Defence Instructions and Notices (Not to be communicated to anyone outside HM Service without authority)	
Title:	Assisted Conception and Fertility Policy
Audience:	All Military Personnel
Applies:	Immediately.
Expires:	When rescinded or replaced.
Replaces:	2009DIN01-104 and 2012DIN01-134
Reference:	**2016DIN01-052**
Status:	**Current**
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Channel:	01 Personnel
Content:	This DIN sets out the policy and process for Service Personnel considering Assisted Conception Services (ACS) or Fertility Preservation (FP). It highlights the link to NHS access criteria and advises when to consider either option.
Sponsor:	People-SPSupport-Welfare HW
Contact:	[redacted] SO1 Health and Wellbeing. [redacted]
Keywords:	Defence Health Policy; Secondary Healthcare; Health Protection
Local Keywords:	ACS; IVF; Reproduction; Fertility; Fertility Preservation; Stability; Overseas; Sperm Harvesting; Egg Harvesting.
Supplements: (Please click on the links to access >>>>)	Annex B: Medical Practitioner Guidance and Patient Confidentiality Consent Form Annex C: Referral to UK for Assisted Conception Treatment – Medical Practitioner Guidance and Patient Confidentiality Consent Form
Related Info:	https://www.gov.uk/government/policies/armed-forces-covenant https://www.nice.org.uk/guidance/cg156 http://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2014/11/n-sc037.pdf. Pregnant Dependant Declining Repatriation in Non-Confinement Location Guidance note 38-15
Classification:	OFFICIAL

Assisted Conception and Fertility

Introduction

1. This chapter contains policy and guidance on sexual reproduction matters where personnel may experience difficulties accessing support due to the exigencies of Service life. The aim is to minimise personal disadvantage whilst ensuring Service commitments are met. The over-riding tenet is that elective treatment for assisted conception is not provided by Defence Medical Services (DMS). This policy should be read in conjunction with maternity policy for Servicewomen as set out in Chapter 20 of JSP 760 and Tri-Service Operational and Non-Operational Welfare Policy in JSP 770.

Assisted Conception Services (ACS)

2. Assisted conception is the name given to the variety of treatments in support of conception, In Vitro Fertilisation (IVF) being one example. They are classed as non-

essential elective[1] procedures and, as such, are not required to return military personnel to operational fitness, therefore they are not provided or commissioned by DMS. Where possible and practicable, in accordance with National Institute for Health and Care Excellence (NICE) guidelines, DMS will facilitate testing of Service and entitled personnel for fertility issues.

3. Under the Armed Forces Covenant the NHS and Devolved Administrations have committed to provide fair treatment to the Armed Forces Community. Part of this commitment has been an agreement to provide military personnel and their partners[2] with access to ACS, provided that they meet set criteria[3], and support to personnel who suffer genital injury as a result of their Service[4]. The services provided by the different NHS authorities vary,[5] but they are regulated and assured[6], providing continuity of care for Service personnel (SP) and their partners.

4. This policy sets out the process for SP to follow when considering ACS in order to ensure Chain of Command (CoC) support and geographical stability when needed. Additionally, it provides guidance on ACS provision for personnel posted overseas and pre-deployment fertility preservation[7].

Entitlement

5. This policy applies both to Regular Servicewomen seeking assistance for themselves or their spouses/partners and to Servicemen whose spouses/partners are seeking assistance either through NHS provisioned services or non-NHS means. It may not cover every individual situation, but such circumstances should be addressed by sensible interpretation of the principles conveyed herein to ensure the proper and sensitive management of individuals.

Eligibility

6. In recognition of regional and CCG variations, those in the Armed Forces Community who this policy applies to and who meet the NHS (NICE) eligibility criteria will be offered the same number of IVF cycles in NHS England and the Devolved Administrations (Scotland, Wales and Northern Ireland) wherever they are assigned. Eligibility is a matter of NHS policy[8]. The National Armed Forces eligibility criteria follow the NICE guidelines and, in the main, SP benefit from guaranteed standards, but regional variations do exist. Consequently, personnel should consider their specific circumstances

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[1] Elective procedures are those chosen (elected) by the patient or doctor which are advantageous to the patient, but are not urgent.

