



HSE Fertility Services Report

2025

Executive Summary

The publicly funded, privately provided AHR service commenced in September 2023. Since then, we have seen the service grow, and it is now providing a service to almost 6,000 couples a year.

The AHR service is built on strong collaboration within the HSE, including colleagues from Healthcare Pricing Office, HSE Procurement and National Communications. That collaborative approach is also evident with the six Regional Fertility Hubs. The HSE has a framework with eight private providers, and the public/private model has worked well in meeting the needs of the public patients availing of the AHR service.

Some of the highlights for 2025 include:

- ▶ **5,818** couples were referred to Regional Fertility Hubs (RFH)
- ▶ Almost **3,000** clinics were run in the RFH, seeing new and review patients
- ▶ **435** pregnancies were reported from the treatments provided by the RFHs
- ▶ **1,996** couples were referred to a private provider of their choice
- ▶ **906** women aged 36-41 years were referred to a private provider. This was the largest age group referred
- ▶ **712** IVF cycles were started by the private providers
- ▶ A clinical pregnancy rate of **30%** was recorded for the IVF cycles
- ▶ **1,202** ICSI cycles were started
- ▶ A clinical pregnancy rate of **31%** was recorded for the ICSI cycles
- ▶ **1,319** Frozen Embryo Transfers (FETs) were started
- ▶ A clinical pregnancy rate of **34%** was recorded for the FET cycles
- ▶ **594** intrauterine insemination (IUI) cycles were started
- ▶ A clinical pregnancy rate of **11%** was recorded for IUIs
- ▶ In all four AHR procedure types the success rate was highest in the ≤ 34 years age bracket, and the ≥40 years had a significantly lower clinical pregnancy rate.

The 2025 activity data demonstrates a well-functioning referral pathway from General Practice to RFHs, and where appropriate, onward from RFHs to private providers. In total, 664 clinical pregnancies were recorded during the year. It is not possible to express overall clinical pregnancy rates as a percentage, as the relevant denominators for RFHs and FET cycles may extend across calendar years. Despite these data limitations, 2025 represents a strong year for publicly funded, privately delivered AHR services, providing a solid foundation for future expansion.



Kilian McGrane,

Director of National Women and Infants Health Programme

Public AHR Service – Progress To Date

2021-2022

Six regional fertility hubs were established to provide secondary level fertility care to couples experiencing fertility challenges. The six regional hubs are located in;

NMH // COOMBE // ROTUNDA // GALWAY
CORK UNIVERSITY MATERNITY HOSPITAL // LIMERICK

2022

Minister announced a €30 million budget to facilitate the provision of public AHR services for the first time in the States history

HSE undertook a procurement process and onboarded 8 approved fertility providers

New Patient pathways were designed and implemented to integrate the new public AHR service provision

Communication Campaign initiated to highlight new service launch

HSE in collaboration with DOH developed the access criteria for publicly funded AHR services

September 2023 Public AHR service commenced

June 2025 public AHR access criteria expanded to include couples who have 1 living child born between them

December 2025 the IUI service was launched in the Cork AHR Centre

Next steps:

- ▶ Standardise the male fertility pathway
- ▶ Review the access criteria in collaboration with the DOH with a view to further expanding the access criteria
- ▶ Further roll out of AHR services in the Public AHR centre in Cork

Glossary of Terms

AHHRA	Assisted Human Reproduction Regulatory Authority
AHR	Assisted Human Reproductive
BMI	Body Mass Index
CNS	Clinical Nurse Specialist
CUMH	Cork University Maternity Hospital
DoH	Department of Health
GP	General Practitioner
HSE	Health Service Executive
HFEA	Human Fertilisation Embryology Authority
HPRA	Health Products Regulatory Authority
ICGP	Irish College of General Practitioners
ICSI	Intra-cytoplasmic sperm injection
ICT	Information and Communication Technology
IUI	Intra-uterine insemination
IVF	In-vitro fertilisation
MoC	Model of Care
NWIHP	National Women and Infants Health Programme
Oocyte	female egg cell
RFH	Regional Fertility Hub
SI	Secondary Infertility

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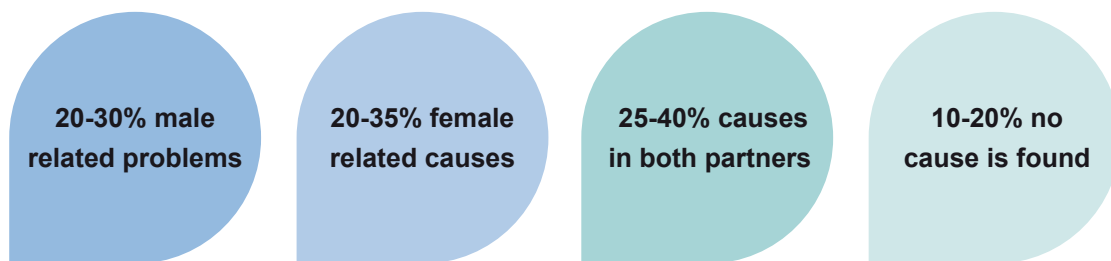
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1.0 Introduction

The Health Service Executive's (HSE) National Women and Infants Health Programme (NWIHP) is responsible for the ongoing management and development of reproductive medicine services within Ireland's public health system. This work is guided by the Model of Care (MoC) for Fertility Services, developed by the Department of Health (DOH) in collaboration with the NWIHP. The MoC provides a structured, equitable, and evidence-based framework to support the delivery of high-quality fertility services nationally starting at the lowest level of complexity.

Infertility affects a significant proportion of the population. It is estimated that approximately one in six heterosexual couples experience difficulties in achieving pregnancy. In addition, single individuals and same-sex couples who wish to become parents may require assisted reproductive supports, including donor sperm, donor eggs, or surrogacy. Fertility challenges may arise from female factors, male factors, a combination of both, or, in some cases, no identifiable cause despite appropriate investigation.



In response to this need, fertility teams within regional fertility hubs provide holistic, patient-centred care. For heterosexual couples, both partners are assessed and managed as a unit, recognising the shared nature of fertility and the importance of coordinated investigation and treatment planning.

Age remains one of the most significant determinants of fertility outcomes. Women under 30 years of age have approximately a 25% chance of conceiving per menstrual cycle; this probability declines progressively with age, falling to approximately 5% by age 40. Nevertheless, more than 80% of couples will conceive within one year where the woman is under 40 years of age and regular unprotected sexual intercourse (every two to three days) occurs. Of those who do not conceive within the first year, a substantial proportion will do so during the second year.

Timely referral and assessment are critical to optimising outcomes. Couples who have been attempting to conceive for six months without success where the woman is aged 36 years or older, or for 12 months where the woman is under 36 years of age, should seek medical advice from a general practitioner to initiate appropriate evaluation and management. Early engagement with healthcare services ensures that potential underlying causes are identified promptly and that individuals and couples receive appropriate, evidence-based support in line with the national MoC.

This year's report opens with key updates on the delivery of public Assisted Human Reproduction (AHR) services, with particular focus on the establishment of the inaugural public AHR service in Cork and the expansion of DOH defined access criteria implemented in 2025.

The report then provides an overview of activity data for 2025 across the regional fertility hubs and HSE-approved private providers. Finally, an addendum includes activity data for the period September to December 2024 and 2024 private provider data to ensure that all periods since September 2023 when the service commenced are reported. Data for the period September 2023 to August 2024 are detailed in our first HSE Fertility Services report.

2.0 Updates Regarding Public AHR Service Delivery

This section outlines key developments in the delivery of public AHR services during the reporting period. It summarises progress in service implementation, including the establishment and operationalisation of the new the public AHR centre, updates to access pathways and eligibility criteria, and measures undertaken to enhance service quality, governance, and patient access. Collectively, these developments reflect ongoing efforts to strengthen equitable, sustainable, and patient-centred AHR service provision within the public health system.

2.1 Building Capacity for Delivery of a Public AHR Service

Cork University Maternity Hospital (CUMH), supported by NWIHP, has continued to advance the comprehensive programme of work required to deliver Ireland's first publicly funded, publicly provided AHR facility. This programme encompasses workforce planning and recruitment, detailed service design, and a phased implementation model commencing with the introduction of an Intrauterine Insemination (IUI) service.

In parallel, significant progress has been made in ICT development to support the specialised clinical and laboratory requirements of fertility services. Procurement planning and enabling infrastructural works are also underway to ensure that the facility will be fully compliant with all relevant regulatory and legislative requirements.

During 2025, NWIHP, in collaboration with HSE and CUMH colleagues, successfully secured approval for embryology grade codes within the public health sector. The establishment of these grade codes represents a critical enabler for service development, facilitating the recruitment of appropriately qualified specialist embryology personnel while standardising the minimum training and competency requirements associated with each grade. It is anticipated that these posts will be filled during 2026 in preparation for the launch of the full AHR service.

In 2025, the Cork Regional Fertility Hub successfully obtained authorisation and licensing from the Health Products Regulatory Authority (HPRA) to deliver IUI treatment. This marks a significant milestone in the phased implementation of public AHR treatment. As of December 2025, referrals for IUI treatment have commenced from within the Cork region. As referral pathways continue to embed and operational processes mature, it is anticipated that the Cork regional centre will expand to accept referrals from additional regional fertility hubs.

Since September 2025, substantial progress has been achieved in securing the necessary capital investment to support full service delivery. A dedicated project management team has been appointed, and CUMH, in collaboration with HSE Capital and Estates, is advancing key programme components, including planning and design development, enabling surveys, and the procurement of specialist contractors.

The current programme plan is targeting full operational launch in Q4 2027. This timeline is contingent upon the completion of essential policy development, the establishment of robust audit pathways, and the implementation of comprehensive quality management systems, all of which are prerequisites for securing full HPRA licensing for a complete AHR service

2.2 Expansion of the AHR Packages of Care

In 2025, the HSE tendered for three additional packages of care within publicly funded fertility services. These included:

- ▶ Sperm cryopreservation for up to two months to support men who may be required to produce a sample in advance of egg collection;
- ▶ Provision for cancelled frozen embryo transfers, ensuring standardised payments across all fertility providers; and
- ▶ The introduction of micro-TESE (microsurgical testicular sperm extraction).

