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THE Dandelion

THE NEWSLETTER OF FERTILITY NEW ZEALAND, A REGISTERED CHARITY SUPPORTING PEOPLE WITH FERTILITY ISSUES

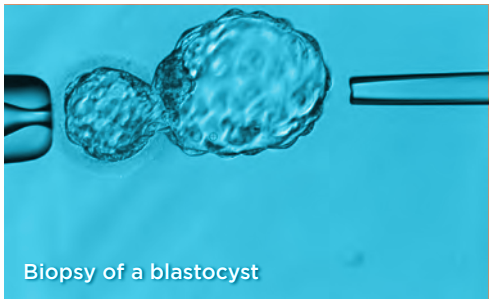
MARCH 2021

PGS, PGT-A, PGT-M, PGD... what does it all mean?

Allecia Swale, Board Advisor, Fertility NZ and Senior Embryologist, Repromed explains

Within the IVF sector there are many different terms that all mean the same or similar procedure. When clinics refer to PGS (Pre-implantation Genetic Screening) or PGT-A (Pre-implantation Genetic Testing – Aneuploidy) they are talking about checking suitable embryos to see if they have the correct genetic make-up. To really understand this though, we first need to understand a little more about human genetics.

We, as humans, contain 23 pairs of chromosomes; these chromosomes contain all of the instructions that the cells in our bodies need to be able to function normally. Each of the chromosomes contain many thousands of genes which are the specific instructions. When PGS or PGT-A is completed on an embryo we are checking to see the embryo contains a full set of chromosomes. Sometimes the embryos can have extra copies (three times more) of any one of the chromosomes. There can also be copies missing or there can be additional/missing segments of the chromosomes. These embryos would all be considered abnormal and not suitable for treatment. This is because many would not be able to establish a pregnancy, some would result in a miscarriage, others in a still-birth. Some of the embryos considered abnormal may result in a live birth, however, the child would have a genetic abnormality that, depending on the chromosomes involved, can have a range of impacts on the child.



Biopsy of a blastocyst

The method of genetic laboratory

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Welcome **Notes**

Welcome to *The Dandelion* newsletter.

Living the highs and lows of infertility is one of life's experiences which can only be truly understood by those who have walked in those shoes. Most of Fertility NZ's work is carried out by a team of dedicated volunteers who have 'been there' and know how difficult, and all-encompassing, fertility challenges are.

One of these wonderful volunteers, Hannah, kindly agreed to sit down with us and talk about her own journey. Read about Hannah and husband Joe's journey and motivation for 'giving back' on page 4.

Trying to understand and make decisions about fertility treatment options can feel overwhelming, as there are a multitude of treatments, procedures and options, each with its own acronym. Fertility NZ Board Advisor, Allecia Swale of Repromed, gives an explanation of Pre-implantation Genetic Screening (PGS) and Pre-implantation Genetic Diagnosis (PGD) in this issue.

In the uncertainty of these COVID times, we are extremely grateful for all the support we have received, particularly over the past six months. Our '30 years of supporting Kiwis to become parents' video campaign was met with a deluge of donors who were grateful for our support.

As a Good Registry charity, we felt very honoured to receive proceeds of many 'Good Gift Cards' around Christmas, where Good Gift Card holders chose Fertility NZ to receive all or some of their donation value.

Finally, the kind team at The Collective chose Fertility NZ as recipient for their staff Christmas raffle (see www.thegoodregistry.com).

Thank you to everyone who recognises and values the important work we do for the many New Zealanders walking the difficult road of infertility.

Ngā mihi
Juanita Copeland – Chair

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*As The Dandelion is going to print, New Zealand has gone back into COVID Alert Levels 2 and 3. Thinking of everyone within our community and especially those in the turbulent midst of fertility treatment. Our support groups will be paused temporarily, however, we remind you that we offer great information resources, and a Helpline for free advice (**0800 333 306 / support@fertilitynz.org.nz**). Our Webinar recordings can be found in the News section of our website. Kia kaha, kia maia, kia manawanui.*

About Fertility New Zealand

Fertility New Zealand is committed to supporting, advocating for and educating all people who face fertility challenges.