[2] This includes married personnel, civil partnerships, as well as partners in a substantial and exclusive relationship as defined in JSP 765, Chapter 4; Armed Forces Compensation Scheme; support for single personnel will be on a case-by-case basis. NICE defines a couple as two people in a partnership, irrespective of gender and sexual orientation, who are having difficulty conceiving.

[3] National Institute for Health and Care Excellence (NICE) guidelines https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2014/11/n-sc037.pdf.

[4] Three cycles of IVF are provided by NHS(E) for all personnel with Service related genital injuries.

[5] For example military couples are entitled to up to 3 cycles of IVF if based in England, up to 2 cycles if in Scotland or Wales and 1 in NI. Personnel with an Armed Forces Compensation Award for infertility are entitled to three full cycles of IVF treatment or otherwise approved best practice treatment provided by the NHS.

[6] Assisted reproduction is regulated by law and its use controlled by the Human Fertilisation and Embryology Authority.

[7] 2009DIN01-104- and 2012DIN01-134 are now obsolete.

[8] http://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2014/11/n-sc037.pdf . Access criteria varies in the Devolved Administrations, personnel are advised to seek clarification from their local Clinical Commissioning Group and bring any perceived disadvantage to the attention of the CoC. CoC should contact SG COS-SCT-Asst Hd for further advice.

and the options available to them. Personnel who are ineligible for, or choose not to access, NHS-commissioned ACS services can choose to finance the process privately; guidance for both circumstances is contained in this document.

Stability in the UK

7. The investigation and diagnosis of fertility issues and any subsequent treatment takes time and, as Armed Forces personnel are more mobile than the majority of the UK population, this can impact on continuity of care and increase the stress associated with the process. Therefore, where possible and practicable, Defence will provide up to three years of geographic stability, in the UK, for military couples accessing ACS. This will be assessed on a case by case basis by the single Services (sS). The process map at Annex A outlines the procedure for requesting geographic stability which should be followed by both the individual requesting stability and the CoC.

Service Person

8. All SP accessing ACS may request geographic stability using the form at Annex B. A SP wanting to maintain stability in order for themselves and / or their partner to complete such treatment will need to consult their doctor and inform their CoC in order to set the conditions for stability as early as possible. Individuals may seek guidance from the assigning authority as to the impact their decision to accept geographic stability may have on their military career. Personnel should not expect any concession to be made if a professional development course is missed as a result of this request. SP do not have the right to demand an assignment to a particular location or to avoid an assignment for which the order has already been issued, in order to seek treatment.

9. If a reservist receives notification that they are to be mobilised and they or their partner is undergoing, or about to start, a period of assisted conception treatment, he/she may make an application to an Adjudication Officer for deferment of, or exemption from, the mobilisation in accordance with the Reserve Forces Act 1996.

Engagement with CoC

10. The CoC should acknowledge the requirement for stability and consider potential assignment options with the SP in order that they can inform the assignment process.

Career Implications

11. Whilst career managers have a duty to try to accommodate the needs of the individual there may be occasions when this is not possible because of the overriding needs of the Service. Assigning authorities must:

a. Endeavour to ensure that any assignment generated by the need for stability does not adversely affect the SP's career profile, acknowledging that this cannot be guaranteed.

b. Be alert to the risk of adversely affecting the career of a third party when considering extending a person in post or assigning them to a particular post in order to achieve stability. Enabling one SP to maintain stability must not be allowed to deny a career opportunity or promotion to another SP.

c. Assume that the stability required is for both partners together. Where this is not achievable, priority should be given to the partner who is trying to conceive.