NWIHP fully recognises that male factor infertility must be comprehensively addressed within the overall fertility care pathway. In this context, NWIHP is working collaboratively with colleagues in the Irish Society of Urology to formalise and standardise the male fertility patient pathway at a national level.

The introduction of micro-TESE in December 2025 represents a significant milestone in the development and enhancement of services for male patients. Appendix 1 outlines the male patient pathway in detail.

Investment in the national standardisation and further development of this pathway in 2026 remains a key strategic priority for NWIHP.

2.3 Broadening of AHR Access Criteria

Secondary infertility (SI) occurs at a rate comparable to primary infertility, affecting approximately one in six couples. It is estimated that cases of SI are attributable in roughly equal measure to male and female factor infertility.

In June 2025, the DOH announced an expansion of the defined access criteria for publicly funded, privately provided AHR treatment. This expansion included eligibility for couples with one existing child within their current relationship, provided they had not previously received publicly funded AHR treatment. All other established clinical and social eligibility criteria continue to apply. See appendix 2 for list of full access criteria

This development represents a significant broadening of access and reflects an evolving, evidence-informed approach to service provision. It also signals an intention to keep the access criteria under ongoing review as the public AHR service continues to embed and mature.

It is anticipated that this expansion will encourage couples who may not previously have considered themselves eligible for referral to regional fertility hubs to seek assessment through their General Practitioner (GP). Earlier engagement with referral pathways will support timely clinical assessment and ensure that fertility challenges are appropriately evaluated and managed within the public system.

2.4 AHR Regulator

In 2025, the Minister for Health formally established the Human Reproduction Regulatory Authority (AHRRA). Professor Deirdre Madden was appointed as the inaugural Chairperson, alongside seven additional members appointed to serve on the Authority's Board.

AHRRA has been constituted as a statutory, independent regulatory body. Its primary function is to safeguard and promote the health, safety, and wellbeing of individuals experiencing fertility challenges who are accessing AHR services, as well as children born as a result of AHR treatment.

The establishment of the Authority represents a significant milestone in the commencement and implementation of the AHR 2024 legislation. It provides a robust regulatory framework for what is a rapidly evolving and highly specialised area of medicine. Given that AHR services have historically operated largely within a private, commercially driven market, the creation of AHRRA is an important step in strengthening oversight, ensuring compliance with statutory standards, and enhancing patient protection.

NWIHP welcomes the establishment of AHRRA and looks forward to engaging constructively with the Authority as its executive structures and workforce are developed, in whatever capacity may be appropriate to support safe, equitable, and high-quality AHR service provision.

3.0 Trends and Data Overview

Since the introduction of formal referral pathways enabling eligible public patients to access treatment through six regional fertility hubs to an HSE-authorised private AHR Provider, national-level data has been systematically collated and analysed by the NWIHP. This analysis supports NWIHP's oversight role in the strategic development and governance of reproductive medicine services in Ireland.

This report presents an overview of the principal datasets currently available in relation to the development of reproductive medical services nationally, with particular emphasis on the delivery of publicly funded, privately provided AHR services to eligible public patients. The data referenced has been derived from activity metric returns submitted from primary sources from the six Regional Fertility Hubs, the eight HSE authorised private fertility providers while the referral activity data is sourced and captured from the access to care IT system.

3.1 Regional Fertility Hub Activity

The data represented in this section is derived directly from the fertility hubs who submit key metrics to NWIHP on a monthly basis. Data is verified at local level and thereafter submitted to NWIHP for analysis of service demand and delivery.

3.1.1 Referral Activity Nationally 2025

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
Referrals Accepted Nationally	482	467	499	408	469	410	627	476	568	514	447	451	5818

On average, the regional fertility hubs accepted 484 referrals per month for fertility assessment during 2025. Referral activity peaked in July, which may be associated with the Ministerial announcement expanding the AHR access criteria.

It is important to note that, for reporting purposes, referrals to a regional fertility hub are counted based on the female partner as the primary patient. However, in practice, each referral represents a couple experiencing fertility challenges.

Accordingly, the 5,818 referrals recorded in 2025 correspond to approximately 11,636 individuals who were referred to one of the six regional fertility hubs over the course of the year.

Of all referrals received to the regional fertility hubs, 86% of referrals originated from GPs with the remainder being comprised of other public medical specialist referrals.

3.1.2 Clinic Activity 2025

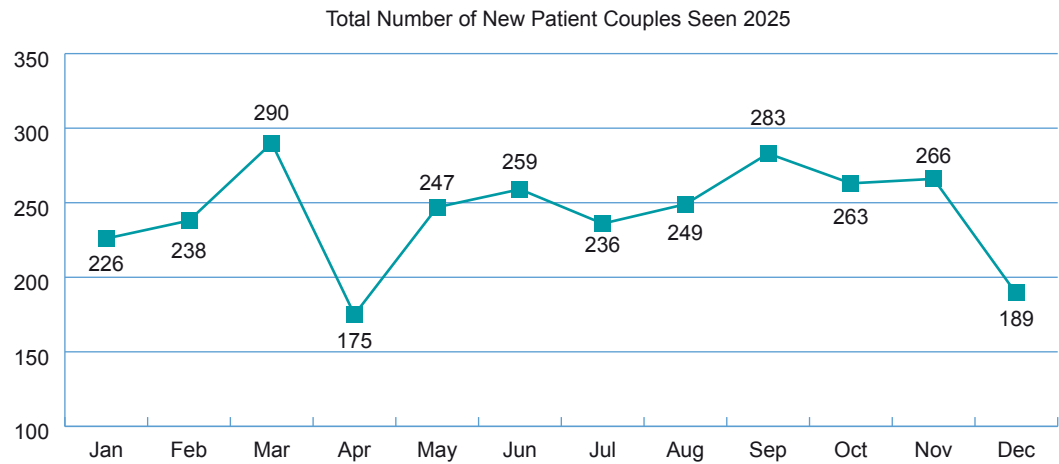
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
Total number of Consultant clinics provided	58	61	60	60	59	62	63	61	76	70	58	37	725
Total number of CNS clinics	186	167	158	156	177	221	239	223	240	171	177	155	2270

The data represents the number of structured clinics provided across the six regional fertility hubs in 2025. The patient pathways within the regional fertility hubs are designed such that there is early engagement with patients further to a referral being received and accepted by the CNS team.

Once a referral is accepted a patient health questionnaire is posted out to patients with a view to obtaining early in the care pathway a suite of standardised information regarding the health status and medical history of each patient. Upon receipt of the questionnaire, the nursing team will coordinate baseline investigations for the referred couple inclusive of bloodwork, ultrasound scans and semen analysis with the average approximate time to be seen by a specialist nurse at 13 weeks nationally.

Once all results are available, an appointment is offered by the nursing team to see the Consultant specialist within the hub to review all findings and to determine the next appropriate clinical steps whether that be further secondary level care or consideration of advanced fertility treatment. Nationally, on average, the majority of patients are seen by the Reproductive Medical Consultant for this plan of care consultation within a 6-month timeframe.

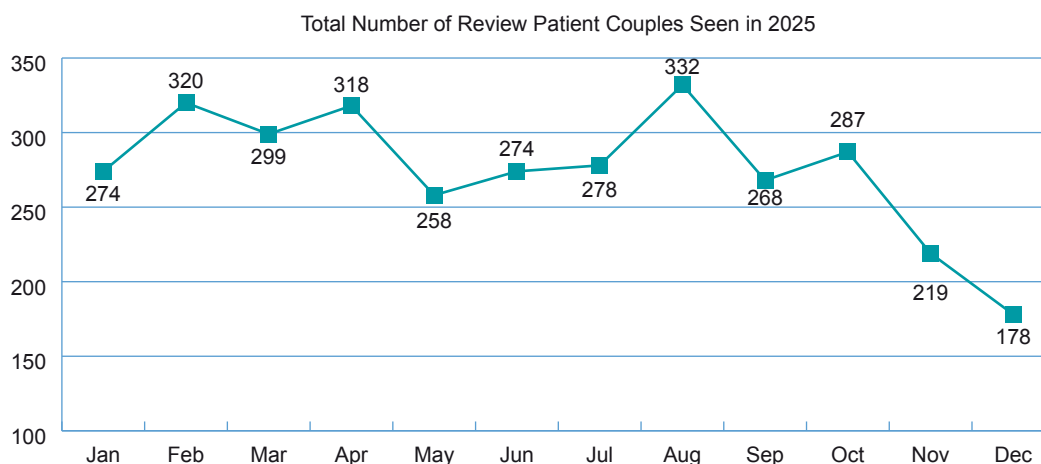
3.1.3 Number of New Patients Seen in Consultant Clinics, 2025



As previously mentioned in relation to referral data above, within this report patient activity is counted by the primary patient referred but, in fact, each referral represents a male-female couple. As such it is important to note that the six regional fertility teams manage new and review patients within the context of them being a couple. This means that both the female and the male are active patients of the hubs and both are assessed and managed with a view to determining the best plan of care for them with reference to both the female and the male’s individual needs

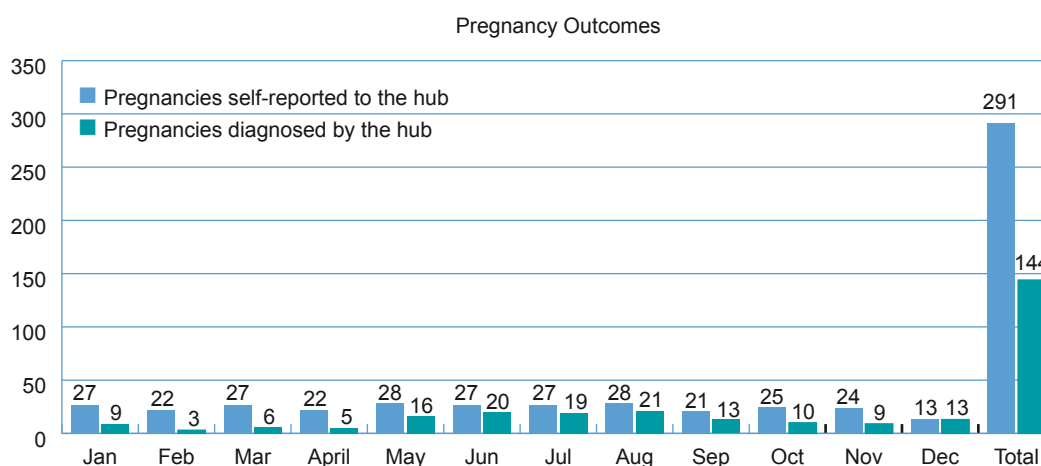
During the course of 2025, a total of 2,921 new couples have had a consultation with a specialist across the six regional fertility hubs. This equates to an average of 42 new couples being seen per hub per month over the 12 months. This data is consistent with the previous AHR report in terms of new patient couples seen.