Fertility NZ was founded in 1990 and is a registered charity. It operates on a national level and much of its work is undertaken by dedicated volunteers. Fertility NZ provides assistance for people with fertility issues through the following channels:

- **Support** A network of regular support gatherings, workshops and contact groups throughout the country; an 0800 line and email address for enquiries, and infertility forums on our website where members can provide support to one another.
- **Information** Fertility NZ's website **www.fertilitynz.org.nz** is the focal point of information; informative fact sheet brochures are available for members and through clinics; regular publication of *The Dandelion* newsletter and email updates to members; conferences and information events. An annual campaign to raise awareness of infertility and fertility issues.
- **Advocacy** Representing the voice of people affected by infertility on medical, ethical and policy issues.

Our vision

Fertility NZ has a vision of a 'fertility friendly' and fertility-aware New Zealand where:

- Infertility is recognised, understood and supported;
- All New Zealanders faced with the medical condition of infertility have access to appropriate, timely and fully-funded medical treatment;
- Men and women have all the information necessary to enable them to make informed decisions regarding their fertility;
- Young New Zealanders learn about fertility preservation;
- Fertility and all alternative forms of whānau-building are respected and valued.

Fertility NZ's Board

At Fertility NZ's AGM in November, there were a few changes to its Board. Juanita Copeland, Chair, thanked departing members for their generous gift of time and skill.

Our Board members are based around the country and are all dedicated to helping New Zealanders on a journey to create whānau. Each member brings skills and knowledge from their professional lives which will enhance the organisation and benefit our members and wider community.

Visit our www.fertilitynz.org.nz for Board member bios and to learn more about what each person brings to the Board table.

Fertility NZ's 2020-21 Board is:
Juanita Copeland – *Chair*
Kim Wiseman – *Vice Chair*
Brad Edley – *Treasurer*
Natasha Loulanting – *Secretary*
Jo Barnett
Madeleine Setchell
Stuti Misra

Board Advisors:
Allecia Swale (Repromed)
Fiona McDonald (Fertility Plus)
Dr Greg Phillipson (independent clinical advisor)
Mel Olds (Regional Representative – Wellington)
Michelle MacKinven (Regional Representative – Auckland)
Michelle Parris-Larkin (Fertility Associates)

PGS, PGT-A, PGT-M, PGD...

From page 1

testing that is performed when using PGS/PGT-A is a process called *next generation sequencing*. This type of testing is looking for a very large amount of information on the embryo. Due to the vast amount of genetic information that is analysed, very small changes in the embryo's genetics are not able to be identified. Something called a single gene disorder (e.g., Cystic Fibrosis) is a very small change in one of the genes located on the chromosomes. This type of genetic change is not able to be detected through standard next generation sequencing. However, we do also have specific testing that can be done to identify these types of disorders. This type of testing is referred to as PGD (Pre-implantation Genetic Diagnosis) or PGT-M (Pre-implantation Genetic Testing – Monogenic). Only patients that are known to be carriers or have a family history of a single gene disorder will be referred to have PGD/PGT-M. Often these patients will also have PGS/PGT-A completed on the embryos at the same time as PGD/PGT-M. These patients may have embryos that are affected by the single gene disorder, but no abnormalities detected by PGS/PGT-A.

How are embryos tested? In order to explain this, we need to go back to the start. In the IVF laboratory, eggs and sperm are put together to create embryos. All of the normally fertilised embryos are cultured in the laboratory for five to seven days. The embryos need to reach a stage called the blastocyst stage of development. This stage of development can be observed from day five, however some embryos may take a day or two longer to reach the full blastocyst stage. These blastocysts will have anywhere from 70-200 cells inside them. There will be two types of cells identifiable in the blastocyst embryo, the first forms a tight ball of cells called the inner cell mass (ICM). These cells go on to develop into the fetus. The second type of cells are called the trophectoderm cells (TE). These cells will go on to develop into the placenta. The quality of these two types of cells will be graded from A to D with A being the best. Blastocyst embryos need to be good quality (commonly A's or B's but each laboratory will have its own criteria) to be suitable to undergo genetic testing.

Right: Embryologist Allecia Swale

At the blastocyst stage of embryo development both the ICM and TE cells will be representative of the embryo's genetic make-up. It is for this reason that the IVF laboratory is able to take a sample of cells (usually 5-10 cells) from the TE part of the blastocyst embryo. The embryo is held in place using a holding pipet. Looking down a high-powered microscope, the embryologist will then take the sample of TE cells into a biopsy pipet (using a device that can apply very controlled and small amounts of suction). Once the correct number of TE cells are in the biopsy pipet, a laser is used to cut the connections between the cells – this process is called the embryo biopsy. The biopsied cells will then be washed and transferred in a very small volume of solution to a small tube that is frozen and sent to the genetics laboratory for the genetic testing to take place. The embryo is immediately frozen, following confirmation the cells are seen in the tube, and placed into storage to await the genetic results.