Retention of accommodation

12. If an extension in post is granted, personnel will also need to apply for retention of their Service accommodation in line with the direction set out in JSP 464, Tri-Service Accommodation Regulations.

Leave

13. As ACS is a non-essential elective procedure personnel should plan to utilise their individual leave allowance accordingly. However, many of the processes can be complicated and involve additional leave requirements. Special paid leave may be considered for personnel accessing ACS and in need of additional time off for treatment or recuperation; in addition, due consideration should be given to the health and wellbeing of both individuals. The authority for granting special paid leave in these circumstances, rests with the Commanding Officer of the Unit on whose strength the SP concerned is borne and should be considered in conjunction with the individual's existing individual leave allowance.

Access to ACS Overseas

14. MOD undertakes to ensure that Service personnel and those in the wider AF community will have NHS 'equivalent' care in the eligibility and entitlement criteria when assigned abroad. ACS will often be available privately in countries where military personnel are assigned, although the services available will be country dependent. MOD is unable to assure ACS clinics overseas and therefore will not commission ACS overseas[9].

15. If personnel choose to use overseas facilities they do so at their own risk and own cost, noting that MOD cannot guarantee the quality or safety of the service provided. Nor can MOD guarantee continued geographic stability to permit completion of treatment. In addition, personnel should be aware that IVF cycles undertaken overseas, or privately funded in the UK, are taken into account by the NHS when calculating the entitlement for the number of cycles provided in the UK.

16. **Investigations**. Subject to the needs of the Service, personnel will be permitted to return to the UK to undergo investigations into potential infertility at MOD expense.

17. **Self-funding**. Not all personnel who have fertility issues will be eligible for NHS-funded ACS. Personnel can elect to self-fund treatment in the UK and request an early return to the UK; the return is subject to the same assessment of Service need as per NHS-funded treatment.

Return to UK

18. Should fertility treatment be required, SP can elect to request an early posting back to the UK. The return to UK will ensure they are able to access UK assured ACS services and take full advantage of the NHS provision, where eligible. Each case will be considered in accordance with Service need and through engagement with the manning authorities to consider any career implications of such a move. The process is set out at Annex A.

[9] Neither will the NHS commission ACS overseas.

19. MOD is committed to providing NHS equivalent care whilst abroad; in turn the NHS undertakes to avoid disadvantage to SP and their families. Subject to Service need, personnel in accompanied overseas locations who require fertility testing or who require fertility treatment and for Service reasons cannot be returned permanently to the UK will be permitted to return temporarily to the UK to access NHS provisioned services before returning to their accompanied overseas location. This is a more complex process which is also at Annex A.

20. **Travel and Subsistence**. Those personnel who qualify under the para 18/19 process will be afforded return travel to the UK at public expense which will normally be undertaken by the officially recognised method of travel[10][11]. However, expenses incurred whilst in the UK will be an individual responsibility.

21. **Leave**. Special Paid Leave may be permitted for personnel temporarily returning to the UK from overseas to access ACS. The authority for granting Special Paid Leave, in this circumstance, rests with the CO of the Unit on whose strength the SP concerned is borne and should be considered in conjunction with the individual's existing Leave Allowance.

22. **Childbirth.** Childbirth is an event that is usually foreseen and can be supported by medical contingency planning with a good understanding of the medical capability and morbidity data overseas. In most situations, the decision to remain abroad or return to UK at a suitable time is mutually agreed by the patient, their GP and the CoC. The discussion should explicitly include issues of maternal and neonatal morbidity and the challenges associated with emergency medical evacuation if remaining overseas. It should also be made clear that, whilst the patient may change her mind, travel out of the country may not be possible as airlines have strict policies on flying in the latter stages of pregnancy. Further guidance can be found in DPHC Guidance note 38-15[12].