3.1.4 Number of Review Patients Seen in Consultant Clinics, 2025



During 2025, the six regional fertility hubs have reported that approximately 3,305 couples have been provided with review consultations in the hubs. This highlights the complex needs of this patient cohort where often multiple attendances at secondary level are indicated in order to achieve a pregnancy and/or refer for publicly available AHR intervention.

3.1.5 Outcomes at Regional Hub Level



The data presented in this graph reflects pregnancy outcome activity reported by regional fertility hubs during 2025. This information should be interpreted with caution, as it is largely based on patient self-reporting of pregnancies following care at secondary level.

Regional fertility hubs do not routinely perform dedicated pregnancy confirmation scans as part of conservative management pathways. Consequently, pregnancies recorded at hub level are typically identified either through patient self-reporting or incidentally during ovulation induction monitoring, rather than through systematic imaging.

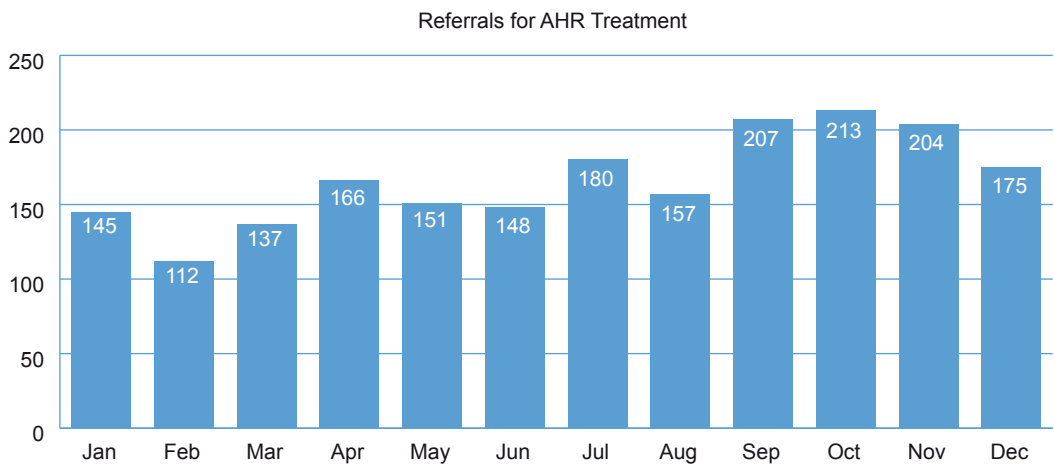
In 2025, a total of 435 clinical pregnancies were recorded across all regional hubs. Of these, 291 were self-reported by patients, while the remaining pregnancies were identified through scans conducted within the hubs. Given the reliance on patient self-reporting and the absence of systematic pregnancy confirmation processes, it is likely that this figure underrepresents the true number of pregnancies achieved among couples attending public regional fertility services.

Notwithstanding these limitations, the data demonstrates that a substantial proportion of couples experiencing fertility challenges can achieve pregnancy following management at secondary care level, without requiring AHR intervention.

3.2 AHR Referral Data

The data set out in the following section is derived from the Access to Care IT system. In reviewing this data, it is important to bear in mind the nature of AHR services and the prolonged period over which a couple may remain under the active clinical management and care of a private AHR Provider before they are discharged.

3.2.1 Total Number of Referrals per month for AHR Treatment in 2025



In 2025, **1,996** AHR referrals were made from the network of six fertility hubs. The number of patients being referred has grown month on month as patients continue to move through the six regional fertility hubs and exhaust treatment options available at secondary level care. Over the course of 2025 the average AHR referrals per month was 166. This rate has grown substantially from the previous year’s activity where the average referrals per month was 122. NWIHP expects referrals to plateau at approx. 180 per month with the current access criteria now that patient pathways have been established and processes embedded.

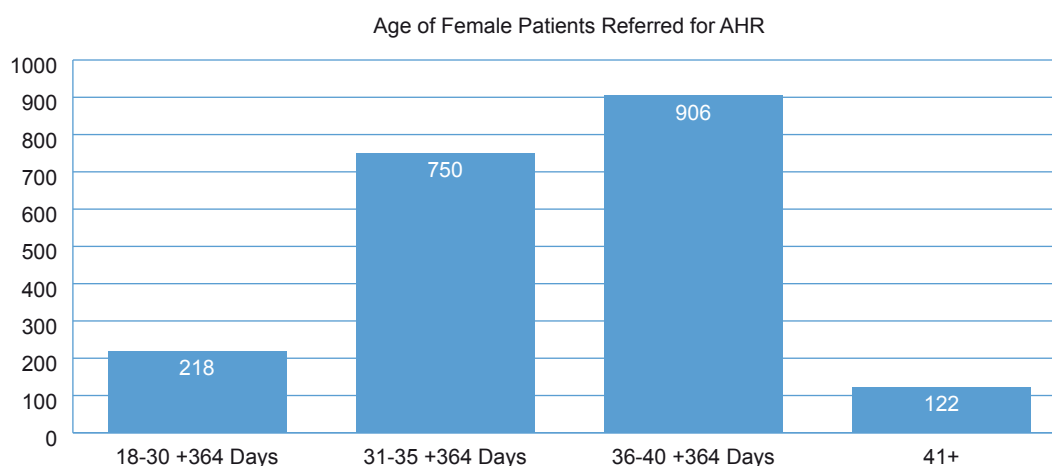
The ability for patients to choose their preferred AHR Provider is a key principle of the patient pathway. Under the service agreements in place, the chosen provider must provide their initial consultation with the patient within six weeks of receipt of referral. As such, there are no waiting lists held with the AHR Providers to be seen for the initial consultation.

3.2.2 Total Number of Referrals made by Hubs per month per Treatment Type for 2025

Product	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
IUI – 1 Cycle	8	9	7	14	10	6	15	12	15	18	3	1	118
IUI – 2 Cycle	1	1	1			1	2	1		2	4	2	15
IUI – 3 Cycle	12	8	12	3	8	7	15	19	19	28	20	18	169
IVF	52	33	59	69	64	55	65	63	85	79	101	79	804
ICSI	70	60	53	71	64	77	77	54	82	77	63	68	816
ICSI plus TESE	2	1	3	7	3	3	5	4	5	8	7	5	53
FET			2	2	2		2	5	1	3	6	6	29
ICSI plus MicroTESE												1	1
Total	145	112	137	166	151	149	181	158	207	215	204	180	2005

In terms of treatments for which patients are referred, as expected IVF and ICSI continue to trend as the most frequently referred product. As of December 2025, the regional fertility hubs were enabled to refer eligible patients for micro-TESE. A considerable milestone for the service.

3.2.3 Breakdown of the Female Age of Patients Referred for AHR during 2025



As shown above, female patients aged 36-40 years constituted the largest cohort (45%) referred to an AHR private provider by one of the six regional fertility hubs. Patients aged 41 years and older accounted for 6% of referrals, while those in the youngest age category (18-30 years) represented 11% of all referrals. These findings are consistent with trends identified in the previous AHR report.

With regard to patients aged 41 years and over, eligibility criteria as defined by the DoH require that patients must be under 41 years of age at the time of referral by their General Practitioner to a regional fertility hub. Consequently, following assessment and review at hub level, a small minority of patients are aged 41 years or older at the point of referral for AHR treatment.

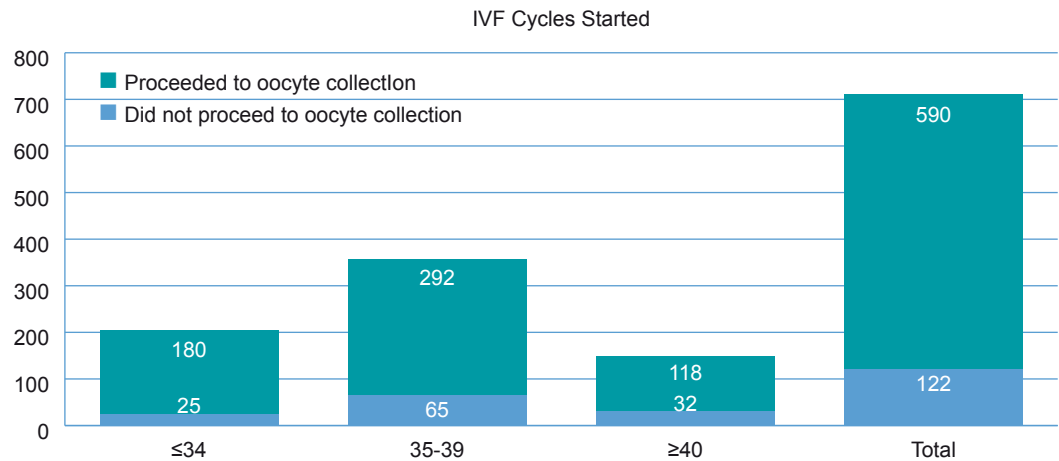
3.3 Private Provider Metrics

This section outlines the key activity metrics recorded during 2025. All eight HSE-approved providers have contributed to the dataset presented.

The data contained within this report are presented in an anonymised and aggregated format to ensure that individual providers are not identifiable. This approach is intended to support transparency while safeguarding patient autonomy and ensuring that reporting does not unduly influence patient choice when selecting a HSE-approved private fertility provider.

