertility staff should be aware that women who remain childless 10 years after unsuccessful IVF/ICSI treatment are not more likely to develop psychiatric disorders than women of the same age who never underwent fertility treatment	I believe that this is definitely valid in the Indian context and my practice	15	53.6	53.6	53.6
	I believe that this is possibly valid in the Indian context and my practice	8	28.6	28.6	82.1
	I believe that this is not valid in the Indian context and my practice	5	17.9	17.9	100.0
	Total	28	100	100	

Chart: 112

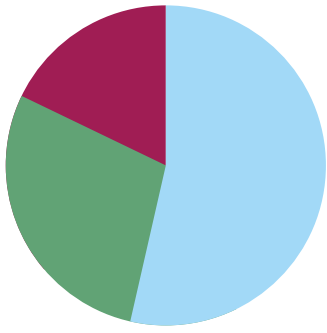


Table: 113

Reccomendations	Valid	Frequency	Percent	Valid Percent	Cumulative Percent
Fertility staff should be aware that women with a persistent desire for pregnancy 3 to 5 years after unsuccessful treatment may experience more anxiety and depression than women who find new life goals or women who become mothers	I believe that this is definitely valid in the Indian context and my practice	23	82.1	82.1	82.1
	I believe that this is possibly valid in the Indian context and my practice	5	17.9	17.9	100.0
	Total	28	100	100	

Chart: 113

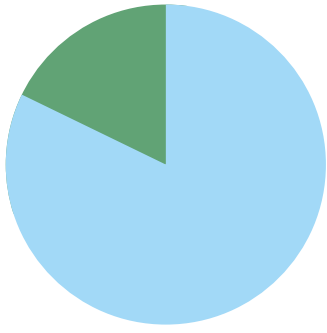


Table: 114

Reccomendations	Valid	Frequency	Percent	Valid Percent	Cumulative Percent
Fertility staff should be aware that women who experienced multiple failed ART cycles or high stress during treatment may be more likely to experience symptoms of anxiety during pregnancy	I believe that this is definitely valid in the Indian context and my practice	20	71.4	71.4	71.4
	I believe that this is possibly valid in the Indian context and my practice	8	28.6	28.6	100.0
	Total	28	100	100	

Chart: 114

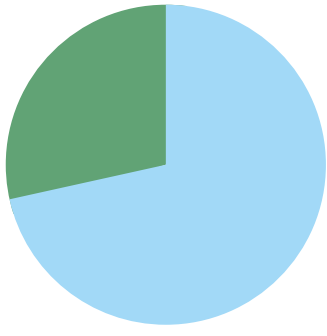


Table: 115

Reccomendations	Valid	Frequency	Percent	Valid Percent	Cumulative Percent
Fertility staff should be aware that patients with multiple pregnancies after ART are not more likely to experience poorer mental health than patients with a single ART pregnancy	I believe that this is definitely valid in the Indian context and my practice	18	64.3	64.3	64.3
	I believe that this is possibly valid in the Indian context and my practice	6	21.4	21.4	21.4
	I believe that this is not valid in the Indian context and my practice	4	14.3	14.3	100.0
	Total	28	100	100	

Chart: 115

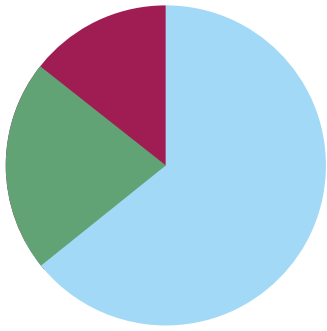


Table: 116

Reccomendations	Valid	Frequency	Percent	Valid Percent	Cumulative Percent
The guideline development group recommends that fertility staff refer patients who, when ending unsuccessful treatment, experience or are at risk of experiencing (in the short or the long term) clinically significant psychosocial problems, to specialized psychosocial care (infertility counselling or psychotherapy).	I believe that this is definitely valid in the Indian context and my practice	24	85.7	85.7	85.7
	I believe that this is possibly valid in the Indian context and my practice	4	14.3	14.3	100.0
	Total	28	100	100	

Chart: 116

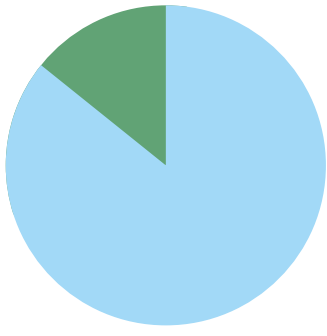


Table: 117

Reccomendations	Valid	Frequency	Percent	Valid Percent	Cumulative Percent
The guideline development group recommends that fertility staff offer patients the opportunity to discuss the implications of ending unsuccessful treatment	I believe that this is definitely valid in the Indian context and my practice	24	85.7	85.7	85.7
	I believe that this is possibly valid in the Indian context and my practice	4	14.3	14.3	100.0
	Total	28	100	100	

Chart: 117

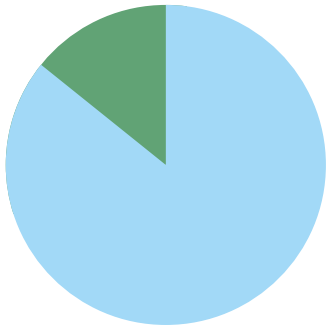


Table: 118

Reccomendations	Valid	Frequency	Percent	Valid Percent	Cumulative Percent
The guideline development group recommends that fertility staff refer patients who experience or are at risk of experiencing clinically significant psychosocial problems after successful treatment, to specialized psychosocial care (infertility counselling or psychotherapy)	I believe that this is definitely valid in the Indian context and my practice	22	78.6	78.6	78.6
	I believe that this is possibly valid in the Indian context and my practice	5	17.9	17.9	96.4
	I believe that this is not valid in the Indian context and my practice	1	3.6	3.6	100.0
	Total	28	100	100	

Chart: 118

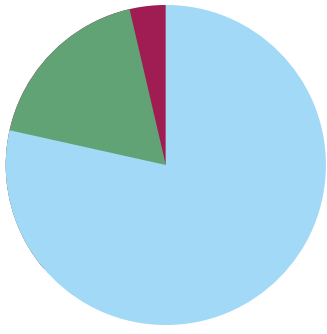


Table: 119

Reccomendations	Valid	Frequency	Percent	Valid Percent	Cumulative Percent
The guideline development group recommends that fertility staff offer additional psychosocial care to patients at risk of increased infertility-specific psychosocial distress after successful treatment.	I believe that this is definitely valid in the Indian context and my practice	19	67.9	67.9	67.9
	I believe that this is possibly valid in the Indian context and my practice	8	28.6	28.6	96.4
	I believe that this is not valid in the Indian context and my practice	1	3.6	3.6	100.0
	Total	28	100	100	

Chart: 119

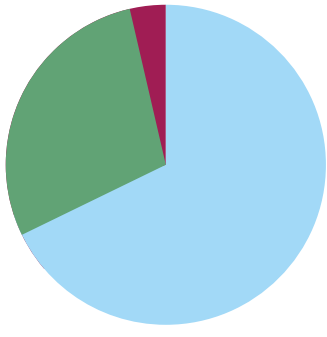
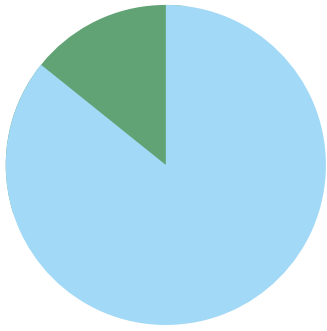


Table: 120

Reccomendations	Valid	Frequency	Percent	Valid Percent	Cumulative Percent
The guideline development group recommends that fertility staff offer patients the opportunity to discuss their worries about pregnancy achieved with fertility treatment.	I believe that this is definitely valid in the Indian context and my practice	24	85.7	85.7	85.7
	I believe that this is possibly valid in the Indian context and my practice	4	14.3	14.3	100.0
	Total	28	100	100	