Fertility Preservation

23. The elevated IED threat on some operations is associated with an increase in lower limb polytrauma which may include injuries to the groin and abdominal areas with associated damage to the reproductive organs. Whilst the immediate medical priority in all such cases is the preservation of life, follow-on procedures to preserve sexual and reproductive function have been developed and are available for SP who require them[13]. In addition, when deemed appropriate, access to NHS 'sperm harvesting' and storage is offered. This procedure is required by a relatively small number of injured personnel and is considered a 'rescue' procedure therefore success cannot be guaranteed[14]. There are, however, fertility preservation (FP) measures that can be taken prior to deployment to a high risk area.

Fertility Preservation (FP) Entitlement

[10] This acknowledges that the AF community should have NHS 'equivalent' care when assigned abroad. Personnel choosing to self-fund ACS whilst abroad will be required to fund their own travel.
[11] For personnel returning to an overseas assignment after fertility treatment Class 5 Aeromed patient status may be appropriate.
[12] Guidance Note 38-15
[13] The normal period that the MOD will pay for storage is 10 years.
[14] Genital injury treatment is funded by Department of Health in England, the Devolved Administrations have their own arrangements.

24. NHS-funded elective FP in the UK is currently limited to cancer patients prior to undergoing treatment that is likely to cause infertility. Non-cancer related FP is considered to be an elective procedure that is to be privately arranged and funded by an individual. The MOD supports this view, but recognises that it has a responsibility to provide all personnel with sound, impartial advice through the military CoC should they seek it.

Fertility Preservation Process

25. Fertility preservation involves freezing and storing eggs, sperm, or embryos for use in a person's future fertility treatment. In rarer cases, this can involve freezing and storing ovarian or testicular tissue. Both men and women may wish to preserve their fertility for a number of reasons including:

- To delay parenthood until a date at which they are ready to start a family
- To allow treatment of a medical condition which may affect future fertility, such as some cancer treatments
- In cases where there is risk of injury or death

26. The process of freezing sperm or eggs is called cryo-preservation. In the UK, FP is only allowed in clinics which have been granted a licence by the Human Fertility and Embryology Authority (HFEA) (http://www.hfea.gov.uk) to run cryo-preservation facilities. The Clinics may be NHS or private sector. The British Andrology Society, an independent UK learned body for the sector, compiles and updates a list of HFEA licensed centres offering FP to Service personnel. This can be found at: http://www.britishandrology.org.uk/. Female personnel considering preserving eggs should be aware that the process is complicated and takes considerably more time than freezing sperm; this should be taken into account when considering doing so ahead of deployment.

Ethical and Legal issues

27. In the UK, consent of the person banking the sperm, eggs or embryo is required in order for any sample to be used. The consent taken for storage, by the HFEA-licenced centre, will require the SP to decide what they wish to happen in the event of their death or mental incapacity. If the SP consents samples can be used, to treat a named partner, and the SP's name placed on the birth certificate. This already occurs around the UK for cancer patients. The additional emotional stress that this may generate for their partner at an already difficult time should not be underestimated. Notwithstanding the fact that SP wishing to take up FP would do so with an independent external organisation, the MOD and the CoC are to ensure wherever possible that SP are made aware of these considerations.

Screening and Counselling

28. The services offered by FP providers will vary, but typically they will all offer counselling to the SP (and partner if appropriate). Counselling is not mandatory under HFEA guidelines and individuals may elect not to undergo this process.

29. Individuals considering FP should be aware that:

a. **They will be tested for HIV, Hepatitis B and Hepatitis C**. SP must be aware that this screening process may reveal STI or other blood borne viruses that were previously unknown to them. Although it would be inappropriate for the FP provider to divulge any

such information, SP should be encouraged to share that information with their unit medical authorities in order that DMS can act appropriately. In the event of the screening process revealing diseases such as HIV, significant welfare and medical support would be necessary. SP must also be made aware of the potential impact on life insurance that such revelations would have.

b. **They may discover adverse information about their current fertility status.** SP should understand that 1 in 50 men have no sperm in their semen and approximately 1 in 10 will be classed as having a low sperm count. Neither of these mean that they have always had that condition, or automatically that they have not, or will never father their own child. However, these findings may cause distress and confusion to SP and further Welfare support may be required.