> Even though every precaution and care is taken to protect the embryo/ patient material, there are always risks associated with any laboratory procedure.

But what are the risks?With any laboratory procedure, even though

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We sat down with Wellington support volunteer Hannah and husband Joe to hear about their toughest challenge to date.

WALKING THE ROAD OF INFERTILITY TOGETHER

Can you give us an overview of your fertility journey?

Hannah: I'll try and summarise a bit, as it felt like so much happened! Over the course of four years we had:

- Two years trying the old-fashioned way;
- Appointment with a fertility clinic diagnosed male-factor infertility;
- Three full rounds of IVF with ICSI;
- Five embryos transferred;
- Two embryos didn't take;
- Two miscarriages;
- Lucky embryo number five (our day six, double-thawed embryo) gave us our beautiful daughter Jasmine who is now a year old.

What were the toughest parts of your journey?

Joe: The miscarriages were really difficult, especially for Hannah having to deal with both the emotional and physical pain. That said, for me these were events that I could attempt to manage whereas the long slog of going through the process was the toughest for me. I guess I was ashamed because it was male factor and I blamed myself; it felt like a very lonely place especially when friends around us were all having babies. Being surrounded by all of the various triggers didn't help with feelings of jealousy, envy, anger, etc. I became quite introverted and did not like myself over this period of time.

Hannah: I really struggled after our second miscarriage. A NIPT test at 11 weeks confirmed our baby had Down Syndrome and we spent 5 days facing a heart-breaking decision of whether to continue with the pregnancy or not. I truly believe that whatever decision someone in that situation makes, it is the right decision, but when you're faced with it yourself, you feel like any decision is wrong.

In the end, we found out at the 12 week scan that our baby had stopped growing at 8 weeks and we had had a missed miscarriage. The relief I felt that we didn't have to make a decision was overwhelming, but the guilt that followed was incredibly hard to deal with.

How did you deal with that grief, and move onto the next phase of your journey?

Joe: My main concern going through the grief of the miscarriages was to look after Hannah which I think helped me cope and stopped me delving too much into how I felt about losing our babies. Feeling quite helpless in the matter I did turn my attention to something I could control and so began cross training at the gym regularly which again gave me focus and I felt that anything to help the swimmers would be a good thing. The counselling offered at our clinic was also useful for me and sharing the journey with someone outside of our family/friendship group eased the

"We went on a bucket-list trip to Alaska! It felt great to do something that made us feel 'us' again, and to make some positive memories."

process and taught me to be kinder to myself. Unfortunately the counselling sessions would book up quickly and as this process doesn't work to schedules, we set up a rolling appointment just to check in to make sure we had the help when we needed it.

Hannah: We went on a bucket-list trip to Alaska! It felt great to do something that made us feel 'us' again, and to make some positive memories. I also really took some time to look after myself emotionally: I went down to four days at work; started mindfulness and meditation; did a gratitude journal; stopped feeling guilty for not attending friend's baby showers. I also got my first (and so far only) tattoo to represent our journey which was a very cathartic experience.

The biggest thing that helped me though, was connecting with others going through infertility. I attended a few FNZ events in Wellington and started a fertility Instagram account so I could meet with people all over the world. Realising I wasn't alone and that all my emotions were completely normal made me feel so much less isolated and gave me a lot of strength to face our next round.

Did your fertility challenges impact your relationship, and how did you deal with that?

Joe: Yes, I became very insular and slightly anti-social, however, we've always been able to communicate well and so I didn't feel completely on my own. Much of the time in our clinic counselling sessions we would come up with the same observations and it was nice to know we were both on the same page. We were very kind to each other and no matter how irrational we may have seemed, we had trust and so could let loose "the crazy" and knew the other person had our back.

Did you tell your friends and family?

Hannah: Yes we told pretty much everyone, including our workplaces. It is such a deeply personal experience, so you have to do what is right for you with regards to this.

Joe: Family yes, but not at first with friends. I felt embarrassed and ashamed and struggled with letting people know, but the more I shared, the better I felt. That said, it took a while to open up that it was a male factor issue although people are kind when going through this sort of thing and usually don't question about the finer details of the journey.