Chart: 120



Annexure 2

Abbreviations

- ART Assisted Reproductive Technology
- BAI Beck Anxiety Inventory
- BDI Beck Depression Inventory
- BMI Body Mass Index
- BREC Behavioural, Relational and Social, Emotional and Cognitive
- BSI Brief Symptom Inventory
- CES-D Centre for Epidemiologic Studies Depression Scale
- CI Confidence Interval
- COMPI Copenhagen Multi-Centre Psychosocial Infertility
- DAS Dyadic Adjustment Scale
- DSM Diagnostic and Statistical Manual of Mental Disorders
- FPI Fertility Problem Inventory
- GDG Guideline Development Group
- GRIS Golombok–Rust Inventory of Sexual Satisfaction
- HADS Hospital Anxiety and Depression Scale
- ICSI Intracytoplasmic Sperm Injection
- IUI Intrauterine Insemination
- IVF in Vitro Fertilization
- MAR Medically Assisted Reproduction
- MHP Mental Health Professionals
- OI Ovulation Induction
- OR Odds Ratio
- OS Ovarian Stimulation
- PCC Patient-Centred Care
- PDQ-R Personality Disorders Questionnaire
- PGD Preimplantation Genetic Diagnosis
- PGI HQ Post Graduate Institute Health Questionnaire N2
- PGI GWB Post Graduate Institute General Well Being Scale
- PRCI Positive Reappraisal Coping Intervention
- PSS Perceived Stress Scale
- QoL Quality of Life
- RCT Randomized Controlled Trial
- SCL-90 Symptom Checklist
- SD Standard Deviation
- SE Standard Error
- IIEF International Index of Erectile Function
- FSFI Female Sexual Function Index
- ED Erectile Dysfunction
- FSD Female Sexual Dysfunction
- PE Premature Ejaculation

Annexure 3

Glossary

1. **Acceptance:** Acknowledging infertility, finding meaning in the experience, and redirecting efforts towards new life aspirations.
2. **Adoption:** The legal process of taking another's child into one's family as one's own.
3. **Affective Symptoms:** Emotional symptoms such as sadness, anger, or irritability related to infertility.
4. **Anxiety:** A mental health condition characterized by excessive worry, often seen in individuals undergoing fertility treatments.
5. **Anonymity:** The state of being anonymous, often relevant in the context of anonymous sperm or egg donation.
6. **Anonymity of Donor:** Ensuring the donor's identity is not disclosed to the recipient.
7. **ART (Assisted Reproductive Technology):** Medical procedures used to address infertility, including IVF and ICSI.
8. **ART Clinics:** Facilities specialized in offering assisted reproductive technologies.
9. **ART Consultations:** Initial and ongoing discussions between patients and fertility specialists about ART options.
10. **Attendant:** A person present to assist during medical procedures, often nurses or support staff in ART clinics.
11. **Arousal:** The physiological and psychological state of being awoken or alert, which can be affected by fertility treatments.
12. **Avoidance:** A coping mechanism where individuals evade dealing with infertility-related stressors.
13. **Azoospermia:** The absence of sperm in ejaculate, leading to male infertility.
14. **Behavioral Needs:** Specific actions required to support individuals undergoing infertility treatments.
15. **Benefits:** Positive outcomes or advantages, such as increased chance of pregnancy through ART.
16. **Breaking Bad News:** The process of informing patients about unfavorable medical outcomes, such as infertility.
17. **Burden:** The heavy emotional, physical, or financial load carried by individuals facing infertility.
18. **Children's Adjustment:** The process by which children adapt to family changes, such as the inclusion of adopted siblings due to infertility.
19. **Clinic Factors:** Issues in fertility clinics that impede effective treatment.
20. **Clinically Significant Distress:** A level of psychological stress that warrants clinical attention, often seen in individuals dealing with infertility.

21. **Clinician:** A healthcare professional involved in diagnosing and treating infertility.
22. **Client-Centered Care:** A healthcare approach focusing on the needs and preferences of the patient.
23. **Cognitive and Emotional Representations:** Mental and emotional perceptions related to infertility.
24. **Cognitive Needs:** The need for information and understanding about infertility and its treatments.
25. **Commitment Theory:** The concept that individuals' commitment to a goal affects their behavior and coping mechanisms.
26. **Comprehensive Care:** A holistic approach to treating infertility, addressing medical, emotional, and psychological needs.
27. **Concomitant Medical Conditions:** Other health issues that may affect or be affected by infertility treatments.
28. **Consensus Statements:** Agreements among experts on best practices for treating infertility.
29. **Continuous Care:** Ongoing support and treatment for individuals undergoing infertility treatments.
30. **Context-Specific Measures:** Assessment tools tailored to the specific context of infertility treatment.
31. **Continuity of Care:** Ensuring consistent and coordinated care throughout infertility treatment.
32. **Coping Methods:** Techniques used to manage stress related to infertility.
33. **Coping Skills:** Specific abilities that help individuals handle infertility-related stress.
34. **Coping Strategies:** Plans or actions taken to manage infertility stress.
35. **Couple's Relationship:** The dynamics between partners dealing with infertility.
36. **Counseling Services:** Professional support provided to individuals and couples dealing with infertility.
37. **Counseling Work:** The tasks and processes involved in providing support to those facing infertility.
38. **Counselling:** The professional guidance offered to support individuals or couples dealing with infertility.
39. **Cultural Concerns:** Issues related to cultural beliefs and practices that affect infertility treatment.
40. **Cultural Norms:** Shared expectations and rules that guide behavior within a cultural group, impacting views on infertility.
41. **Decision Making:** The process of making choices about infertility treatments.
42. **Decisional Conflict:** The state of uncertainty about which course of action to take regarding infertility treatment.
43. **Decisional Regret:** The distress or remorse experienced after making a decision regarding fertility treatment.

44. **Denial of Pregnancy:** The psychological state where a woman is unaware of or denies her pregnancy.
45. **Depression:** A mental health disorder characterized by persistent sadness and loss of interest, common among those facing infertility.
46. **Depression, Hopelessness, Distress, Emotional Stress:** These are interrelated psychological conditions frequently observed in individuals undergoing infertility treatment.
47. **Desire:** The strong feeling of wanting to have a child, often a central motivator in infertility treatments.
48. **Diagnostic Procedures:** Medical tests and assessments used to determine the cause of infertility.
49. **Diagnostic Protocols:** Established procedures for diagnosing infertility.
50. **Diagnosis:** The identification of the cause of infertility through medical assessment.
51. **Diagnosis and Treatment:** The process of identifying a medical condition (such as infertility) from its signs and symptoms, and the subsequent care and management of the condition.
52. **Disclosure:** The action of making new or secret information known; revealing something previously unknown.
53. **Direct Communication:** Communication that is clear, straightforward, and unambiguous.
54. **Distress Screening:** The process of assessing and identifying psychological distress in individuals.
55. **Distressing Psychologic Symptoms:** Severe emotional reactions or symptoms related to mental health.
56. **Donor Oocyte Recipient:** An individual who receives a donated egg for fertility treatment.
57. **Drop-Out Rates:** The proportion of participants who withdraw or discontinue a course of treatment or study.
58. **Dropout:** A person who withdraws or discontinues participation in a course of treatment or study.
59. **Duration of Infertility:** The length of time a couple has been unable to conceive despite regular unprotected sexual intercourse.
60. **Dyadic Adjustment Scale (DAS):** A scale used to measure the quality of relationships between two partners.
61. **Dyadic Coping:** The mutual support and strategies used by couples to manage stress together.
62. **Dyadic Relationship:** The relationship or interaction between two individuals, especially within a romantic or familial context.
63. **Dyspareunia:** Painful sexual intercourse, typically due to medical or psychological causes.
64. **Egg Donors:** Individuals who donate eggs for use in assisted reproduction or fertility treatments.
65. **Elevated Depression Levels:** Higher than normal rates of depression symptoms or severity.