3.3.1 IVF data

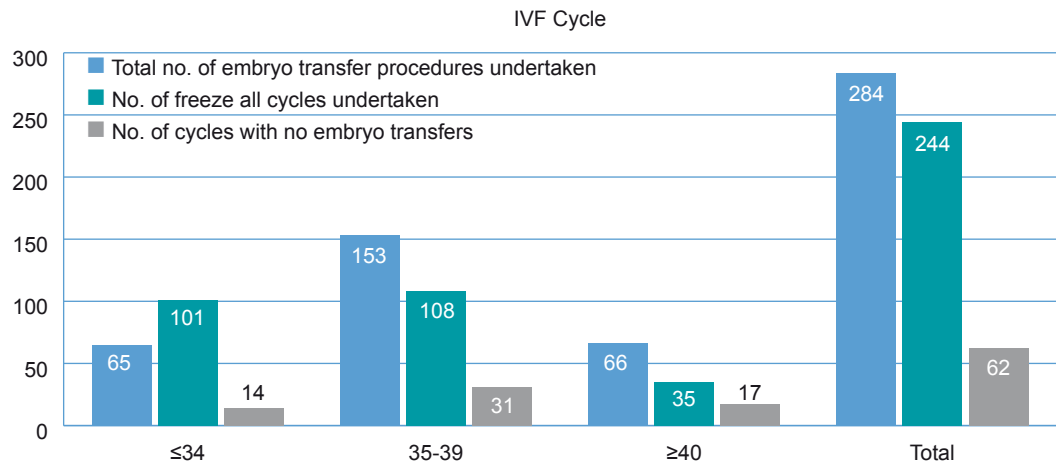
3.3.1 (i)



During 2025, a total of 712 IVF cycles were initiated, representing a 57% increase compared with the number of cycles commenced in 2024. Of these, 590 cycles progressed to the oocyte collection stage, indicating that approximately 20% of initiated cycles were cancelled during the course of stimulation.

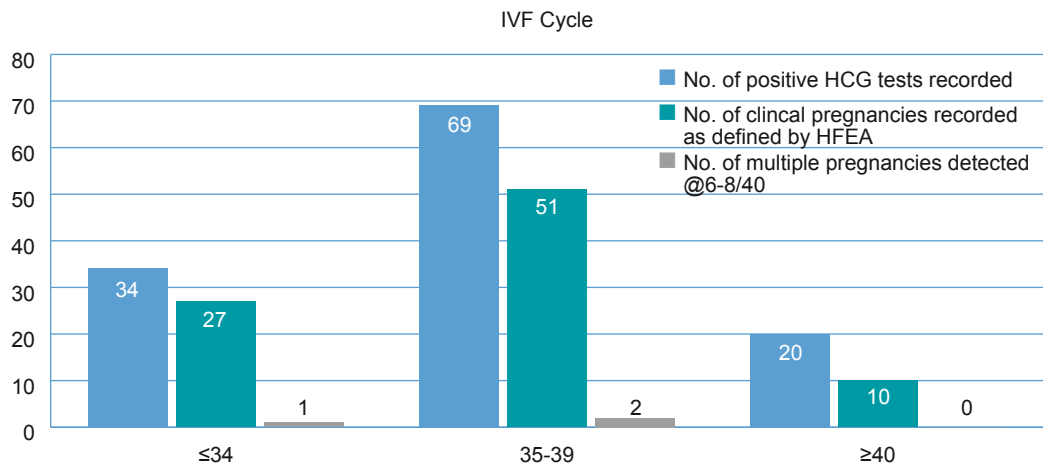
Analysis of patient demographics shows that individuals aged 35-39 years accounted for the largest proportion of cycles commenced. This distribution is consistent with the AHR age-related referral patterns outlined elsewhere in this report, demonstrating alignment between referral trends and treatment activity during the reporting period.

3.3.1 (ii)



The data presented in this chart illustrates the total number of IVF fresh embryo transfers, IVF freeze-all cycles, and IVF cycles in which no embryos were available for transfer. In 2025, the eight HSE-approved private providers performed 284 fresh embryo transfers and 244 freeze-all cycles as part of IVF treatment.

3.3.1 (iii)

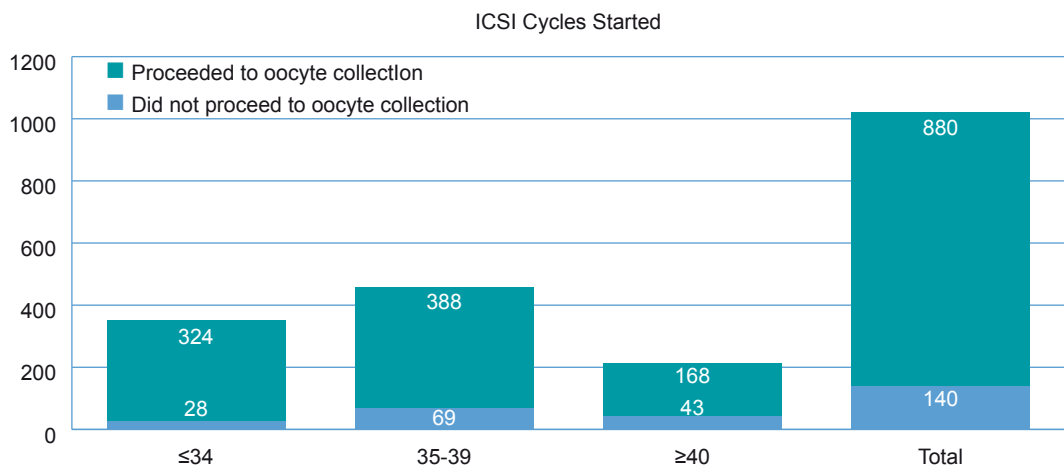


The outcome data for IVF cycles in 2025 have resulted in a number of pregnancies using the HCG test to assess for biochemical pregnancies and 8 weeks scan, which as per Human Fertilisation and Embryology Authority (HEFA) definition, detects fetal heartbeat scans for clinical pregnancies. Using the total number of IVF embryo transfer procedures undertaken in 2025 as the denominator and the number of clinical pregnancies as the numerator a **30%** positive clinical pregnancy rate is yielded across all age ranges for 2025 IVF cycles. See below table which further interrogates the clinical IVF pregnancy outcomes per age cohort.

≤34 years	42%
35-39 years	33%
≥ 40 years	15%

3.3.2 ICSI data

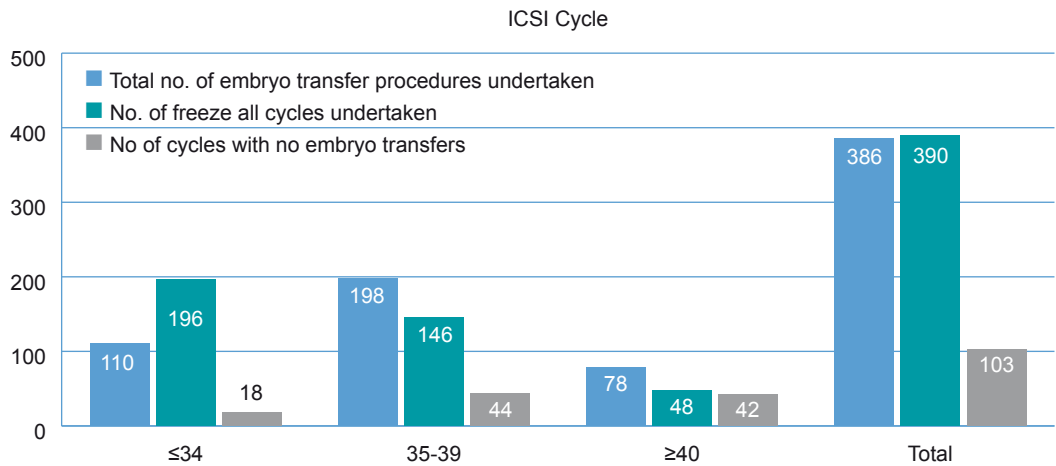
3.3.2 (i)



ICSI remained the preferred method of AHR in both 2024 and 2025. Although referral data indicate that fewer patients were initially referred for ICSI, the eight HSE-approved fertility providers retain clinical discretion to convert a cycle to ICSI where semen analysis at the time of oocyte collection suggests that this approach would optimise outcomes for the patient couple.

In 2025, a total of 1,020 ICSI cycles were initiated, representing an increase of 405 cycles commenced compared with 2024. Of these, 880 cycles progressed to the oocyte collection stage, indicating that approximately 14% of initiated cycles were cancelled during the course of stimulation.

3.3.2 (ii)

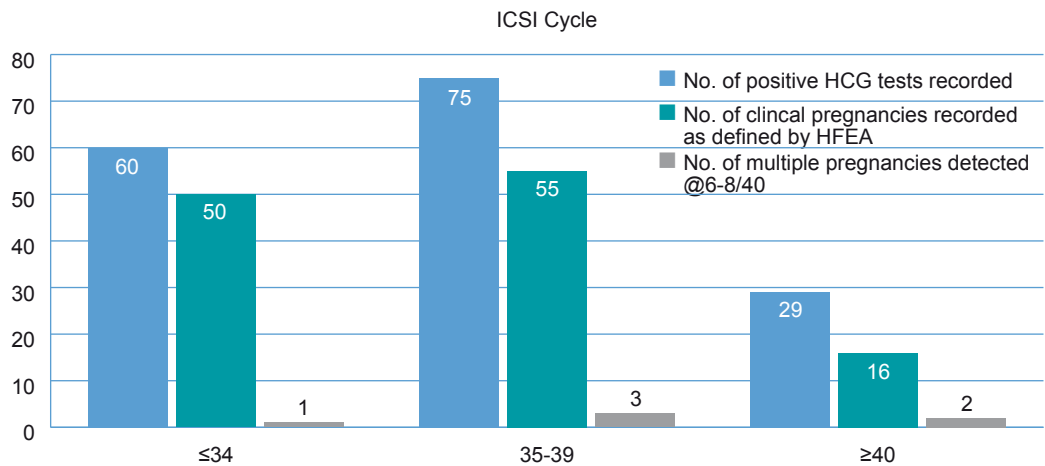


The data presented in this chart illustrate the total number of ICSI fresh embryo transfers, ICSI freeze-all cycles, and ICSI cycles in which no embryos were available for transfer.

In 2025, there was minimal variation in the number of patients undergoing fresh embryo transfer compared with freeze-all cycles, with 386 and 390 cycles respectively. This contrasts with 2024, when a higher number of patients underwent fresh embryo transfer compared to freeze-all ICSI cycles (254 versus 208).

Given the relatively small dataset, caution should be exercised in interpreting these findings, and additional data will be required to determine whether these differences represent a sustained trend in clinical practice.