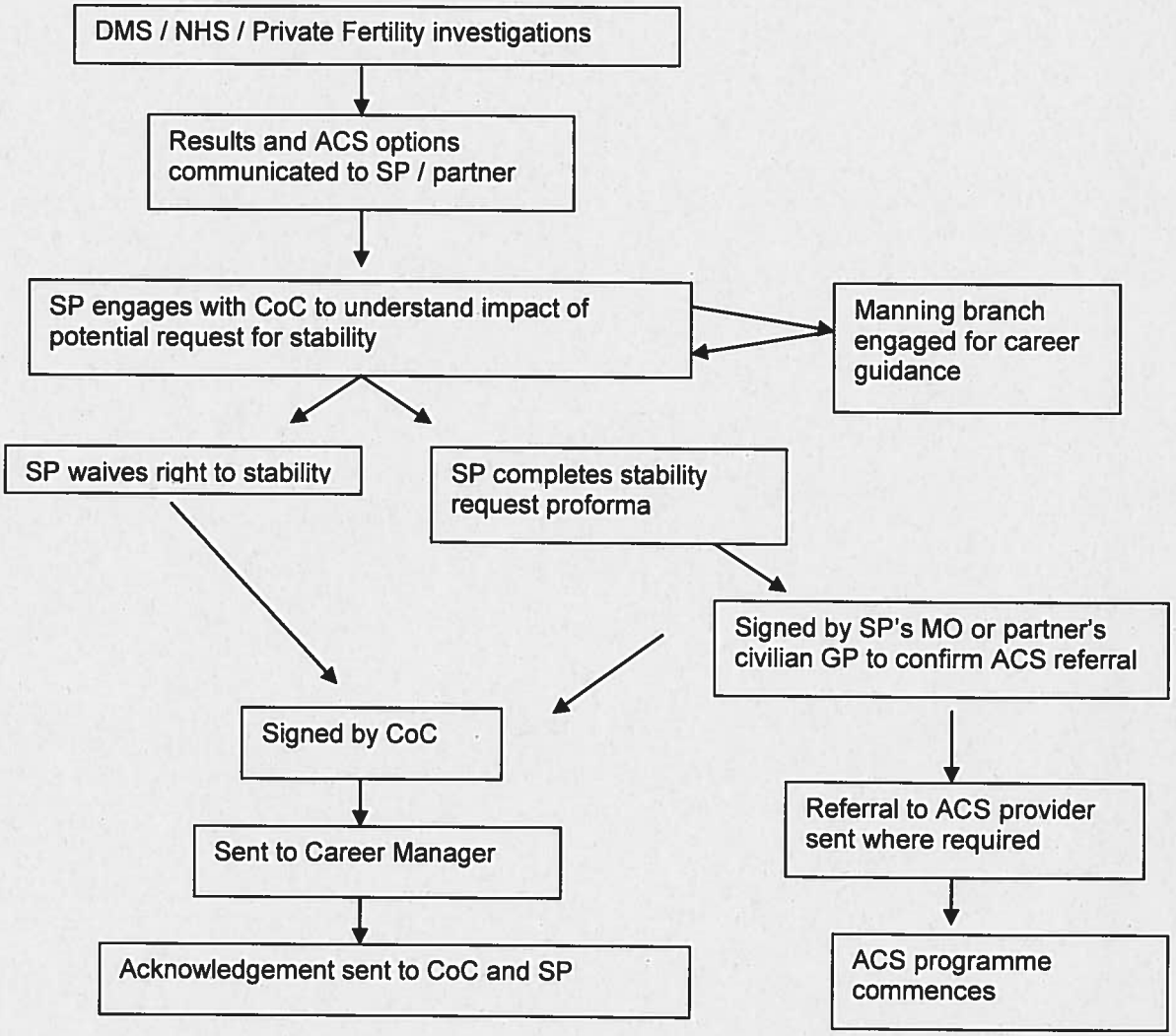
30. FP is already available for those injured SP requiring it on return from operations. This process will continue to be funded by the MOD. The MOD does not provide a funded, elective FP service for SP prior to operational deployment.