66. **Emotional Bonding:** The process of forming a close emotional connection with another person.
67. **Emotional Care:** The provision of support and assistance to address emotional needs or concerns.
68. **Emotional Crisis:** A period of intense emotional difficulty or instability.
69. **Emotional Distress:** Extreme emotional suffering or anguish.
70. **Emotional Needs:** Psychological or emotional requirements for well-being.
71. **Emotional Problems:** Psychological issues or difficulties affecting emotions or mood.
72. **Emotional Reactions to Infertility Treatment:** Responses or feelings experienced during fertility treatment.
73. **Emotional Representations:** Mental or cognitive perceptions and interpretations of emotional experiences.
74. **Emotional Rollercoaster:** A situation or experience involving extreme and unpredictable changes in emotions.
75. **Emotional Support:** Help or assistance provided to someone experiencing emotional difficulties.
76. **Empathy:** The ability to understand and share the feelings of another person.
77. **Embryo Transfer:** The procedure of placing an embryo into a woman's uterus during assisted reproduction.
78. **Embryologists:** Specialists involved in the study and manipulation of embryos in fertility treatments.
79. **Empathy:** The ability to understand and share the feelings of another.
80. **ESHRE:** The European Society of Human Reproduction and Embryology, an organization focusing on reproductive medicine.
81. **Evidence:** The available body of facts or information indicating whether a belief or proposition is true or valid.
82. **Factors:** Circumstances or elements contributing to a particular result or situation.
83. **Failed Treatment:** A lack of success in achieving the desired outcome in medical or therapeutic treatment.
84. **Family Dynamics:** The patterns of relating, connecting, and communicating within a family.
85. **Family Life:** The quality and stability of relationships within a family unit.
86. **Family Structure:** The composition and organization of a family, including roles and relationships.
87. **Feelings of Guilt:** Emotional experiences of culpability or remorse.
88. **Female Factor Infertility:** Infertility attributed to issues specific to the female reproductive system.
89. **Female Feticide:** The practice of selectively aborting female fetuses, particularly in cultures favoring males.

90. **Female Sexual Dysfunction (FSD):** Problems related to sexual function in women.
91. **Female Sexual Function Index (FSFI):** A questionnaire assessing female sexual function.
92. **Female Sexual Health:** The overall state of well-being related to sexual function and satisfaction in women.
93. **Fertility Care:** Medical services and treatments aimed at assisting individuals and couples in achieving pregnancy.
94. **Fertility Problem:** Difficulty in conceiving or achieving pregnancy despite attempts.
95. **Fertility Staff:** Healthcare professionals specializing in fertility treatment and care.
96. **Fertility Treatment:** Medical interventions intended to enhance fertility and promote conception.
97. **Fertility Bad News:** The communication of negative information regarding fertility.
98. **Final Communication:** Concluding discussions or exchanges, often regarding outcomes or decisions.
99. **Financial Reasons:** Motives or circumstances related to money or finances.
100. **Focused Psychotherapies:** Therapeutic approaches tailored to address specific psychological issues or concerns.
101. **Garbh Sanskar:** Traditional Indian practices aimed at prenatal education and influencing the mental and physical development of the unborn child.
102. **Gender Differences:** Variations in experiences and responses to a situation or condition, such as infertility, based on an individual's gender.
103. **Gender-Neutral Counselling:** Counselling approaches that do not assume or reinforce stereotypical gender roles or biases.
104. **Gender Preference:** The desire for a child of a specific gender, which may influence decisions regarding infertility treatments.
105. **Generalized Anxiety Disorder-7 (GAD-7):** A screening tool used to assess the severity of generalized anxiety disorder symptoms.
106. **Grieving Process:** The emotional journey of coping with loss, including the inability to conceive, experienced by individuals dealing with infertility.
107. **Grief:** Deep sorrow, especially caused by someone's death or loss, but also applicable to the emotional distress due to infertility.
108. **Group Interviews:** A qualitative research method where multiple participants are interviewed together to explore their experiences and perspectives on a specific topic.
109. **Health Care:** The maintenance and improvement of physical and mental health through medical services, including treatments for infertility.
110. **Healthcare Staff:** Professionals involved in providing medical and supportive services within the healthcare system.
111. **Hydroceles:** Fluid-filled sacs surrounding a testicle that can affect male fertility.
112. **Hypoactive Sexual Desire Disorder:** A sexual dysfunction characterized by a lack of sexual desire.

113. **Identifying Sexual Disorders:** The process of diagnosing and categorizing sexual dysfunctions that may contribute to infertility.
114. **Illness Representation:** How individuals perceive and understand their illness or condition, influencing their coping strategies and emotional responses.
115. **Increased Risk:** Higher likelihood of experiencing negative outcomes or events related to infertility.
116. **Infertility:** The inability to conceive after an extended period of unprotected sexual intercourse.
117. **Infertility Counseling:** Psychological support provided to individuals and couples dealing with infertility, helping them cope and make decisions regarding treatment.
118. **Infertility Diagnosis:** The process of determining the underlying causes of infertility through medical assessment.
119. **Infertility-Related Concerns:** Worries and anxieties specific to the inability to conceive or achieve pregnancy.
120. **Infertility-Related Stress:** Psychological stress caused by infertility and its treatment.
121. **Infertility-Specific Distress:** Emotional suffering directly linked to the experience of infertility.
122. **Infertility Treatment:** Medical interventions aimed at enhancing fertility and helping individuals achieve pregnancy.
123. **Infertility Treatment:** Medical and supportive care provided to individuals and couples experiencing infertility.
124. **Individual Interviews:** A qualitative research method where one-on-one interviews are conducted to gather detailed insights on a specific topic.
125. **Indirect Communication:** Communicating sensitive or difficult information through subtle or non-verbal means.
126. **Increased Risk:** Elevated probability of adverse outcomes or events related to infertility treatment.
127. **Indian Context:** Specific cultural, social, and economic factors influencing infertility and its treatment within India.
128. **Indian Population:** The demographic characteristics and specific challenges related to infertility within the Indian population.
129. **Informed Choices:** Decisions made by individuals or couples regarding infertility treatments, based on comprehensive information about options and risks.
130. **Intense Grief:** Overwhelming emotional distress experienced due to infertility, characterized by profound sadness and loss.
131. **In Vitro Fertilization with Embryo Transfer (IVF-ET):** An assisted reproductive technology (ART) procedure where fertilized embryos are transferred into the uterus.
132. **ICSI (Intracytoplasmic Sperm Injection):** An ART procedure where a single sperm is directly injected into an egg to facilitate fertilization.
133. **Invasive Procedures:** Medical interventions or techniques that involve entering the body to diagnose or treat conditions like infertility.

134. **IVF-ET with Donor Sperm:** In vitro fertilization procedure where donor sperm is used to fertilize an egg before embryo transfer.
135. **Lifestyle Behaviors:** Personal habits and choices that can impact fertility, such as diet, exercise, and substance use.
136. **Lifestyle Improvement:** Changes made to enhance fertility outcomes, such as adopting healthier habits and reducing stress.
137. **Long-term Partnership:** The enduring relationship between partners navigating infertility challenges together.
138. **Local Norms:** Sociocultural norms and expectations regarding fertility, infertility treatment, and family-building practices within specific regions or cultures.
139. **Long-term Psychological Adaptation:** Psychological adjustments made over time in response to the challenges of infertility and its treatment.
140. **Low Risk of Bias:** Research studies with minimal methodological biases that accurately assess the effects of infertility treatments.
141. **Male Factor Infertility (MFI):** Infertility attributed to issues with sperm production, motility, or morphology in male partners.
142. **Male Sexual Health:** The physical and psychological well-being of men concerning sexual function and fertility.
143. **Marginalization:** The social and emotional experience of being treated as insignificant or peripheral, often due to infertility status.
144. **Marital Relations:** The quality and dynamics of the relationship between spouses or partners, affected by infertility.
145. **Marital Satisfaction:** The level of fulfillment and contentment within a marriage or partnership, impacted by infertility stress.
146. **Masculinity:** The qualities traditionally associated with being male, including behaviors and roles that can affect how men experience and cope with infertility.
147. **Maternal Mental Health:** The psychological well-being of women during the reproductive phase, influenced by factors such as infertility.
148. **Maternal Wellbeing:** The overall health and happiness of women during the reproductive phase, influenced by factors like infertility.
149. **Medically-Assisted Procreation:** Techniques and procedures used to achieve pregnancy when natural conception is not possible, including ART methods.
150. **Mental Health:** The psychological well-being and emotional resilience of individuals undergoing infertility treatments, influenced by stress and treatment outcomes.
151. **Mental Health Problems:** Disorders or conditions affecting psychological well-being, such as anxiety or depression, often exacerbated by external factors such as infertility.
152. **Mental Health Professionals:** Healthcare providers specializing in psychological support and counseling for individuals and couples dealing with various challenges, including infertility.
153. **Mindfulness:** A mental state achieved by focusing one's awareness on the present moment, while calmly acknowledging and accepting one's feelings, thoughts, and bodily sensations, used as a therapeutic technique.

