Coalition for Fertility

February, 2026

For Mental Health and Quality of Life in Involuntary Childlessness

Background

Involuntary childlessness, infertility and fertility treatments are profound life experiences that can have an impact on mental health and wellbeing, potentially triggering emotional exhaustion, hopelessness and financial stress, affecting relationships and social participation. Repeated attempts at pregnancy, lack of desired results, long waiting periods, and stigma all compound the distress and even trauma. These implications occur across genders, family structures, as well as social, economical and cultural contexts.

While this statement focuses specifically on policies related to psychosocial support, the mental health of those affected by involuntary childlessness is also impacted by other policies and can for instance be exacerbated by discriminatory criteria for access to treatment and limited funding. Therefore, recommendations of this statement should be implemented in conjunction with the recommendations on equal access to care and public funding set out in previous statements of the Coalition for Fertility.[1] [2]

Addressing fertility-related mental health will contribute to achieving the UN Sustainable Development Goals and WHO non-communicable disease targets by addressing social, emotional, and behavioural determinants of health. Moreover, such action would be in line with the EU Comprehensive Approach to Mental Health (2023)[3], which calls for investment in mental health systems, workforce development, prevention, and stigma reduction across all sectors.

The mental health impact of involuntary childlessness needs to be recognised in EU and national policies

Fertility should be recognised not only as a reproductive issue but as a determinant of overall mental health, wellbeing, and quality of life. As such, it should be embedded into EU and national mental health strategies. Moreover, the impact of fertility challenges on work - including stress, absences, and discrimination - must be recognised in workplace wellbeing and equality policies, in line with EU frameworks on psychosocial risks at work.[4] Lastly, there is a need for public funding to support research and data collection, including in registers, on fertility-related mental health to inform care practices and EU and national policy.

Fertility clinics should be equipped to meet the mental health needs of their patients

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[1] For Universal Access to Fertility Treatments, Coalition for Fertility

[2] For Inclusive Fertility Care for All, Coalition for Fertility

[3] EU comprehensive approach to mental health

[4] EU strategic framework on health and safety at work 2021-2027. Occupational safety and health in a changing world of work

Psychosocial support should be integrated as a routine component of care before, during, and after fertility treatment. To ensure equal access, public and insurance-based funding for fertility treatments should cover psychosocial care and counselling.

Staff training and qualifications
Fertility clinics must include trained mental health professionals with clear referral mechanisms to be able to provide psychosocial support directly within the care context. Every fertility professional should receive training in routine psychosocial care, ensuring that emotional wellbeing is treated as a shared clinical responsibility between medical and mental health professionals.

Screening
Early and systematic screening for psychological distress should be a standard component of fertility care, allowing timely referral to appropriate mental health support. Screening programmes should be publicly funded and implemented without stigma or discrimination to deliver due care for those in need.

Decision-making counselling
People often face uncertainty about which treatment options to choose, whether and when to consider third-party reproduction, and when to stop treatment. These choices carry significant psychological, relational, and social implications. Decision-making counselling, including planning for the whole fertility journey[5], should therefore be routinely available within fertility clinics.

Support during treatment
Psychosocial support needs can differ based on the personal circumstances, medical conditions, and treatments involved. Fertility care must recognise the mental health needs of all patients in an inclusive manner, and whenever concerned, also support partners' communication and resilience. In the case of chronic conditions like endometriosis, PCOS or erectile dysfunction[6], comprehensive care should encompass pain, stigma, body image, and sexual health. Similarly, pregnancy loss, including recurrent miscarriages, carries specific emotional consequences, which must be addressed with appropriate, trauma-informed approaches. With regard to treatment forms, particular attention is required in donor conception, which can present complex emotional, ethical, and social considerations. Information and counselling should be available to donors, recipients, offspring, and families, with support for disclosure and identity issues for donor-conceived people.

Long-term support
Mental health challenges related to involuntary childlessness often persist for a long time. Dedicated long-term support, including adjustment and reorientation of life goals where

[5] Talking about possible IVF/ICSI failure and need for multiple cycles in treatment planning: qualitative investigation of multi-cycle planning and its acceptability to patients and staff.
[6] Sexual dysfunction and male infertility

needed, should be provided for those navigating “life after infertility”, regardless of treatment outcome. Sustained care ensures that wellbeing, not just medical outcome, defines success in fertility support.

General health systems should be equipped to support people facing involuntary childlessness

Alongside fertility clinics, the general health system should provide mental health and wellbeing support to those affected by involuntary childlessness. People may need support to cope with the realisation that they are facing involuntary childlessness, as well as counselling to decide whether to opt for fertility treatment. Those who choose not to pursue treatment might still need psychological care, and the support needs of people during and after treatment may go beyond what can be provided by fertility clinics. Thus, it is important that fertility-specific competencies are integrated into the general training of mental health professionals, so that all mental health services can provide appropriate support.

Conclusion

Involuntary childlessness has a substantial impact on mental health. Policymakers have a duty to ensure that the healthcare system, including fertility clinics, are equipped with resources to provide integrated, person-centred care to all those affected.

The Coalition for Fertility calls on EU institutions, national governments, and healthcare providers to act now to ensure that every person facing fertility challenges receives comprehensive support across their entire fertility journey, contributing to a healthier, more inclusive Europe.