31. Fertility preservation is a subject that is rarely considered in advance of the necessity arising which, in some cases, may be too late. All SP should be made aware by the CoC of the options available to them. It is recommended that a paragraph should be included periodically in daily orders referencing this policy.

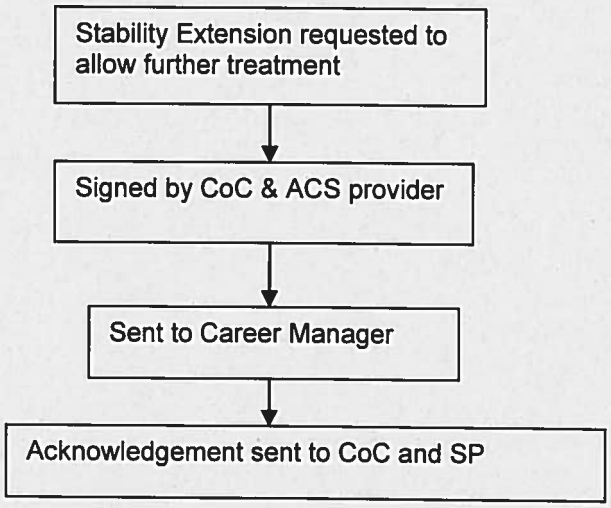
32. Commanders should not wait until their units or formations are warned for operations as there is a need for SP to be in possession of the facts and to have time to discuss the implications of FP with their partners and families prior to participating in the process. SP considering self-funded pre-deployment FP are also to be encouraged to engage with Service medical authorities for advice. Lead times and costs vary between different FP organisations and between male and female treatment, so early engagement is essential to enable personnel to complete the necessary procedures prior to deployment. Personnel subsequently wishing to access NHS-funded ACS using their frozen sperm/egg/embryo would still be subject to the NHS access criteria.