154. **Mood Disturbances:** Fluctuations or disruptions in emotional states, such as sadness or irritability, experienced by individuals coping with stressful conditions like infertility and its treatment.

155. **Moral and Ethical Concerns:** Issues involving principles of right and wrong behavior, particularly related to ethical dilemmas and moral considerations in medical practices, including infertility treatments.

156. **Multi-Cycle Planning:** Strategic planning involving multiple phases or attempts, such as in infertility treatments, taking into account various factors like financial resources and emotional resilience.

157. **Negative Coping Mechanisms:** Unhealthy or maladaptive strategies used to manage stress and emotional distress, such as avoidance behaviors or substance abuse, often seen in response to infertility.

158. **Negative Emotions:** Unpleasant or undesirable feelings experienced in response to challenging circumstances, including infertility, such as sadness, anger, or disappointment.

159. **Negative Self-view:** Poor self-perception or low self-esteem resulting from stressors associated with infertility, societal pressures, or perceived personal shortcomings.

160. **Neuropsychiatric Disorders:** Disorders affecting both neurological and psychiatric functioning, influencing emotional well-being and cognitive processes, potentially exacerbated by factors like infertility.

161. **Needs During ART:** Specific requirements and support systems necessary for individuals undergoing assisted reproductive technologies (ART), tailored to optimize treatment outcomes and emotional well-being.

162. **Network Analysis:** The systematic study and analysis of relationships and interactions among individuals or groups, particularly relevant in understanding support networks among those dealing with infertility.

163. **Non-Obstructive Azoospermia (NOA):** A condition in males characterized by the absence of sperm in the semen due to impaired production within the testes, contributing to infertility.

164. **Oocyte Donation:** The process of using donated eggs from a female donor in infertility treatments to facilitate pregnancy in recipients.

165. **Oocyte Retrieval:** Surgical procedure to retrieve mature eggs from the ovaries for use in assisted reproductive technologies (ART) such as in vitro fertilization (IVF).

166. **Online Support Groups:** Virtual communities or forums on the internet providing emotional support, shared experiences, and information exchange among individuals and couples facing infertility challenges.

167. **Optimism:** A hopeful and positive outlook toward future outcomes and possibilities, crucial in maintaining resilience and psychological well-being amid infertility challenges.

168. **Orgasm:** The climax of sexual excitement, characterized by intense physical pleasure and release of sexual tension.

169. **Orgasmic Dysfunction:** Difficulty or inability to achieve orgasm during sexual activity, affecting sexual satisfaction and potentially influencing fertility-related aspects of relationships.

170. **Outcome Measures:** Quantifiable parameters used to evaluate the effectiveness or success of medical treatments, including infertility treatments, in achieving desired results.

171. **Ovum Pick-Up:** Surgical procedure to retrieve mature eggs from the ovaries for use in assisted reproductive technologies (ART) such as in vitro fertilization (IVF).

172. **Partner's Coping Differences:** Variations in how individuals and their partners manage and adapt to the emotional and practical challenges associated with infertility.

173. **Partnered Mothers:** Women in committed relationships who are navigating motherhood, considering the social and psychological dimensions of fertility and family dynamics.

174. **Patient-Reported Outcomes:** Data collected directly from patients to assess their health status, symptoms, experiences, and quality of life related to medical treatments, including infertility treatments.

175. **Pelvic Inflammatory Disease (PID):** Infection of the female reproductive organs, typically caused by sexually transmitted bacteria, potentially leading to infertility due to damage to the reproductive system.

176. **Pelvic Organ Prolapse (POP):** Condition where pelvic organs like the bladder, uterus, or rectum descend into the vaginal space, often due to weakened pelvic floor support, potentially affecting fertility and sexual function.

177. **Positive Coping Mechanisms:** Adaptive strategies employed to effectively manage stress, emotional distress, and challenges associated with infertility, promoting psychological resilience and well-being.

178. **Positive Coping Strategies:** Practical actions and mental approaches used to effectively handle the emotional and physical stressors of infertility, supporting resilience and emotional well-being.

179. **Post-counselling:** Supportive psychological counseling provided after completing a cycle of infertility treatment, focusing on emotional adjustment, decision-making, and future planning.

180. **Post-treatment:** The period following completion of infertility treatment cycles, addressing recovery, emotional adaptation, and considerations for further treatment or alternative paths to parenthood.

181. **Post-treatment Psychological Adaptation:** Long-term psychological adjustments and coping strategies developed after completing infertility treatment, focusing on emotional responses and adjustment to outcomes.

182. **Pre-treatment Distress:** Emotional distress experienced by individuals or couples before initiating infertility treatment, characterized by anxiety, fear of failure, and uncertainty about treatment outcomes.

183. **Pre-treatment Consultation:** Initial evaluation and counseling sessions conducted before starting infertility treatment, assessing readiness, discussing options, and setting expectations.

184. **Pre-treatment Interventions:** Psychological, behavioral, or medical interventions implemented before starting infertility treatment to optimize emotional well-being, physical health, and treatment success.

185. **Pre-treatment Mental Health Assessment:** Comprehensive evaluation of psychological well-being conducted before initiating infertility treatment, ensuring adequate support and intervention.

186. **Pre-treatment Consultation:** Initial medical and psychological evaluation and counseling sessions conducted before starting infertility treatment, aimed at assessing readiness, discussing treatment options, and setting expectations.

187. **Pre-treatment Distress:** Emotional distress experienced by individuals or couples before initiating infertility treatment, often characterized by anxiety, fear of failure, and uncertainty about the outcome.

188. **Pre-treatment Assessment:** Comprehensive evaluation of medical, psychological, and reproductive health conducted before starting infertility treatment, guiding treatment planning and personalized care.

189. **Pregnancy Rate:** The percentage of treatment cycles resulting in a clinical pregnancy, used as a measure of success in infertility treatments such as in vitro fertilization (IVF) or intrauterine insemination (IUI).

190. **Psychological Concerns:** Emotional and mental health issues related to infertility, such as anxiety, depression, grief, and stress, which may require psychological support and intervention.

191. **Psychological Counseling:** Therapeutic interventions provided by mental health professionals to address emotional distress, coping strategies, and decision-making related to infertility and its treatment.

192. **Psychological Interventions:** Therapeutic strategies and psychological treatments aimed at addressing emotional distress, enhancing coping skills, and improving psychological well-being during infertility treatment.

193. **Psychological Distress:** Emotional suffering, anxiety, or depression experienced by individuals or couples undergoing infertility treatment, affecting overall well-being and treatment outcomes.

194. **Psychological Problems:** Mental health issues such as anxiety disorders, depression, or adjustment disorders exacerbated by the stress of infertility and its treatment.

195. **Psychological Outcomes:** Psychological effects and emotional responses experienced by individuals or couples following infertility treatment, including resilience, adaptation, and quality of life.