How did your employers handle this? Did it have any impact on your work or career?

Joe: My work was fantastic and offered so much support and never questioned any of the many appointments I needed to take. Other members of staff had also been through the same thing so it was nice to share the journey with folk that 'get it'.

Hannah: I missed out on a lot of international travel due to treatment which feels like a missed opportunity for my career. But, overall I feel really lucky as my boss and colleagues were incredibly supportive; in fact I think my colleague found out we were pregnant once before Joe did as I got the call at work.

Through your own experience, what have you learnt about how infertility is viewed in New Zealand?

Joe: It is a very hard topic to relate to unless you are going through it or have experienced it. For males, it seems a very difficult area to cover and there is a certain stigma attached that makes it hard for fellas to open up. It is always refreshing to hear a bloke's perspective and can be very insightful for the partners too. Occasionally there are flurries of exposure in the media but no real consistent message and I would like to see more education in schools about this. It could be that some young people assume they will be okay and put off having children until later on in life only to find out they can't or will struggle to do so.

And Hannah – you are now a facilitator in Wellington for FNZ, what made you decide to do that?

Hannah: I started to feel so much better about our journey when I started to talk to others going through it, either in person or online. I also had an amazing colleague/friend who was my 'person' after our second miscarriage because she understood that grief I was facing, she texted me every day for months and was absolutely invaluable in helping me come to terms with everything. Now we are lucky enough to have Jasmine, I want to help others, and maybe be that person for someone else.

Not everyone wants to, or is ready to talk (and that is absolutely fine, you do what's best for you!), but if you are keen then you'd be amazed how many people say how much lighter they feel when they have had a good chat to someone who understands how they feel. FNZ has so many great resources, and run some fabulous support groups; I would love to see you there.

Do you have any advice for others navigating fertility challenges?

Joe: Be kind to yourself and accept that you will experience many of the 'tyrants' like jealousy, envy, anger, desire, pleasure and pain over the course of the journey. Keep talking to your partner, you are both each other's port in the storm and will go through things at different times and so be patient.

Hannah: Find and talk to people that 'get it'. Be gentle to yourself and your partner, be self-full (not selfish!). If you want to tell people about what you're going through, consider what you need from them. Do you want them to ask you every 5 minutes, or do you want them to wait until you give them an update? I think it is hard for others to know how to help or how to act, and that can be upsetting, so sometimes laying out what you need from them can be helpful for everyone.

PGS, PGT-A, PGT-M, PGD...

From page 3

every precaution and care is taken to protect the embryo/patient material, there are always risks associated with it. The first hurdle that the embryo needs to overcome with any type of genetic testing is the biopsy procedure. Even though only the 'top quality' embryos are selected to undergo embryo biopsy the embryos don't always respond the way the embryologist would expect them to. There is around a 2-5% chance that the biopsy procedure could damage the embryo and reduce the embryo's potential for pregnancy (even if there are no abnormalities detected following genetic testing).

The next hurdle is that the cells need to be able to give a result. In less than 5% of cases there may be no, or insufficient genetic material (DNA) detected in the tube by the genetics laboratory. This can arise because the quality of the DNA from the cells was poor, which can be caused by the cells starting to break down (lyse) prior to them being frozen and shipped. Unfortunately this is not something that can be predicted; the IVF laboratory tries to control for this by only performing biopsy on good quality embryos. It can also arise because while every care is taken something has gone wrong with the cell transfer and the cells from the embryo have not survived the process, meaning the genetics laboratory cannot detect any DNA from the embryo.

The final hurdle for the embryo is that it needs to survive the freezing and thawing process. While the majority of laboratories experience embryo survival rates of around 90-95%, there are still some cases where the embryo does not survive the freezing and thawing. Again, the IVF laboratory will take every care to protect the embryo but sometimes for reasons that are not always understood even good quality embryos do not survive the process.