ACS Process Map

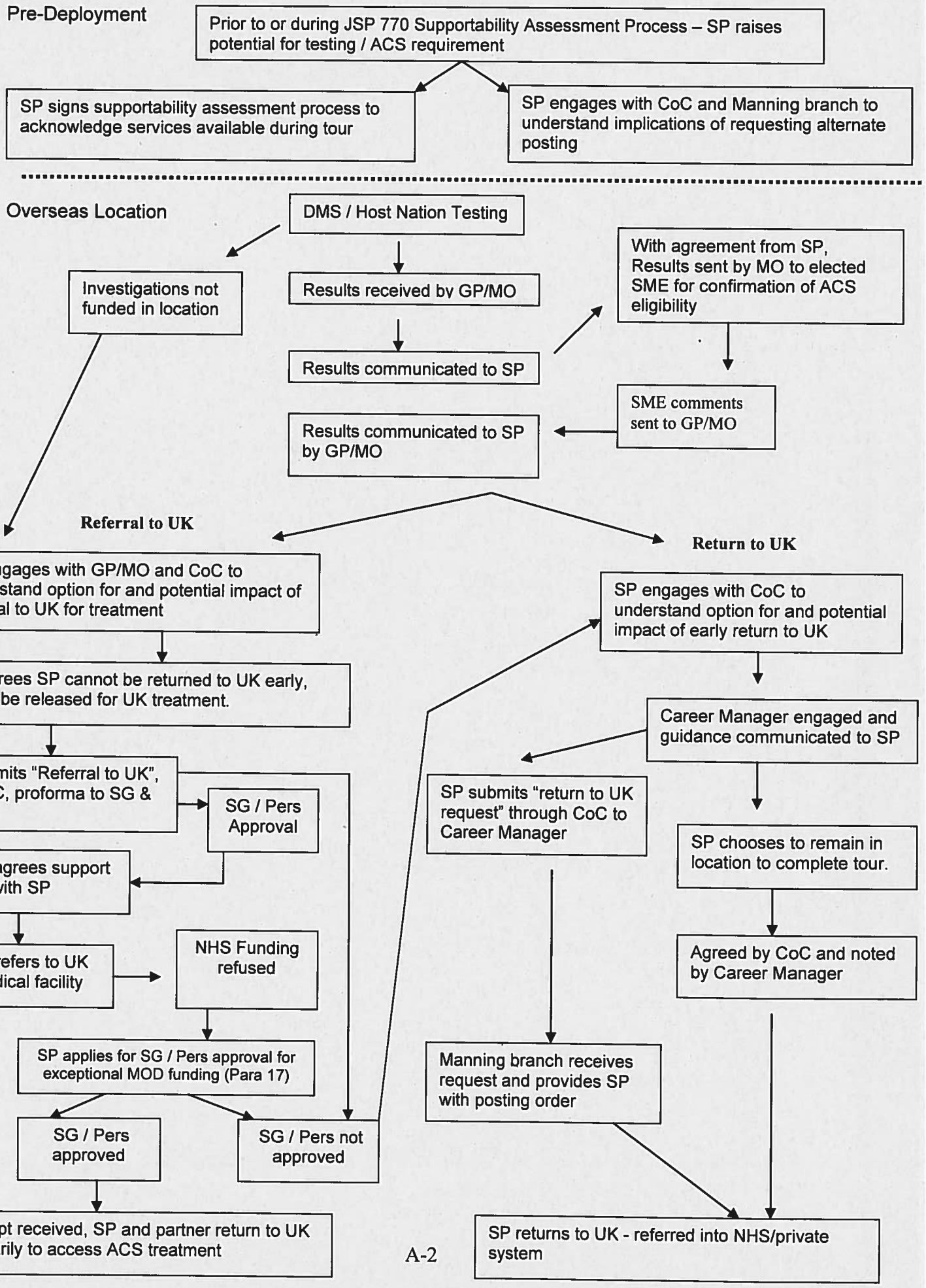
1. **Within UK**



One /Two Year Point



2. Overseas


Pre-Deployment
Prior to or during JSP 770 Supportability Assessment Process – SP raises potential for testing / ACS requirement
SP signs supportability assessment process to acknowledge services available during tour
SP engages with CoC and Manning branch to understand implications of requesting alternate posting
Overseas Location
DMS / Host Nation Testing
Investigations not funded in location
Results received by GP/MO
With agreement from SP, Results sent by MO to elected SME for confirmation of ACS eligibility
Results communicated to SP
SME comments sent to GP/MO
Results communicated to SP by GP/MO
Referral to UK
Return to UK
SP engages with GP/MO and CoC to understand option for and potential impact of referral to UK for treatment
SP engages with CoC to understand option for and potential impact of early return to UK
CoC agrees SP cannot be returned to UK early, but can be released for UK treatment.
Career Manager engaged and guidance communicated to SP
SP submits "Referral to UK", Annex C, proforma to SG & Pers
SG / Pers Approval
SP submits "return to UK request" through CoC to Career Manager
CoC agrees support plan with SP
SP chooses to remain in location to complete tour.
GP refers to UK medical facility
NHS Funding refused
Agreed by CoC and noted by Career Manager
SP applies for SG / Pers approval for exceptional MOD funding (Para 17)
Manning branch receives request and provides SP with posting order
SG / Pers approved
SG / Pers not approved
NHS appt received, SP and partner return to UK temporarily to access ACS treatment
SP returns to UK - referred into NHS/private system