196. **Psychological Stress:** Emotional strain and pressure experienced during infertility treatment due to uncertainty, treatment demands, and psychological challenges.

197. **Psychological Adjustment:** The process of adapting emotionally and psychologically to the challenges and stressors of infertility, treatment outcomes, and future reproductive decisions.

198. **Psychological Adaptation:** Long-term psychological adjustments made in response to infertility, including acceptance, coping mechanisms, and emotional well-being.

199. **Psychological Concerns:** Emotional and mental health issues related to infertility, such as anxiety, depression, grief, and stress, which may require psychological support and intervention.

200. **Psychological Counseling:** Therapeutic interventions provided by mental health professionals to address emotional distress, coping strategies, and decision-making related to infertility and its treatment.

201. **Psychological Intervention:** Therapeutic strategies and psychological treatments aimed at addressing emotional distress, enhancing coping skills, and improving psychological well-being during infertility treatment.

202. **Psychological Problems:** Mental health issues such as anxiety disorders, depression, or adjustment disorders exacerbated by the stress of infertility and its treatment.

203. **Psychological Screening:** Assessment procedures used to identify emotional distress, mental health issues, or psychosocial factors impacting fertility treatment decisions and outcomes.

204. **Psychological Support:** Emotional and psychological assistance provided by healthcare providers or support groups to individuals and couples coping with infertility and treatment-related stressors.

205. **Psychological Symptoms:** Emotional and behavioral manifestations of distress or psychological disorders experienced by individuals undergoing infertility treatment.

206. **Psychological Therapy:** Therapeutic interventions and counseling sessions aimed at addressing emotional distress, enhancing coping skills, and improving overall psychological well-being during infertility treatment.

207. **Psychological Wellbeing:** The overall state of mental health, emotional stability, and life satisfaction experienced by individuals undergoing infertility treatment.

208. **Psychosocial Needs:** Emotional, psychological, and social support requirements of individuals and couples undergoing infertility treatment, including counseling, peer support, and educational resources.

209. **Psychosocial Care:** Holistic support and interventions addressing emotional, psychological, and social aspects of infertility and its treatment, aimed at improving overall well-being.

210. **Psychosocial Intervention:** Therapeutic strategies and supportive care aimed at addressing emotional distress, enhancing coping skills, and improving quality of life during infertility treatment.

211. **Psychosocial Needs:** Emotional, psychological, and social support requirements of individuals and couples undergoing infertility treatment, including counseling, peer support, and educational resources.

212. **Psychosocial Impact:** The emotional, social, and psychological effects of infertility and its treatment on individuals, couples, and their relationships.

213. **Psychosocial Outcomes:** The long-term effects and adjustments in emotional, psychological, and social well-being resulting from infertility treatment and its outcomes.

214. **Psychosocial Wellbeing:** The overall state of emotional, psychological, and social health experienced by individuals undergoing infertility treatment, influenced by coping mechanisms and support systems.

215. **Psychotherapy:** Therapeutic treatment involving psychological counseling and intervention aimed at addressing emotional distress, improving coping skills, and enhancing mental health during infertility treatment.

216. **Quality of Life:** Overall well-being and life satisfaction experienced by individuals undergoing infertility treatment, influenced by physical health, psychological well-being, and social support.

217. **Recurrent ART Failures:** Multiple unsuccessful attempts at assisted reproductive technology (ART) treatments such as IVF or IUI, which can lead to emotional distress and additional challenges.

218. **Relational Coping:** Strategies used by couples to navigate and manage the emotional and psychological challenges of infertility together, supporting each other through treatment.

219. **Relaxation Techniques:** Stress-reducing practices and methods used to promote relaxation, reduce anxiety, and improve emotional well-being during infertility treatment.

220. **Resilience:** The ability to adapt, cope, and maintain psychological well-being in the face of adversity and stress associated with infertility and its treatment.

221. **Risk Factors:** Biological, psychological, or environmental factors that increase the likelihood of infertility or affect the success of infertility treatment, influencing treatment decisions and outcomes.

222. **Screening for Psychological Distress:** Assessment procedures used to identify emotional distress, anxiety, depression, or other psychological issues in individuals undergoing infertility treatment.

223. **Screening Tools:** Assessment instruments and questionnaires used to evaluate emotional distress, psychological well-being, and coping strategies in individuals undergoing infertility treatment.

224. **Self-efficacy:** Belief in one's ability to successfully cope with and manage the challenges and demands of infertility treatment, influencing resilience and psychological well-being.

225. **Sexual Desire:** The emotional and psychological inclination or motivation towards sexual activity and intimacy, which can be affected by infertility-related stress and treatment.

226. **Sexual Dysfunction:** Difficulties or impairments in sexual function, arousal, or satisfaction experienced by individuals or couples undergoing infertility treatment.

227. **Sexual Function:** The ability to engage in and derive satisfaction from sexual activity, which can be impacted by physical, emotional, and psychological factors related to infertility and its treatment.

228. **Sexual Health:** The overall state of physical, emotional, and psychological well-being related to sexual activity and reproductive health, influenced by infertility and its treatment.

229. **Sexual Health-related Distress:** Emotional and psychological distress experienced due to sexual dysfunction, dissatisfaction, or concerns related to infertility and its treatment.

230. **Sexual Problems:** Difficulties, concerns, or dysfunctions related to sexual activity or satisfaction, which may arise or be exacerbated by infertility and its treatment.

231. **Sexual Response Cycle:** The stages of physiological and psychological responses during sexual arousal, which may be affected by infertility-related stress, treatment, or sexual dysfunction.

232. **Shame:** A painful emotion involving feelings of embarrassment, unworthiness, or inadequacy, which may be experienced by individuals or couples dealing with infertility and its societal perceptions.

233. **Situational Anxiety:** Temporary or acute feelings of apprehension, fear, or stress experienced in response to specific situations, such as infertility treatments or medical procedures.

234. **Social Needs:** Emotional and psychological requirements for social support, connection, and understanding from family, friends, and healthcare providers during infertility treatment.

235. **Social Norms:** Cultural, societal, or community expectations and standards regarding family, fertility, and parenthood that may influence perceptions and experiences of infertility.

236. **Social Norms and Stigma:** Cultural beliefs, attitudes, and prejudices surrounding infertility that contribute to social stigma, discrimination, and emotional distress for individuals and couples.

237. **Social Relationship:** Interpersonal connections, bonds, and interactions with partners, family members, friends, and support networks that provide emotional and practical support during infertility treatment.

238. **Sociocultural Influences:** Cultural, societal, and community factors that shape beliefs, attitudes, behaviors, and experiences related to infertility and its treatment.

239. **Sociocultural Factors:** Cultural, economic, social, and environmental influences that impact fertility, infertility treatment decisions, and outcomes, including access to care and support.

240. **Socioeconomic Status:** An individual or family's social and economic position within society, influencing access to healthcare, infertility treatment, and psychosocial support services.

241. **Spirituality:** Personal beliefs, values, and practices related to spirituality, faith, or religion that may provide comfort, guidance, and coping mechanisms during infertility and its treatment.

242. **Spousal Involvement:** The degree of emotional, practical, and decision-making participation of partners in infertility treatment and support, affecting relationship dynamics and outcomes.

243. **Spousal Support:** Emotional, practical, and psychological assistance provided by partners to each other during infertility treatment, enhancing coping, resilience, and relationship satisfaction.

244. **Stigmatization:** The process of labeling, stereotyping, or discriminating against individuals or couples experiencing infertility based on societal perceptions, beliefs, or misconceptions.

245. **Stigma:** Negative attitudes, stereotypes, or social disapproval towards individuals or couples experiencing infertility, influencing emotional well-being, self-esteem, and help-seeking behaviors.

246. **Stressors:** Physical, emotional, or psychological factors that contribute to stress, anxiety, or tension experienced by individuals or couples undergoing infertility treatment.

