



# RRM Success Rates: What the Published Evidence Shows



By RRM Academy ·

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This page brings together the published research on how well Restorative Reproductive Medicine (RRM) and NaProTechnology work. It collects outcome studies from 2008 to today and lays out what each one found, with the context needed to read the numbers correctly.

The page covers live birth and pregnancy rates, how RRM results compare with IVF, pregnancy safety, cost, and findings for specific conditions including endometriosis, PCOS, and recurrent miscarriage. Every study links to its full library record.

The studies measured success in different ways, in different groups of couples, and over different time periods. Rates vary as a result. These are real-world studies, not controlled trials, and the populations in them are not a random cross-section of couples seeking care. No single number fits everyone. Each figure on this page appears with its source and the study context it came from.

## The Evidence at a Glance

### KEY TAKEAWAYS

- Crude live-birth rates across 14 RRM cohorts range from 18.4% ([RRM after IVF failure, 24 months](#)) to 41.5% ([mixed infertility, 24 months](#)).
- Adjusted-cumulative live-birth rates range from 29% to 73.6% across the same corpus, with the variance driven by [population](#) and [follow-up window](#).

- Age is the strongest predictor: in the [largest published cohort \(n=1,310\)](#), adjusted-cumulative live-birth rates ranged from 83.7% (ages 18-30) to 24.4% (over 40).
- The [first head-to-head comparison](#) found RRM crude live-birth rates of 42-44% comparable to contemporaneous SART/CDC IVF benchmarks of 40-41% in the same age band, with lower RRM singleton preterm rates (4.0% vs 11.8% CDC IVF).
- All data are from observational cohorts. No randomized controlled trials comparing RRM to IVF have been published. Selection effects and heterogeneous populations limit direct comparisons across cohorts.
- A full [RRM course runs ~\\$2,000-\\$5,000](#); US IVF is [~\\$19,200 per cycle](#) and frequently [\\$50,000+ cumulatively to one live birth](#).

The stat cards above display two ranges: crude live-birth rates (18.4% to 41.5%) and adjusted-cumulative live-birth rates (29% to 73.6%). These are not the same metric. Crude rates count live births among all couples who started treatment. Adjusted-cumulative (life-table) rates account for couples who withdrew or whose follow-up ended early, estimating the probability of a live birth over the full follow-up window. A crude rate and an adjusted-cumulative rate from different cohorts cannot be compared against each other. The ranges also span heterogeneous cohorts: different populations, follow-up lengths, entry criteria, and RRM methods. Fourteen cohort studies, two systematic reviews, and a narrative review informed this page. What the numbers share is that they come from published literature with documented populations and defined endpoints.

**18.4% to 41.5%**

Crude live-birth rate across cohorts

**29% to 73.6%**

Adjusted cumulative live-birth rate

**14**

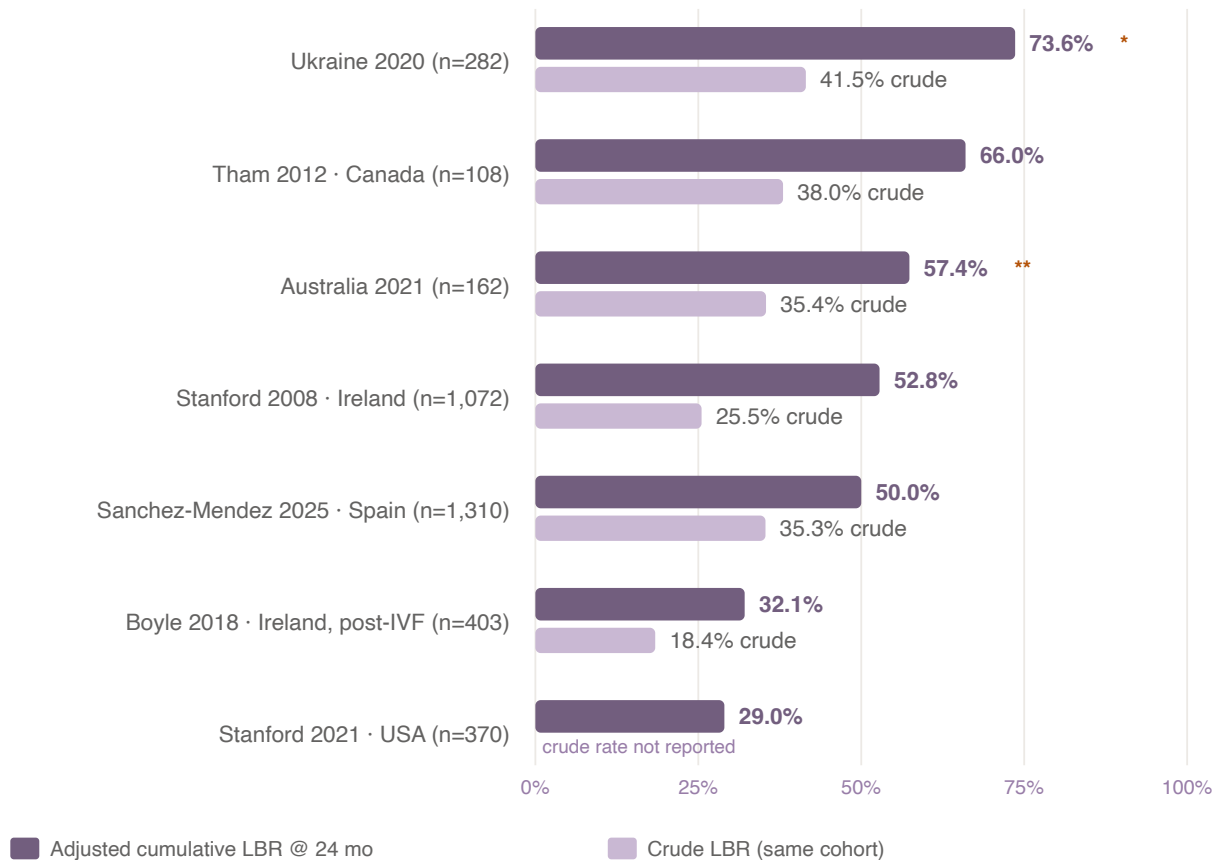
Verified cohort studies across 11 countries