3.3.2 (iii)

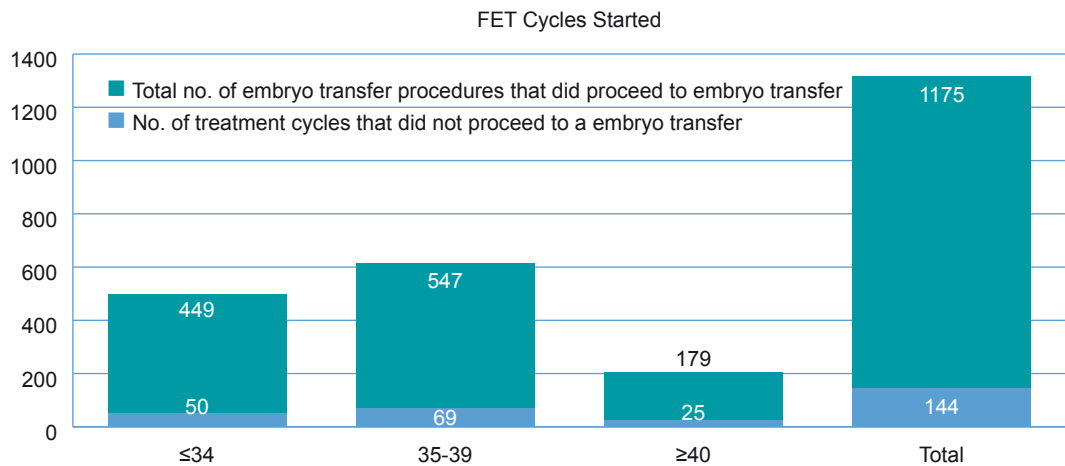


The outcome data for ICSI cycles in 2025 have resulted in a number of pregnancies using the HCG test to assess for biochemical pregnancies and 8 weeks scan which as per HFEA definition detects fetal heartbeat scans for clinical pregnancies. Using the total number of ICSI embryo transfer procedure undertaken in 2025 as the denominator and the number of clinical pregnancies as the numerator a **31%** positive clinical pregnancy rate is yielded across all age ranges for 2025 ICSI cycles. See below table which further interrogates the clinical ICSI pregnancy outcomes per age cohort.

≤34 years	45%
35-39 years	28%
≥ 40 years	21%

3.3.3 FET data

3.3.3 (i)

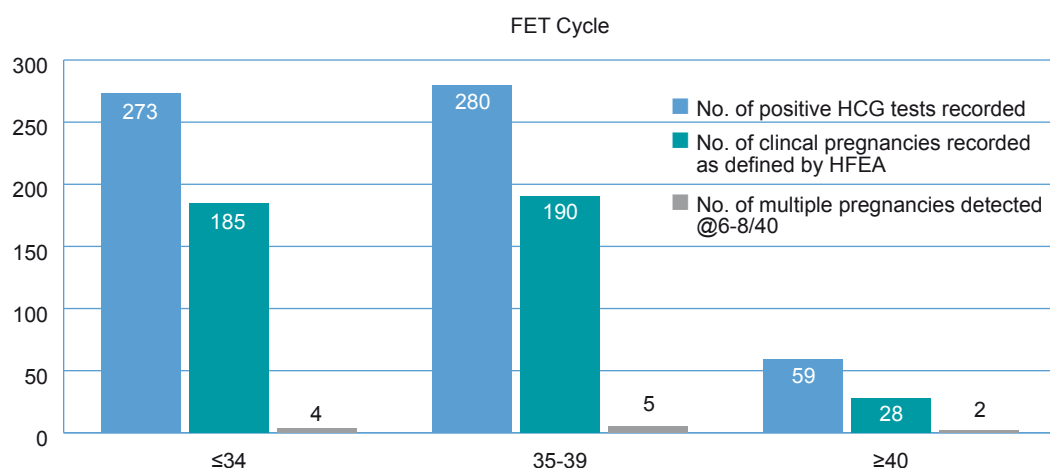


During 2025, a total of 1,319 frozen embryo transfer (FET) cycles were initiated, of which 1,183 progressed to embryo transfer. Women aged 35-39 years represented the largest cohort availing of FET services.

The data presented are cumulative in nature and do not distinguish the number of FET cycles undertaken per individual patient during the reporting period. As such, the figures reflect overall activity rather than patient-level utilisation.

It is anticipated that, as the service continues to mature, the number of FET cycles will increase, as patients return to utilise cryopreserved embryos in pursuit of a successful clinical pregnancy and live birth. International evidence suggests that patients may require multiple embryo transfer attempts before achieving a confirmed clinical pregnancy. However, further data will be required to contextualise this within the public AHR service.

3.3.3 (ii)

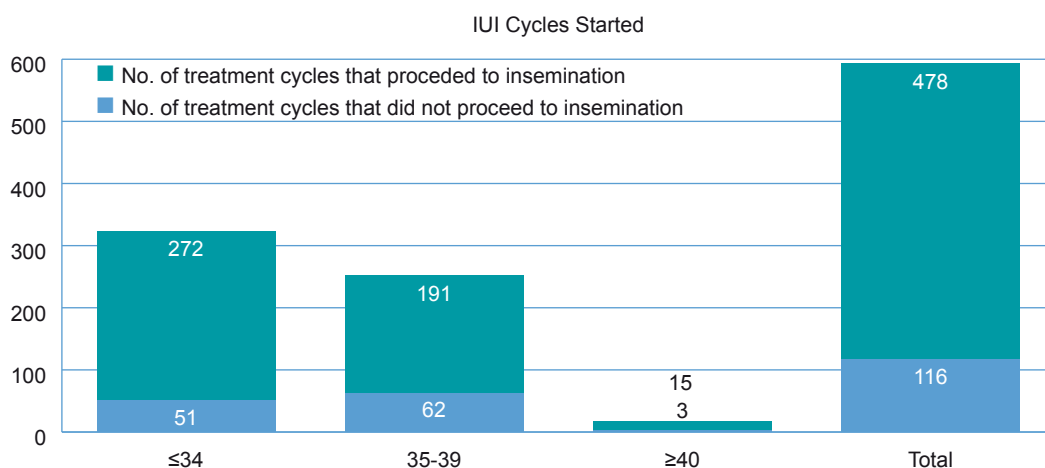


The outcome data for FET cycles in 2025 have resulted in a number of pregnancies using the HCG test to assess for biochemical pregnancies and 8 weeks scan which as per HEFA definition detects fetal heartbeat scans for clinical pregnancies. Using the total number of frozen embryo transfer procedure undertaken in 2025 as the denominator and the number of clinical pregnancies as the numerator a **34%** positive clinical pregnancy rate is yielded across all age ranges for 2025 FET cycles. See below table which further interrogates the clinical FET pregnancy outcomes per age cohort.

≤34 years	41%
35-39 years	34%
≥ 40 years	16%

3.3.4 IUI data

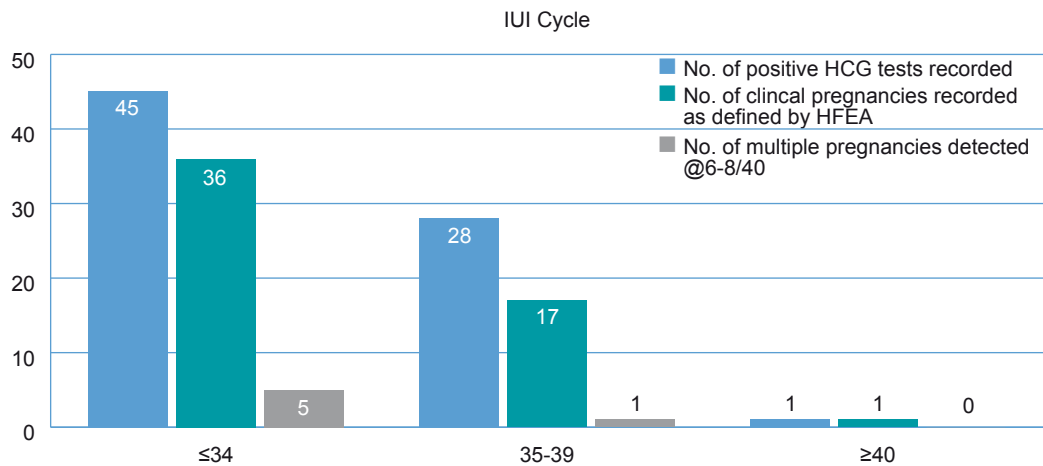
3.3.4 (i)



In 2025, a total of 594 intrauterine insemination (IUI) cycles were initiated, with 478 patients proceeding to the insemination procedure.

As expected, the largest proportion of patients availing of this AHR treatment were within the younger age cohorts, where clinical outcomes are generally more favourable. A comparatively small number of patients aged over 40 years underwent IUI treatment, which is consistent with established best practice guidelines.

3.3.4 (ii)



The outcome data for IUI cycles in 2025 have resulted in a number of pregnancies using the HCG test to assess for biochemical pregnancies and 8 weeks scan which as per HEFA definition detects fetal heartbeat scans for clinical pregnancies. Using the total number of IUI procedures undertaken in 2025 as the denominator and the number of clinical pregnancies as the numerator a **11%** positive clinical pregnancy rate is yielded across all age ranges for 2025 IUI cycles. See below table which further interrogates the clinical IUI pregnancy outcomes per age cohort

≤34 years	13%
35-39 years	9%
≥ 40 years	7%

4.0 Summary

The 2025 report demonstrates that the public AHR service is offering care to patients presenting with fertility challenges and clinical pregnancies are ensuing. This AHR Report provides a comprehensive overview of the development, activity, and early outcomes associated with publicly funded fertility services across the national fertility network. It demonstrates continued progress in expanding access to fertility care through the establishment of regional fertility hubs and the implementation of structured referral pathways to AHR services.

In 2025, a total of **5,818** referrals were accepted across the six regional fertility hubs, representing approximately **11,636** individuals accessing public fertility services. Over the same period, **1,996** patients were referred onward for AHR treatment, reflecting the continued progression of patients through structured care pathways. At secondary care level, **435** clinical pregnancies were recorded, demonstrating that a meaningful proportion of couples can achieve pregnancy without requiring advanced reproductive interventions. This underscores the value of the hub model in delivering timely, appropriate, and less invasive interventions, while reserving advanced reproductive treatments for those who require them.