247. **Stress:** The physiological and psychological response to challenges, demands, or threats associated with infertility, treatment procedures, and emotional distress.

248. **Strong Clinician-Patient Relationship:** A therapeutic alliance and partnership between healthcare providers and individuals or couples undergoing infertility treatment, promoting trust, communication, and shared decision-making.

249. **Study Designs:** Research methodologies and approaches used to investigate infertility, treatment outcomes, psychosocial factors, and quality of life in affected individuals and couples.

250. **Subjective Concerns:** Personal, individualized worries, anxieties, or emotional challenges related to infertility, treatment decisions, and outcomes.

251. **Subgroup Analysis:** Statistical analysis and examination of specific groups or subpopulations within research studies or clinical trials investigating infertility and treatment outcomes.

252. **Supportive Partner:** A spouse or significant other who provides emotional, practical, and psychological support to an individual undergoing infertility treatment, enhancing coping and well-being.

253. **Supportive Care:** Holistic and compassionate healthcare practices and interventions aimed at addressing emotional, psychological, and practical needs of individuals and couples during infertility treatment.

254. **Support Systems:** Formal and informal networks, resources, and relationships that provide emotional, practical, and social support to individuals and couples coping with infertility and treatment.

255. **Survey Instruments:** Questionnaires, scales, and assessment tools used to collect data on fertility-related experiences, emotional distress, coping strategies, and treatment outcomes in research studies.

256. **Survey Studies:** Research investigations and studies using survey instruments and data collection methods to explore infertility prevalence, treatment efficacy, psychosocial impacts, and patient experiences.

257. **Systematic Review:** A comprehensive and structured synthesis of existing research literature and evidence on infertility, treatment modalities, psychosocial factors, and outcomes.

258. **Tailored Interventions:** Personalized and individualized therapeutic strategies, counseling approaches, and support services designed to meet the specific emotional, psychological, and practical needs of individuals and couples undergoing infertility treatment.

259. **Themes:** Common, recurring topics, issues, or experiences identified in qualitative research studies exploring the lived experiences, perceptions, and emotional journeys of individuals and couples dealing with infertility and treatment.

260. **Values:** Personal beliefs, principles, and priorities that influence decisions, attitudes, and choices related to family-building, fertility treatment, and reproductive health.

261. **Traditional Values and Norms:** Cultural, familial, or societal beliefs, customs, and expectations regarding family, parenthood, and fertility that influence individual and collective decisions and experiences related to infertility.

262. **Treatment Duration:** The length of time required for a complete cycle of infertility treatment, including preparation, procedures, recovery, and potential repeat cycles.

263. **Treatment Failure:** Unsuccessful outcomes or lack of success in achieving pregnancy following one or multiple cycles of infertility treatment, leading to emotional distress and reconsideration of treatment options.

264. **Treatment Outcome:** The result or effect of infertility treatment on achieving pregnancy, live birth, or other intended goals, influencing emotional well-being and future reproductive decisions.

265. **Treatment Planning:** The process of developing a personalized and comprehensive strategy for infertility treatment, considering medical, emotional, and logistical factors to optimize success and patient satisfaction.

266. **Treatment Stages:** Sequential phases or steps in an infertility treatment protocol, including assessment, preparation, procedures, monitoring, and follow-up care.

267. **Treatment Outcomes:** The results, effects, and success rates of infertility treatment modalities such as IVF, IUI, or ART, impacting emotional well-being, quality of life, and future reproductive decisions.

268. **Triangulation:** The methodological approach in research involving the use of multiple data sources, methods, or perspectives to validate findings, ensure reliability, and enhance understanding of infertility-related phenomena.

269. **Unmet Needs:** Unaddressed emotional, psychological, or practical requirements and challenges experienced by individuals or couples undergoing infertility treatment, influencing well-being and treatment satisfaction.

270. **Unmet Needs during ART:** Emotional, psychological, and practical challenges and deficiencies in support services, counseling, or resources experienced by individuals or couples undergoing assisted reproductive technology (ART) treatments.

271. **Wellbeing:** The overall state of physical, emotional, and psychological health and happiness experienced by individuals or couples undergoing infertility treatment, influenced by coping strategies, support systems, and treatment outcomes.

272. **Willingness to Adopt:** Openness and readiness of individuals or couples experiencing infertility to consider and pursue adoption as an alternative or complementary family-building option following unsuccessful fertility treatments.

Annexure 4

Reviewer's Comments

Name: Jayant Mehta

Designation: Person Responsible to HFEA, Sub-fertility Laboratory Director, and Quality Control Manager. Barking, Havering Redbridge University NHS Trust. Queen's Hospital. Rom Valley Way. Romford. Essex. RM70AG. UKPerson Nurse

Affiliation: NHS

Suggestions: Editing to improve language ,grammer and presentation

Action: Thankyou for the editorial check. We have incorporated them into the document

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Name: Sunita Lamba

Designation: Director and Head,Department of Ob- Gyn.

Affiliation: Mata Chanan Devi Hospital, New Delhi

Suggestions: This consensus statement on psychosocial care in ART provides a comprehensive framework for addressing the psychosocial needs of couples undergoing fertility treatment.This consensus statement provides practical recommendations for health care providers on how to address the psychosocial needs of patients undergoing fertility treatment. This consensus statement is unique because it emphasises upon the importance of providing emotional support , counselling and education to the couple throughout the entire ART process , from initial consultation to post treatment and in successful outcomes it extends this support till post delivery followups. Also appreciate inclusion of psychosocial support in unfortunate cases of ART failure , which is the most traumatic phase of couple's life, as a part of this statement. This psychosocial counselling will give them the much needed support to cope and to overcome the grief .

Suggestions:

1. Dealing with Psycho social causes of distress especially couples living in joint families or otherwise, where they have immense family pressure to give an heir to family. Counselling of family members can be helpful in decreasing this stress. Provide guidance on how to address issues related to this stigma and social support within the context of ART.

2. Majorly the stress in females is due to societal pressure, domestic fights, domestic violence and threat to divorce if not able to bear a child , females usually are not forthcoming about these fears in couple sessions. In couples with limited financial resources, the onus to arrange finances is on Male partner, especially if female partner is not working. This stress of arranging finances is major cause of stress in male partner, and mostly he doesn't like to share this in couples session in front of his wife.

Hence suggested to offer individual Counselling Session to know their individual reason of stress before embarking on Couple Sessions.

Emphasise the need of multidisciplinary approach to psychosocial care , involving psychologist, fertility specialist and other relevant health care providers. Offer recommendation for self-care strategies and coping mechanisms like accepting the situation, engaging in mindfulness and seeking therapy for positive mindset, in order to manage emotional distress during ART procedure Providing resources and references for further information and support is again a good clinical practice point. To summarise I must congratulate you for meticulously framing this Consensus statement on Psychosocial care in ART. Its going to be a great valuable resource addition for healthcare provider working with infertility treatment. By providing a compre-hensive framework for addressing the

emotional and psychological needs of patients, this statement can help improve the overall quality of care and support provided to individuals undergoing infertility treatment and make this a smooth process with overall high rate of satisfaction.

Action: Thank you for your suggestions. We have recommended involving the men at each and every step understand their personal, marital and domestic situation specially in India. (Recommendations 4.2 ;4.3 .2)

Name: Prof Bindu Bajaj

Designation: Safdarjang Hospital and VM medical college, Delhi

Affiliation: Mata Chanan Devi Hospital, New Delhi

Suggestions: The document "IFS consensus Statement on Psychosocial Care in Assisted Reproduction Techniques (ART)" is a comprehensive document and does justice to its aim.In Indian population illiteracy and resultant inherent communication gaps are a hindrance to psychosocial care delivery. Also, Low resource settings must have psychosocial care incorporated in the clinics.