There is also risk associated with the genetic results:

- A patient may go through the process of PGT-A/PGS/PGT-M/PGD and result in no embryos that are suitable for transfer either because no embryos were suitable for biopsy or because all of the embryos biopsied had abnormalities detected. This is a very upsetting result but is something all patients should be prepared for. The risk of this occurring increases as maternal age increases.
- A false positive/negative result may be given, which occurs in 1-2% of cases. This is when the genetic laboratory reports that an embryo is abnormal, when in actual fact it has no detectable abnormalities. This can also happen in the reverse where an embryo is reported as having no abnormalities detected but does contain abnormalities.
- The genetic condition called mosaicism may occur. Mosaicism is a difficult concept to explain – however at its most basic explanation, it means that not all of the cells in the embryo contain the same genetic make-up. This is reported by the genetics laboratory generally as a percentage of the embryo that has an abnormal genetic make-up (e.g., 40% mosaic for trisomy 21 – means 40% of the cells had an extra copy of chromosome 21). Mosaicism can occur in the embryo in a few different ways as follows:

Type of Mosaicism	Reported as
The whole embryo is mosaic	Percentage mosaic e.g., 40% mosaic
Just the ICM carries abnormal cells but the TE has no detectable abnormalities	No abnormalities detected – suitable for transfer
Just the TE carries abnormal cells but the ICM has no detectable abnormalities	Abnormal embryo – not suitable for transfer

If an embryo is in the category of example two above, this embryo would be considered suitable for transfer. However depending on the chromosome/s involved in the abnormality may not result in a healthy live birth. If the embryo is in the category of example three, it would be considered abnormal and would be discarded; however could have resulted in a healthy live birth. The embryos that arise from example one generally require further discussion with your clinician or a genetic counsellor to consider the possible outcomes that could occur and will be related to the level of mosaicism detected and the chromosome involved.

Due to all of the risks associated with genetic testing of embryos it is always strongly recommend that should an ongoing pregnancy be established, routine obstetric checks and testing is also completed to confirm the genetic results obtained from the embryo.

Why do genetic testing?

The reason to use genetic testing in an IVF cycle will vary from patient to patient. It will depend on each patient's fertility journey and family genetic history. Genetic testing of embryos is not suitable for everyone and there are still conflicting scientific research papers that both support and rebut the benefits of genetic testing. At our Auckland fertility clinic Repromed, we generally recommend it to any patients that have a known genetic condition, or those that meet a list of criteria suggesting testing will be beneficial. It is widely accepted in the IVF sector that PGD/PGT-M is beneficial to prevent the genetic condition being passed on to the future child. There is also a subset of IVF patients that have had what is termed recurrent implantation failure (RIF) – where three or more good quality blastocysts have been transferred but no pregnancy has been achieved. For RIF patients, genetic testing of embryos can help identify and eliminate one aspect that could be causing the failure of embryos to implant.

It is important to remember that the genetic makeup of the embryo is only one part of the puzzle to achieving an ongoing pregnancy and healthy live birth. Careful consideration and discussion with your fertility specialist should be done before opting for genetic testing of embryos.

Kia kaha, Jumpstart participants!

On Monday 15 February, women and men in Auckland and Hamilton began a fitness journey to improve their fertility.

Jumpstart is a 10 week long, semi-structured, goal-orientated programme focussed on improving health and fitness and optimise chances of conception. The pilot programme is currently underway in 12 YMCA centres across Auckland and Hamilton.

Jumpstart is fully customised to each participant and includes guidance for conditions such as Polycystic Ovarian Syndrome and Male Factor infertility as well as fertility-specific nutrition advice. The total cost is $80 for the full 10 weeks including all gym access and one-on-one time. Good luck to all the participants. We look forward to hearing about your results at the end of April!

www.jumpstartprogramme.co.nz/fertility

Thanks for joining us for **our birthday**

A lot has happened in Fertility NZ's 30 years. Alongside the significant medical, scientific, legal and social changes to the landscape of fertility, we have been here to support, inform and advocate for thousands of New Zealanders through the highs and lows of their journeys.

To commemorate our 30th birthday, we produced a video of reflections of the experience of infertility and how Fertility NZ can help. We are very grateful to Debbie, Gareth, Cassandra, Alan, Maddison and Susan for agreeing to share on-camera.

Thank you to everyone who watched and shared our videos and kindly donated via the Givealittle page to help us continue our work.

If you haven't seen the video yet, search '30th birthday' on www.fertilitynz.org.nz We hope it connects with you in some way!

It's our privilege to support the many New Zealanders who encounter challenges creating whānau. We look forward to continuing our important mahi for the next 30 years.

Left: The FNZ team visited fertility clinics to celebrate our birthday and share the video (below).

PUBLIC CEREMONY

Seeds of Hope

Saturday, 1 May 2021, 2.00pm – 3.30pm

Auckland, Wellington and Christchurch

We are holding a Ceremony to acknowledge the losses connected with infertility – childlessness, miscarriage, ectopic pregnancy, acknowledging embryo loss, secondary infertility, and loss of dreams ...