**\$2000 to \$5000**

RRM course ~\$2-5K vs US IVF ~\$19K per cycle

## CUMULATIVE LIVE-BIRTH RATE @ 24 MONTHS

Each cohort: adjusted (life-table / Kaplan-Meier) above, crude below. Live-birth outcomes only.



\* Ukraine 2020: non-PubMed-indexed lower-tier journal. \*\* Australia 2021: medRxiv preprint, not peer reviewed.

*Different cohorts, denominators and case mixes; not a randomized comparison. Conception-only and per-cycle ART rates excluded.*

[rrmacademy.org/rrm-success-rates](http://rrmacademy.org/rrm-success-rates)

Adjusted cumulative (life-table or Kaplan-Meier) live-birth rate at 24 months for the seven live-birth cohorts, paired with each cohort's crude rate. Cohorts differ in case mix, denominators and follow-up, so this is a compendium rather than a randomized comparison.

## The Outcome Studies

Reading reproductive medicine outcome data accurately requires knowing exactly what was measured. Two concepts cause the most confusion.

**Crude vs. adjusted-cumulative rates.** A crude live-birth rate divides the number of live births by the number of couples who started treatment, treating everyone who dropped out as a non-success. An adjusted-cumulative (life-table) rate censors withdrawals and estimates the

probability of success over time, accounting for the fact that some couples left before the study ended, not because they failed. The same cohort can show a crude rate of 18% and an adjusted-cumulative rate of 32%, and both figures are correct; they measure different things.

**Per-couple vs. per-cycle rates.** Most RRM outcome studies report per-couple rates: what fraction of couples who enrolled achieved a live birth over a defined follow-up period. Most IVF registry benchmarks report per-cycle or per-embryo-transferred rates: what fraction of individual transfer events resulted in a live birth. A 24-month per-couple RRM rate and a per-embryo-transferred IVF rate are not the same denominator. The most common reading error in reproductive medicine outcomes literature is comparing these two figures as if they were equivalent. This page labels every rate's denominator type explicitly.

The studies in the table below are grouped by primary outcome type: live-birth cohorts, conception cohorts, systematic reviews, and safety comparators. Within each group, studies appear in chronological order. Follow-up windows are noted for every cohort because a 12-month rate and a 36-month rate from the same cohort cannot be compared to each other without that context.

<h2>Live-birth cohorts <small>8 STUDIES</small></h2>				
Study	Journal · Year · Country	n	Population	Outcome
<a href="#">Stanford JB,</a> <a href="#">Parnell TA,</a> <a href="#">Boyle PC</a> (2008)	Journal of the American Board of Family Medicine · 2008 · Ireland	1,072	avg age 35.8; 33% prior ART; 5.6 yr trying	crude LBR 25.5%; adj. cum. LBR 52.8% @24mo; adj. cum. conception 64.8% @24mo
<a href="#">Tham E,</a> <a href="#">Schliep K,</a> <a href="#">Stanford JB</a> (2012)	Canadian Family Physician · 2012 · Canada	108	avg age 35.4; 8% prior ART (22% prior IUI)	crude LBR 38%; adj. cum. LBR 66% @24mo; adj. cum. conception 73% @24mo