Action: Thank you for your review. We agree that illiteracy in India can be a communication gap and requires special care and more time. Low resoursse setting IVF centres must incorporate this

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Name: Rajvi H. Mehta

Designation: Embryologist

Affiliation: Joint Treasurer, Academy of Clinical Embryologists, India

Suggestions: It is a very good and well written document. Some quick suggestions based on the summary of the survey and recommendations

1. The extended family [in-laws] are highly involved in India, especially non-metro settings. so, maybe some sessions with them or some sessions with couple or the female on how to cope/explain/handle the extended family.

2. Like a clinic has nurses, embryologists and other staff, there needs to be an in-house psychologist whom is an integral part of the clinic and not an extra-paid services.

And right from the start, the couple spends more time with this counsellor - who can be briefed and updated about the pre-treatment and treatment by the clinicians.

3. Any role of embryologist - or maybe that can come later as we do not have much data on that

4. About yoga, why only male - But, again we need to be careful - people may land up doing bhastrika and kapalbhati!!

Action: Thank you for highlighting indian scenario. As per recent law in India an in house counsellor is a must. There are studies on women and we have addressed it in 4.6. The influence of extended family in India is a significant factor and needs to be part of counselling. This will (Recommendations 4.3.2). Sleep hygine is an important part of lifestyle counselling; the disturbed sleep is a very clear marker of stress .The emphasis and focus on this is important. Thank you for pointing it out. It is a part of assessment by the psychologist and taken care of

Name:	Prof. Meerambika Mahapatro
Designation:	Professor and Head of the Department of Social Sciences
Affiliation:	National Institute of Health and Family Welfare, New Delhi
Suggestions:	They are very well articulated and encompass all issues. I have very little observation.
Action:	Thank you

Name:	Yash Shekhar
Designation:	B.TECH ;LLB ;MBA
Affiliation:	Mind development, Mental health and emotinal intelligence, AICTE (Indian Govt); ADOT foundation, London, UK; chamber of Shipping, Bodrum, Turkey ; RJ wellness, RADIO Adda
Suggestions:	Additional Recommendation:- Section 4.1.1 & 4.1.2: Sleep disorder or sleep related issues can also happen in such cases and should be considered as a probable after effect Section 4.1.3:Men may have a more impatient, impulsive & active response whereas women may have a more subtle passive response Section 4.1.4: Stressed emotional relationship causing sexual disorder or sleep related issues can also happen in such cases and should be considered as a probable after effect 4.3.1: RISK PREDICTION can be done by studying the Behaviorial change of the individual (both men and women) and developing Behaviour change indicator program for the same. 4.3.2: Body language reading and Subliminal Body language reading program which give a great hint on behaviourial change & Health Risks can be used effectively and dared within the Fertility care team. 4.4.1: Before giving information to the individuals who come for treatment, a detailed interview should be taken of the patients 4.4.2: Sleep disorder or sleep related issues can also happen in such cases and should be considered as a probable after effect hence Counselling should be done for this and Healthy Sleep program should be provided to them. Communication through interviews to be done with individuals encouraging them to ask questions and receive answers to their doubts and queries. 4.4.3: Interview with view sharing and Counselling is must in such situation. Queries to be encouraged and doubts resolved with optimistic perspective through encouraging questions and providing emotional support program. 4.4.4: Healthy Sleep habits to be developed after successful completion of the procedure. 4.5 & 4.6.2 Lack of emotional communication by the Fertility team. Emotional Commuication to be encouraged by the Fertility Care team. 4.6.3 1Long term Emotional Counselling & Interviewing program 4.6.4 Prescribing suitable Yoga Programs customized to the patients need to be suggested. 4.7.1 Development of better emotional communication channel with the third party under proper counselling by Fertility Care team. 4.7.2: Sleep disorder or sleep related issues can also happen in such cases and should be considered as a probable after effect 4.8 11 Emotional Communication to be more profound with long term support. Encouraging QA sessions with doubt removals for the patient. 4.8.2 Any communication should in sync with the legal perspective prevelent in the country. 4.6.2: By recommending Sleep improvement programs the patient may get benefitted and hence should be recommended during such treatments. Emotional Communication with interview to be encouraged for resolving queries of the patient. Yoga sessions customized to the patients to be encouraged .
Action:	Thank you for your review. We have included the importance of sleep as part of lifestyle management in the document

Name:	Jahnavi Sindhu
Designation:	Advocate, Delhi High Court and Supreme Court
Affiliation:	New Delhi
Suggestions:	The consensus statement on psychosocial care is a well-researched document covering all psychosocial issues arising from ART treatment. There is a strong need for such a statement since the enactment of the Assisted Reproductive Technology (Regulation) Act, 2021, as legal issues and quandaries are bound to come up. These queries can be a source psychosocial distress and mechanisms must be created for their understanding and resolution. As a lawyer, I would recommend that legal support be given to the women who may face psychosocial distress from legal issues arising from treatment as this may further increase psychosocial distress. Couples often have marital problems which increase after an unsuccessful result and often don't resolve even after a successful conception. In India the sociocultural norms often require infertile women to have legal support along with psychosocial support and in many ways, these are interlinked. Third-party reproduction requires affidavits and has intricacies regarding disputes on the rights of the child, surrogate rights, donor rights and couple rights. Hence legal support may help in these cases. Cases of surrogacy may require this support till the birth of the child to ensure that the birth certificate is in the commissioning parents' name. Single women undergoing IVF should be aware of the rights and legal status of their children. It is also possible that divorce and separation may occur during treatment owing to a variety of reasons, including family interference and financial issues. These too should be dealt with promptly to prevent these issues from adding to the stress and anxiety of the couple. Hence it is suggested that while giving psychosocial care the caregiver must always have a lawyer to whom they can refer the legal intricacies to as part of psychological support to the couple and to resolve issues which may cause further distress and anxiety. In the above paragraph, I have tried to address the following questions: 4.6. What is the role of the fertility team in delivering psychosocial care to couples? 4.6.2 How can fertility staff address the needs of patients during treatment? 4.6.3 How can fertility staff address the needs of patients after unsuccessful treatment and breaking bad news in infertility treatment? 4.7 How can the fertility care team provide psychosocial care for couples undertaking third party reproduction? 4.8.1.How is counselling for single women seeking motherhood through ART different?
Action:	Thank you for your review. We have included the need for judiciary support should be at hand if patient requires (4.7)

Name:	Gaurav Kant
Designation:	PhD Candidate, Humboldt University Berlin
Affiliation:	Akanksha IVF Centre
Suggestions:	Thank you for the email. I have thoroughly reviewed the recommendations and found them to be exceptionally comprehensive and well-thought-out. Honestly, there isn't much more I can add to them. However, I would like to emphasize the critical importance of integrating psychological care into infertility treatment. Infertility can be an emotionally taxing journey, often accompanied by feelings of stress, anxiety, and depression. Providing psychological support can greatly enhance the overall well-being of patients by addressing these emotional and mental health challenges. This holistic approach not only helps in coping with the immediate emotional distress but also fosters resilience and a more positive outlook throughout the treatment process. Implementing regular counseling sessions, support groups, and stress management techniques can offer invaluable support to individuals and couples undergoing infertility treatment. It ensures that they do not feel isolated and provides them with coping mechanisms to manage the uncertainties and pressures they face. By prioritizing psychological care, we can significantly improve the overall experience and outcomes for patients navigating the complexities of infertility.
Action:	Thank You for your review

Name:	Poonam kashyap
Designation:	Nurse
Affiliation:	Akanksha IVF Centre
Suggestions:	Thank you for the email madam. I have carefully reviewed the recommendations and found them to be exceptionally comprehensive. They cover all the necessary aspects thoroughly, and honestly, I don't have anything to add. Incorporating psychological care into infertility treatment is of paramount importance. The emotional and mental health challenges faced by individuals and couples undergoing infertility treatments are often significant. Providing robust psychological support can greatly enhance their overall well-being, reduce stress, and improve coping strategies. This holistic approach ensures that patients feel supported not just physically, but also emotionally, which is essential for navigating the complexities and uncertainties of infertility. By addressing both the medical and psychological aspects, we can offer a more compassionate and effective treatment experience
Action:	Thank You for the review

Name: SB

Designation: Female Patient

Affiliation: Delhi

Suggestions: I as a first hand patient who have gone through IUI and IVF for a long period with a hope of conceiving and having a child came through to me as an emotional and physically straining journey.