At AHR level, treatment activity has increased significantly, with **712** IVF cycles, **1,020** ICSI cycles, **1,319** FET cycles, and **594** IUI cycles initiated during 2025. These figures reflect both the maturation of the service and the increasing number of patients progressing to advanced treatment. Cumulative success rates for IVF, ICSI and FET indicate an overall clinical pregnancy rate of approximately **30%**, which is consistent with comparable international data. A total of **664** clinical pregnancies were recorded in 2025.

While challenges remain in relation to data completeness and outcome tracking particularly in capturing live birth outcomes the data in this report is robust, and shows an effective service. Ongoing enhancements in data capture and standardised reporting processes are expected to significantly strengthen the completeness of future datasets. This will support more robust evaluation of clinical outcomes and inform evidence-based service planning. The HSE will continue to work closely with colleagues across the HSE and the Department of Health to further develop and refine the service, ensuring its continued evolution as a high-quality, equitable, and patient-centred model of care.

The demand for the AHR service has continued to grow since the start in September 2023. There are some challenges emerging regarding access times for the RFHs. NWIHP will continue to work with the RFHs and colleagues in DoH regarding any future investment the service may require.

5.0 Addendum Data Report for September 2024-December 2024 Key Data and 2024 Private Provider Metrics

The initial AHR report did not encompass a full calendar year. To ensure completeness of reporting, data for the period September to December 2024 are included for transparency. As this represents historic data, no detailed analysis has been undertaken.

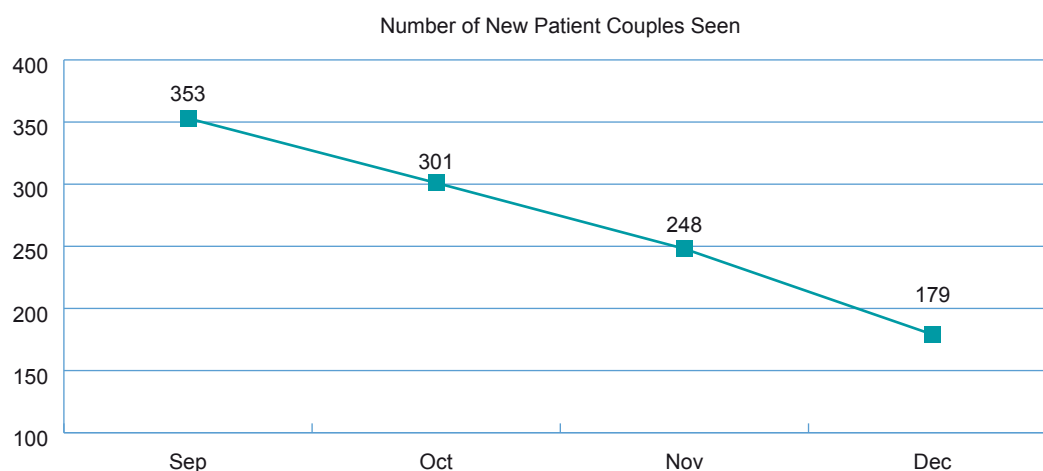
5.1 Referral Activity Nationally September 2024 – December 2024

	September	October	November	December	Total
Referrals Accepted	449	530	403	302	1684

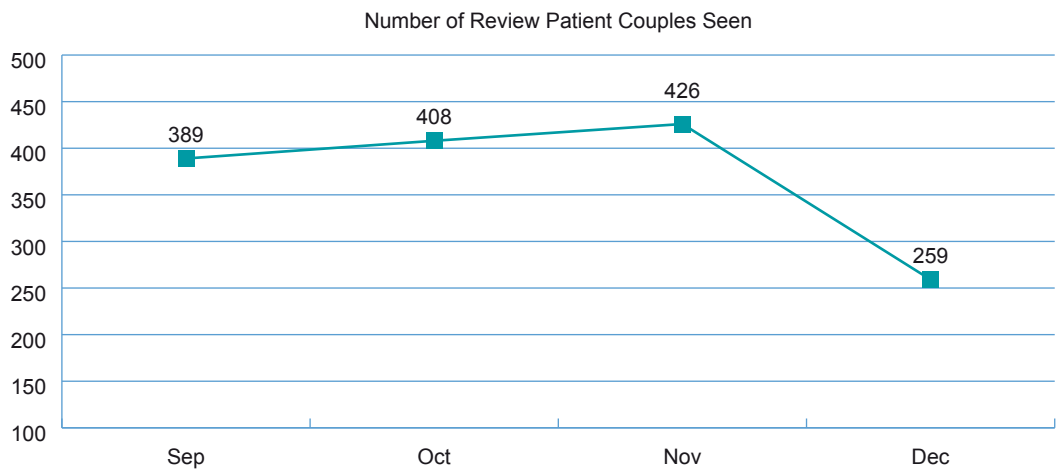
5.2 Clinic Activity September 2024 – December 2024

	September	October	November	December	Total
Number of Consultant Clinics	69	71	53	49	242
Number of CNS clinics	155	155	187	137	634

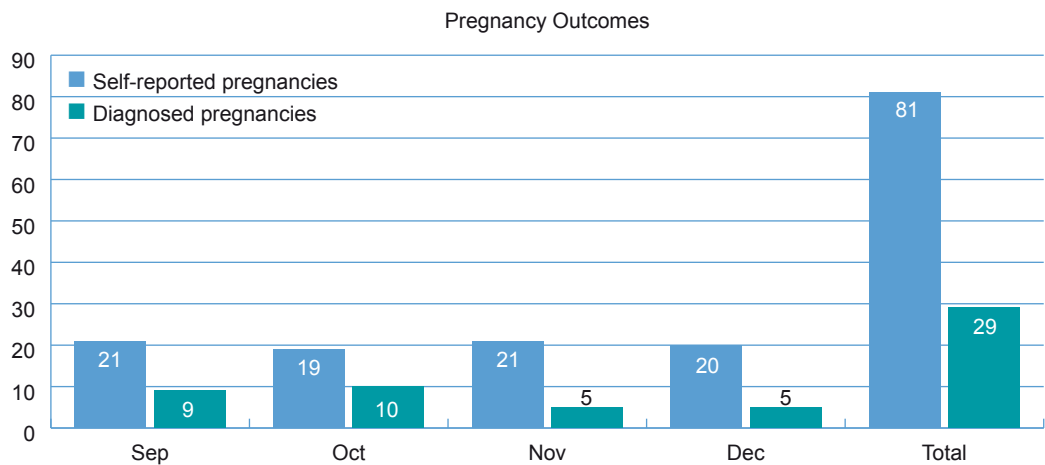
5.3 Number of New Patient Couples Seen in Consultant Clinics September 2024 – December 2024



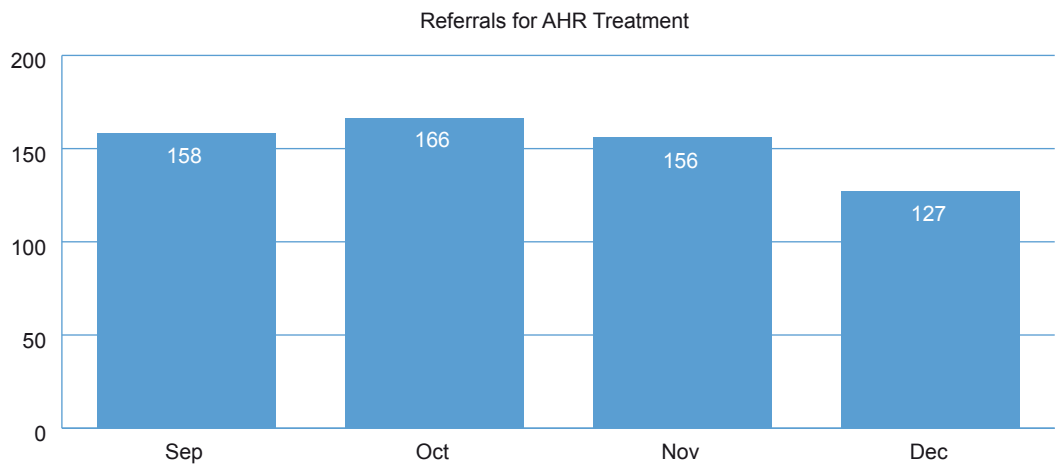
5.4 Number of Review Patient Couples Seen in Consultant Clinics September 2024 – December 2024



5.5 Outcomes at Regional Hub level September 2024 – December 2024



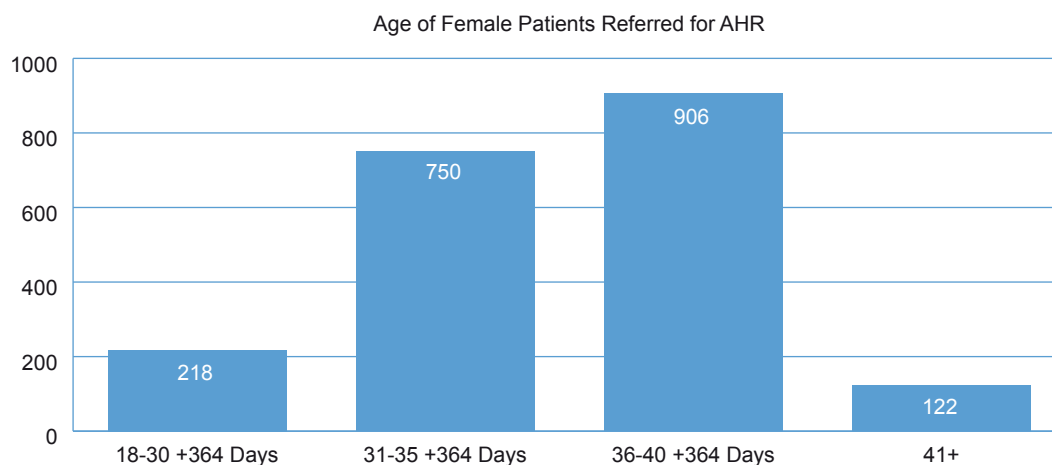
5.6 Referral for AHR September 2024 – December 2024



5.7 Total Number of Referrals per month per Treatment Type September 2024 – December 2024

	September	October	November	December	Total
IUI	21	30	13	16	80
IVF	62	56	66	49	233
ICSI	70	76	69	58	273
ICSI+ TESE	5	3	7	1	16
Total	158	165	155	124	602