Designed and created by two celebrants who have been on an infertility journey of their own, to assist in the healing process and to provide hope.

- Anglican Church of St Columba & Community Centre, 92 Surrey Crescent, Grey Lynn, Auckland
- Johnsonville Uniting Church, 18 Dr Taylor Terrace, Johnsonville
- South Library, 66 Colombo Street, Cashmere, Christchurch

These events are free of charge. Light refreshments served.

For more information and to RSVP please contact

Keeley Jenkins Auckland
keeley@kjcelebrant.co.nz

Winnie Duggan Christchurch
winnie@lifecelebrant.co.nz

Colleen Heward-Carmont Wellington
colleencelebrant@icloud.com

IMPORTANT: Due to Covid 19, please kindly RSVP by email if you are intending to attend the ceremony as we will need to know numbers if restrictions are put in place for gatherings.

noticeboard

Contact your local Support Volunteers for details of group meeting and any questions.

AUCKLAND

CASUAL COFFEE GROUP, MT EDEN
Group meets monthly on Wednesdays at 7pm: 24 March; 21 April; 12 May; 16 June

CASUAL COFFEE GROUP, NORTH SHORE
Group meets monthly on Tuesdays at 7.30pm: 16 March; 13 April; 18 May; 15 June

CASUAL COFFEE GROUP, PUKEKOHE
Group meets monthly on Mondays at 7.30pm: 1 March; 12 April; 3 May; 14 June

FERTILITY SUPPORT SERIES
Semi-structured course ideal for couples – spaces are limited: 2, 9 & 16 March and 15, 22 & 29 June

PREGNANT AFTER FERTILITY TREATMENT
Group meets monthly on Sundays: 7 March; 11 April; 2 May; 13 June

SECONDARY INFERTILITY
Please email for details: secondarysupport@fertilitynz.org.nz

SINGLE MOTHERS BY CHOICE
Group meets monthly: 14 March; 18 April. Please email for details: singlewomensupport@fertilitynz.org.nz

HAMILTON
Group meets every 3rd Saturday at 10am: 20 March; 17 April; 15 May; 19 June

TAURANGA
Group meets every two months on a Saturday at 10.30am. Please email for details: taurangasupport@fertilitynz.org.nz

WELLINGTON
Support and Connect group meets every six weeks on a Wednesday: 31 March; 12 May; 23 June.
Virtual Support and Connect meeting held on the first Thursday of each month via Zoom:
4 March; 1 April; 6 May; 3 June

CHRISTCHURCH
Group meets on the last Tuesday of every month, 6–8pm: 30 March; 27 April; 25 May; 29 June

SINGLE MOTHERS BY CHOICE
Group meets every 6 weeks on a Sunday: 14 March; 2 May; 20 June. Please email for details: singlewomensupportchch@fertilitynz.org.nz

DUNEDIN
Group meets every 6 weeks on a Tuesday, 7.30–8.30pm: 30 March; 11 May; 22 June

NEW QUEENSTOWN
Group meets monthly on a Tuesday, 7.00–8.30pm: 16 March; 13 April; 11 May; 8 June

INVERCARGILL
Group meets on the 4th Wednesday of every month. Please email for details: Invercargillsupport@fertilitynz.org.nz

Queenstown – our team is here for you!

We are delighted to announce that we now offer in-person support in Queenstown. This group is hosted by Eva Hooper (right) who brings experience from her own fertility journey. Eva contacted Fertility NZ last year with enthusiasm to start a support group in Queenstown as she knows first-hand how lonely and isolating this journey can be. Join Eva monthly on the second Tuesday of each month for in-person support and join us for no-obligation gatherings as we walk alongside you on your journey. We look forward to welcoming you, your partner or support person to our new friendly, casual, safe and positive group. Contact us for more information. Email: **queenstownsupport@fertilitynz.org.nz**
Facebook: **FNZ Queenstown Support**

Support information
How can we help you?

Fertility NZ support contacts

Auckland
aucklandsupport@fertilitynz.org.nz (Fertility Support Series, Casual Coffee, Pregnant After Fertility Treatment)
secondarysupport@fertilitynz.org.nz (Secondary Infertility)
singlewomensupport@fertilitynz.org.nz

Hamilton
hamiltonsupport@fertilitynz.org.nz

Tauranga
taurangasupport@fertilitynz.org.nz

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