This is during the mid 90's. it was a long journey of few years, When we wanted to plan our second child and tried to conceive naturally for 2 years and when that didn't happen, we visited our Dr. to consult. There were numerous tests from which finally we got to know that I have fibroids and hormonal imbalance. The long journey of tests, medicines, injections and hysteroscopy and thereafter treatment began which concluded in IUIs and few cycles of IVF.

The short of a long story is that we didn't know where we were heading to, we dint have a road map. I was emotionally drained and went thru a depressive phase. We were not guided that the medicines would give bouts of anxiety. The entire medical team were so mechanical that they lost out on seeing me as a young woman who was going thru an emotional battle and didn't know how to deal with it. My emotional or mental status to deal with all these things were not dealt with nor guided, which did take a toll on my physical & mental health. I was unable to sleep for days and would break down at the hat of a drop. I wish somebody would have counselled us and prepared us to deal with failed cycles and to deal with all the emotional upheavals I was going thru.

Finally, when I was totally broken and gave up the treatment, I decided to gather myself physically and emotionally. My journey of self-realization began, I read a lot gathered information on overall good health and fertility. I worked on a good diet plan, exercise, meditation and lifestyle modification. This lead to a natural pregnancy after a year.

In a treatment like A.R.T where it is just not dealing with two individuals (a couple) on a physical level but also on an emotional level of creating a new life, the individuals have to be treated differently. Here we are not talking about a product to buy from the store, but to create a human life, for which both the man and the woman go thru altogether a different perspective. They have to be Prepared mentally and emotionally to deal with the entire process. A specialized psychological counselling would help a great deal for the couple to open up freely to a third party and share their pains, anxiety and stress. The systematic counselling can be phase wise and guide and prepare the couple, with lifestyle modification, diet plans, exercise regimen and calming and ways to deal with anxiety at all level

Action: Thank you for sharing your innermost feelings; It is to adress these very concerns that the clinical consesus guideline was developed ,to improve the quality of care and reduce emotional trauma for the couple

Name: AB

Designation: Patient

Affiliation: Delhi

Suggestions: It was very challenging to go through this whole process. Uncertainty, Rays of Hopes, Getting initial success, and then shattered all of a sudden. Restart it all over again. Repeated failures was very draining, not only financially, but also mentally (for women, it is more physically than anything elss). After every failure and pain, we thought not to do it again. But desire of having kids was too strong to numb the pain and keep going again. Thinking back now, I dont know how we did it! Meeting several doctors, it felt like well oiled money-making industry. Here is recipe of treatments, go through it in order, make advance payment, no guarantee of success, just pure luck. No personal consultation on, what individual's situation is, what they have gone through (not just medically but overall), and whats best for them. I had to read up lot of details myself to understand what this is all about and how it is done and what are challenges. It kind of prepared me on whats coming. But when its actually happening, it was still challenging to deal with. The stress, the anxiety, the uncertain outcome! Doctors usually are not available for after hours, non-clinic visit consultations. In this process, anything can go wrong any time. It did happen to us. We were lucky to have a doctor who was somewhat available (this was also result of seeing many doctors and rejecting them after first meeting due to their non-emotional attitude). But even then, there was no one else to talk about this. We cant talk to family or friends about it. So its just us couple who ended up tendering to each others need and consoling each other. There were times when we had our differences and things wasnt good all the times, but we somehow managed it and consider ourselves lucky to get out of it. When it was finally done, we felt so happier (not because we have baby now, but more because we dont have to deal with this again). Abroad, there are well-being classes, and consultations to make sure, you are prepared for it and able to manage it well. We were on our own. Stress & depression is probably biggest factors, we had to repeated deal with and overcome with, in order to keep moving forward. We were financially ok, so we didn't have to worry about it. But if this wasn't the case, it would have multi-folded the stress. Men dont have to endure physical pain of this process. It is hard to imagine what women goes through on top of everything else. At the end, we are glad we did it. Pain was all worth it, as we had results. I wish it was easier, smoother & stress-free to go through it! This is so nostalgic to pen down my memory as a client, where me and wife went through the journey of IVF treatment. As a journalist I have written many articles, but this was different. When my wife asked me to write my part of experience about those years and when she shared how and what she was feeling at that time, I felt a bit guilty and anger dawned upon me, as I was merely present but did not contribute to my wife fully, as I was myself unaware of all the emotional and mental stress she went through. Yes it was very mechanical where I had to perform and collect the semen to be handed to the lab guy, or a particular time was decided to have a physical relation as per the doctors advise. Lot of time I would be anxious myself and not able to perform at all. It was a big financial burnout. A road map with step by step process, financial involvement and when to withdraw yourself if things didn't go as per your plan, could have made our life a bit more easier. A woman goes thru her journey of pregnancy in a different way and a man goes through it very differently. A psychological counselling for both the couple would have made it a team work, rather than the woman's work. Men could have been guided better to deal with their and the wife's challenges in a better way. It is a great initiative for IVF centres to start psychological counselling for couples. It would definitely help couples to do much better in dealing with the entire process and the journey less stressful.

Action: Yes , Knowing your pain, we have taken up this initiative to help patients. Thank you for sharing your experience. It is very brave of you .It will increase the level of awareness of the fertility care team and enable them to provide more empathetic service

Name:	Rajvi Mehta
Designation:	Psychiatrist
Affiliation:	Consultant Psychiatrist, CMHT South West Parkwood, Northamptonshire Healthcare NHS Foundation Trust, Danetre Hospital, London Road, Daventry. NN11 4DY
Suggestions:	Thanks very much for sending the IFS consensus Statement on Psychosocial Care in Assisted Reproduction Techniques (ART). I have thoroughly reviewed as well as enjoyed going through the document. I found the document to be very thorough and comprehensive and it covers every possible aspect of psychological care related to ART. The document has very clear recommendations for patients as well as the Care teams and will serve as a clear guidance to improve the understanding of ART for both. The document Is based on a thorough review of the available information, answers very specific questions relevant to this field and finally it makes specific recommendations on various topics related to ART. The recommendations cover psychological impact of sub fertility and ART on men and women, the differences in response and has separate recommendations on impact on sexual function. Further it gives clear guidance to the care team on important issues e.g. risk prediction and impact of successful as well as unsuccessful treatments. Finally the document also provides guidance for specialised areas like psychological impacts of such treatments on single women/gender preferences ETC. In my opinion the consensus statement would be an extremely useful tool for the patients as well as healthcare teams and would be very positively received all over the world.

Name:	AB
Designation:	Male patient
Affiliation:	xxxxxx
Suggestions:	This is so nostalgic to pen down my memory as a client, where me and wife went through the journey of IVF treatment. As a journalist I have written many articles, but this was different. When my wife asked me to write my part of experience about those years and when she shared how and what she was feeling at that time, I felt a bit guilty and anger dawned upon me, as I was merely present but did not contribute to my wife fully, as I was myself unaware of all the emotional and mental stress she went through. Yes it was very mechanical where I had to perform and collect the semen to be handed to the lab guy, or a particular time was decided to have a physical relation as per the doctors advise. Lot of time I would be anxious myself and not able to perform at all. It was a big financial burnout. A road map with step by step process, financial involvement and when to withdraw yourself if things didn't go as per your plan, could have made our life a bit more easier. A woman goes thru her journey of pregnancy in a different way and a man goes through it very differently. A psychological counselling for both the couple would have made it a team work, rather than the woman's work. Men could have been guided better to deal with their and the wife's challenges in a better way. It is a great initiative for IVF centres to start psychological counselling for couples. It would definitely help couples to do much better in dealing with the entire process and the journey less stressful.
Action:	Thank you.