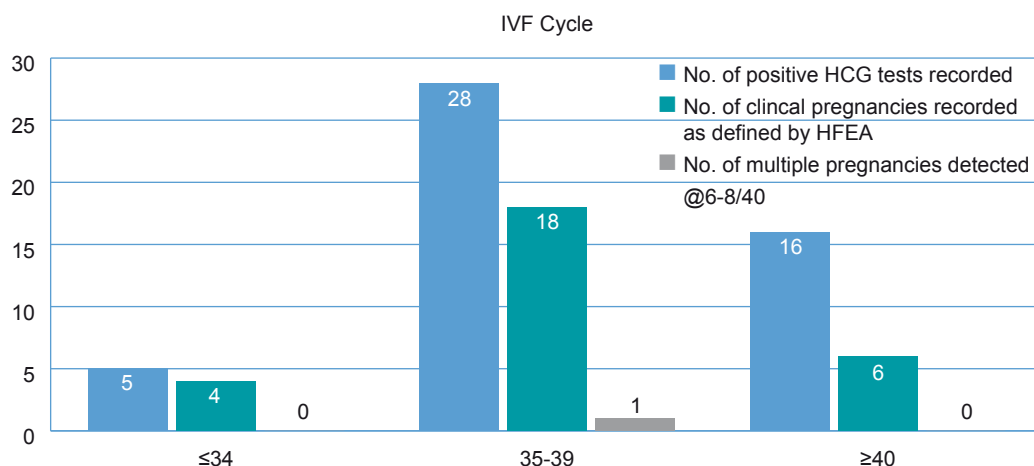
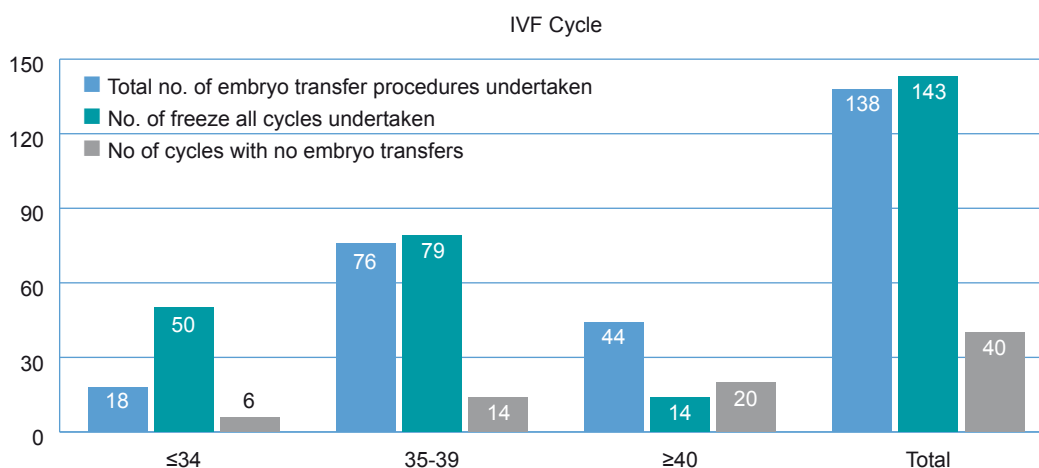
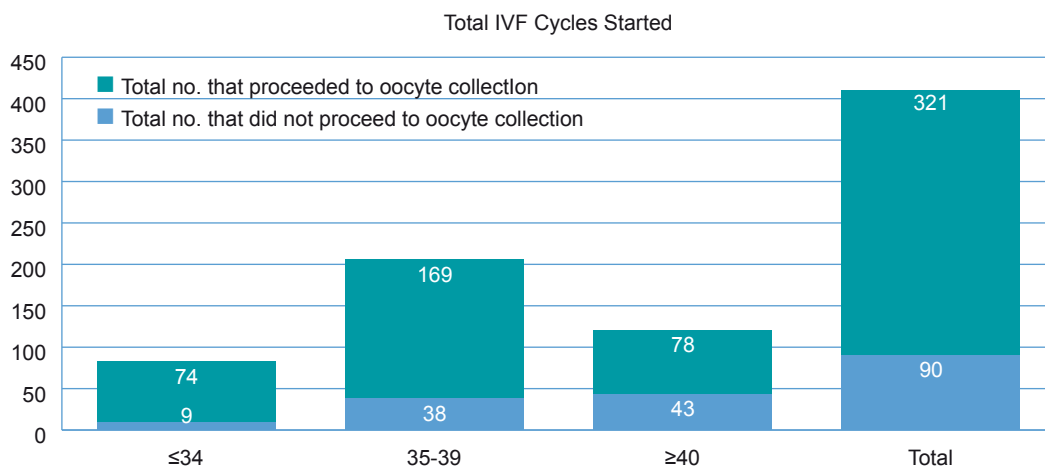
5.8 Breakdown of the Female Age of Patients Referred for AHR September 2024 – December 2024



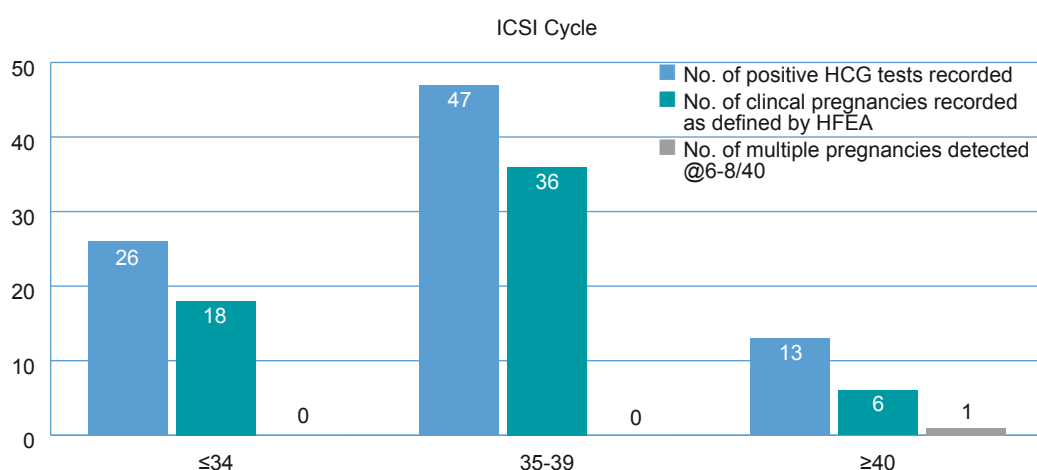
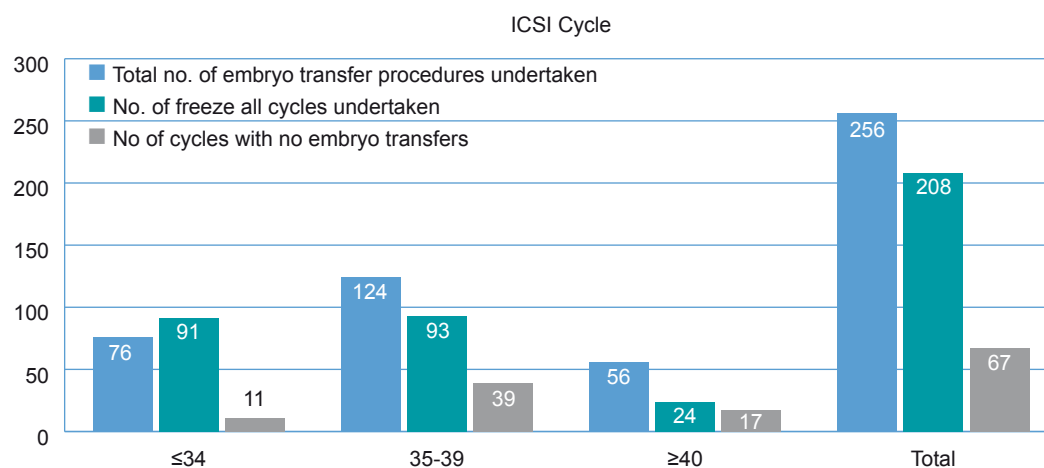
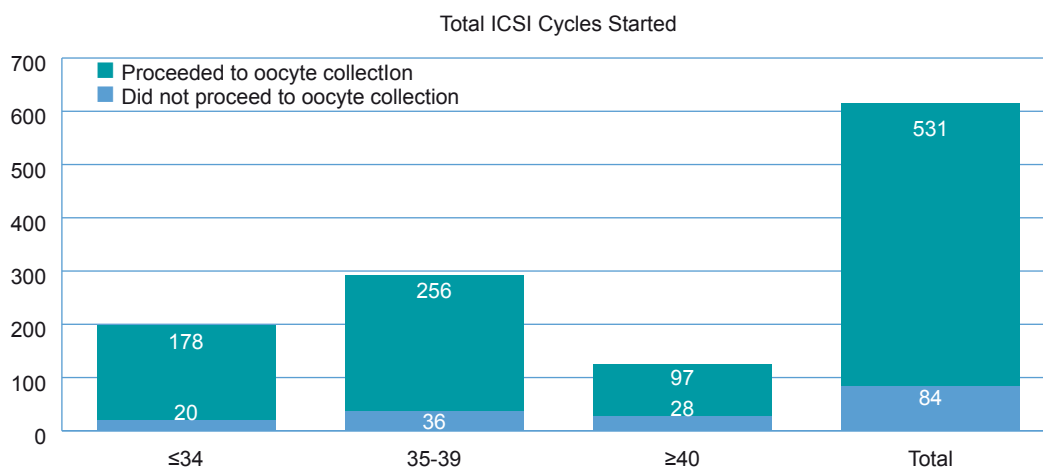
5.9 Private Provider Metrics 2024

At the time of publication of the first AHR report, the dataset relating to private fertility activity was incomplete. To ensure comprehensive reporting and full transparency, the complete dataset is therefore presented here as an addendum to the 2025 report. This approach ensures that all relevant activity is accurately represented and that readers are provided with a complete and transparent account of the data.

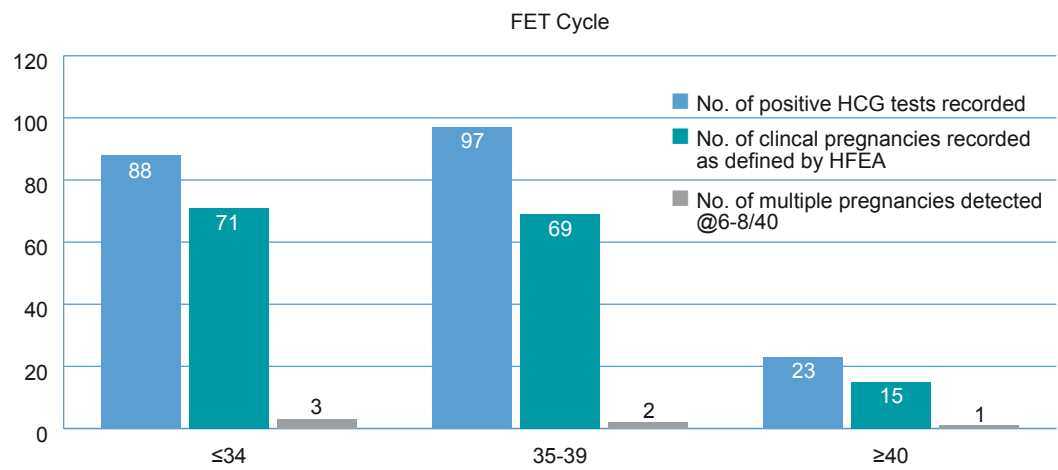
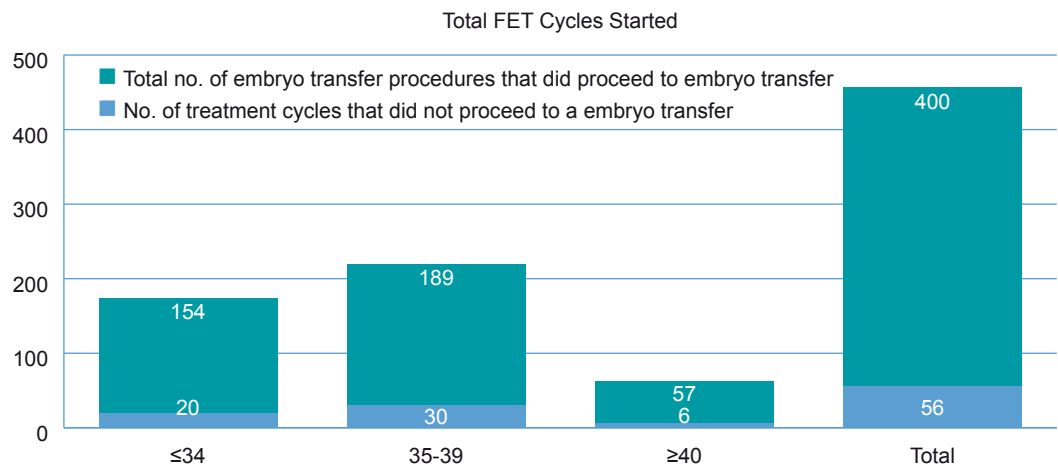
5.10 IVF Data 2024



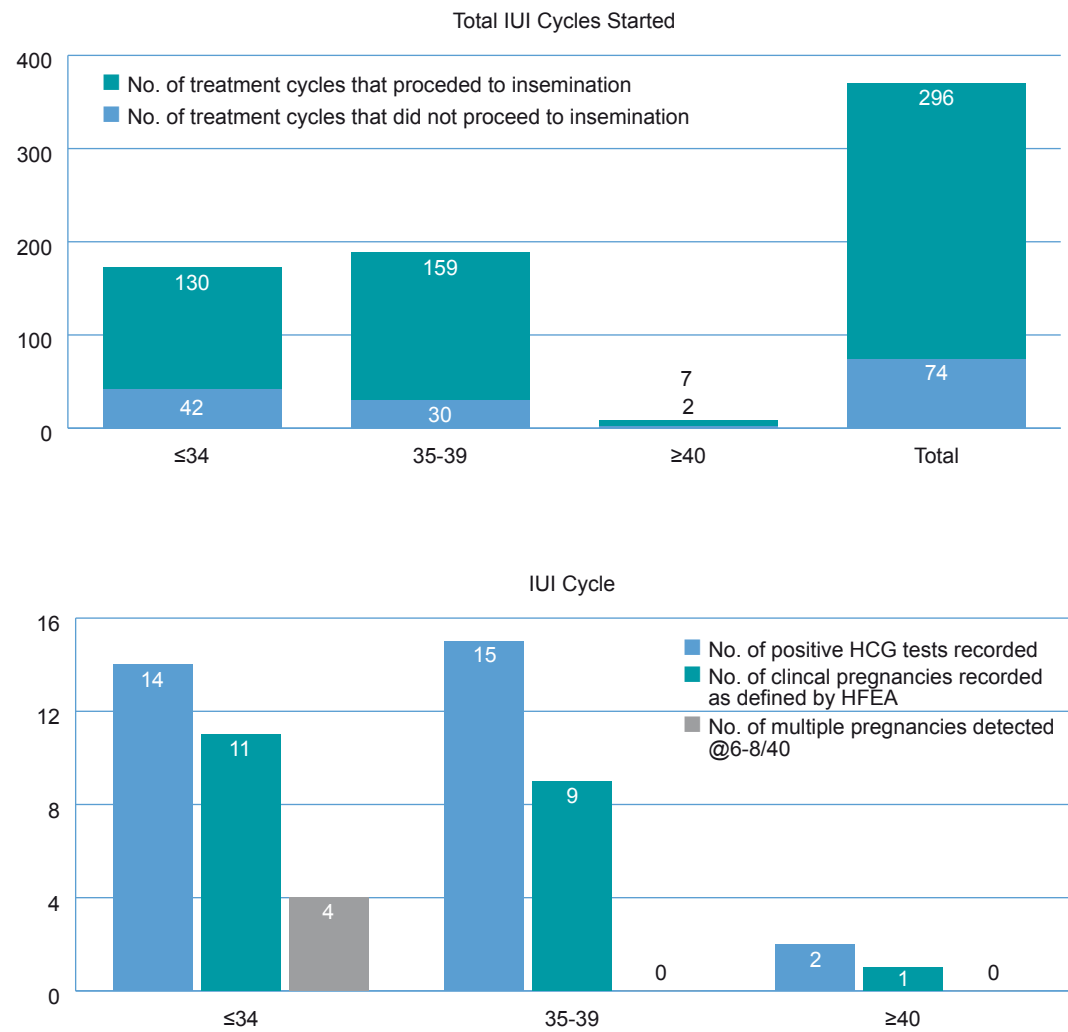
5.11 ICSI Data 2024



5.12 FET Data



5.13 IUI Data



Appendix 1 Male Factor Fertility Care Pathway

Regional Fertility Service

Male patient investigated as per **HSE National Clinical Practice Guidelines – Fertility: Investigation & Management in Secondary Care**. Gonadotropin (T,FSH,LH,PRL) and Genetic Testing undertaken as/when clinically indicated.

Referral made to specialist andrology service for review +/- treatment in following circumstances:

- Ongoing/potentially treatable or reversible male factor identified;
- Physical symptoms identified e.g. testicular pain/swelling, erectile dysfunction;
- Severe oligospermia (Conc < 5M/ml); and/or or
- Azoospermia.

Referral to be accompanied by SA results, hormone profile and any genetic testing results undertaken.

Referral made to CHI genetics service based on genetic testing results.

Specialist Andrology Service

Male patient reviewed and examined as clinically appropriate and appropriate care package identified. Engagement with referring regional fertility hub as to management of male patient vis-à-vis management and timing of fertility needs of couple.

Possible scenarios:

- Male patient managed and treated directly by specialist andrologist in public sector and then discharged back to fertility hub for ongoing care

OR

- Male patient discharged directly back to fertility hub for ongoing fertility care with specialist advice and recommendations provided to fertility team

OR

- Male patient referred back to fertility hub for ongoing fertility care with specialist advice and recommendations provided to fertility team with intention that male patient will subsequently be treated by specialist andrology services following completion of AHR treatment.

CHI Genetics Service

Genetic test results reviewed by CHI Genetics service and appropriate genetic counselling +/- additional tests provided to male patient.

Engagement with referring regional fertility hub as to management of male patient with specialist advice and input provided by CHI genetics services to fertility hub service.

↔ Liaising between teams as necessary ↔

Regional Fertility Service (follow-up)

Couple reviewed in regional fertility hub further to:

- specialist andrology review +/- treatment and recommendations
- AND**
- input from CHI Genetics service where relevant.

Possible scenarios:

- AHR clinically indicated (no mTESE involved)
- Couple meet national access criteria

Referral for publicly funded AHR made

- AHR clinically indicated; and
- Couple do not meet national access criteria

Couple discharged

- Male patient identified for consideration for mTESE
- AHR is clinical indicated
- Couple meet national access criteria
- Fertility team arrange presentation of case at national Male Factor MDT.

National Male Factor MDT

Case presented and reviewed at Male Factor MDT.

All clinical parameters considered including:

- Male clinical parameters
- Female clinical parameters
- Anticipated success rates of mTESE intervention and AHR treatment

Recommendation determined at national MDT as to whether publicly funded mTESE and AHR treatment is clinically appropriate to proceed with.

If recommended for publicly funded treatment, referral to be made to HSE Authorised AHR Providers who can provide mTESE care packages. Couple choose preferred AHR Provider. +/- Genetic Pathway applied to AHR referral as per normal process.

If not recommended for publicly funded treatment, patients to be counselled regarding future options e.g. DAHR, and couple discharged from fertility service.

Appendix 2 AHR Public Access Criteria

AHR Public Access Criteria	
Female Age (at time of GP referral)	18 – 40 + 364 days
Male age (at time of GP referral)	18 – 59 + 364 days
Female BMI	18.5 – 30.0
Fertility Diagnosis	IUI or IVF/ICSI recommended by Regional Fertility Hub
Relationship	Couple – in relationship for at least one year and maximum 2 intending parents
Residency	Ordinarily resident in the state
Welfare of child issues	No known serious concerns
Recreational drugs (incl. methadone)	None
Existing children	Only one of you has living children from before this relationship and you have only 1 living child together (child is biological, non-biological or adopted)
Previous IVF treatment	Maximum of one previous IVF cycle and all embryos from that cycle have been used
Voluntary sterilisation	Neither partner has had same
Smoking	Non-smoking x 3 months pre referral for AHR
Alcohol	Ideally women max 4 standard drinks per week, men 10 standard drinks per week