Study	Journal · Year · Country	n	Population	Outcome
<a href="#">Boyle PC, de Groot T, Andralojc KM, Parnell TA (2018)</a>	Frontiers in Medicine · 2018 · Ireland	403	100% prior failed IVF (avg 2.1 cycles, range 1-9; only 5% had prior IVF live birth); avg age 37.2	crude LBR 18.4%; adj. cum. LBR 32.1% @24mo
<a href="#">Stanford JB, Carpentier PA, Meier BL, Rollo M, Tingey B (2021)</a>	BMC Pregnancy and Childbirth · 2021 · USA	370	mean age 34.8; 27% prior live birth; two Massachusetts family-medicine clinics	adj. cum. LBR 29% @24mo
<a href="#">Boyle P, Toth A, Minjeur M, Turczynski C (2025)</a>	Journal of Restorative Reproductive Medicine · 2025 · Ireland	187	mean age 36.4; 19% prior IVF (2.3 cycles); mean 32.2 mo trying; 2019 Dublin clinic cohort	crude LBR 41%; crude conception 52%
<a href="#">Sánchez-Méndez JI, Lombarte M, Abengózar-Muela R, et al. (2025)</a>	Frontiers in Reproductive Health · 2025 · Spain	1,310	mean age 35.0; 27.5% prior ART; median 24 mo infertility; Madrid (Fertilitas Center) single center, 5-year cohort	crude LBR 35.3%; adj. cum. LBR 50% @24mo
<a href="#">James G, Mclindon LA, Hatch J, Mol BW, Turner JV (2021)</a>	medRxiv · 2021 · Australia	162	162 couples at an Australian hospital-based multidisciplinary fertility clinic (Brisbane), 2005-2010; median female age 33.7; median 33.9 mo infertility; non-assisted (restorative) treatment model	crude LBR 35.4%; adj. cum. LBR 57.4% @24mo <span>Preprint, not peer reviewed</span>

Study	Journal · Year · Country	n	Population	Outcome
<a href="#">Horodenchuk Z, Furman O, Datsko H (2020)</a>	Kwartalnik Naukowy Fides et Ratio · 2020 · Ukraine	282	282 married couples with infertility or recurrent miscarriage at 2 outpatient gynaecological centers, May 2010-Dec 2014; Creighton Model FertilityCare System or symptothermal charting + adjunctive medical treatment (NaPro-style)	crude LBR 41.5%; adj. cum. LBR 73.6% @24mo; adj. cum. conception 77.7% @24mo  Lower-tier journal

## Conception and pregnancy cohorts 5 STUDIES

Study	Journal · Year · Country	n	Population	Outcome
<a href="#">Barbato M, Del Zoppo S, Parazzini F, Graziani A, Guida M, Ferlin A, Frigerio L, Grande G (2026)</a>	Frontiers in Reproductive Health · 2026 · Italy	41	FAM arm n=41 of 97 total (41 FAM vs 56 ART control); primary idiopathic infertility, female age <40, seeking natural conception; CAMeN symptothermal method; multicenter Italy 2010-2014	crude pregnancy 51.2%

Study	Journal · Year · Country	n	Population	Outcome
<a href="#">Bernot G,</a> <a href="#">Lallemand L, Le</a> <a href="#">Menager C,</a> <a href="#">Ecochard R</a> <a href="#">(2025)</a>	European Journal of Obstetrics & Gynecology and Reproductive Biology · 2025 · France	551	French couples receiving fertility counselling + treatment 2022-2023 via trained fertility instructors + 15 GPs with fertility- chart-based therapeutic patient education; 4 of 551 women lost to follow- up (547 analyzed)	crude conception 37%
<a href="#">Grande G, Garolla</a> <a href="#">A, Graziani A,</a> <a href="#">Astorri AL,</a> <a href="#">Camarota MV,</a> <a href="#">Merola A, Polidori</a> <a href="#">MP, Lulli E, Busato</a> <a href="#">E, Pesce F, Pompa</a> <a href="#">G, Pontecorvi A,</a> <a href="#">Milardi D, Ferlin A</a> <a href="#">(2025)</a>	Andrology · 2025 · Italy	1,014	1,014 couples with primary infertility, comprehensive male- factor (andrological) + gynecological workup; male mean age 37.7, female 33.4; 266/1014 (26%) prior ART failure; 919 treated after excluding 95 untreatable causes; multicenter Italy 2015-2022	crude pregnancy 40.9%
<a href="#">Marshall M, Corkill</a> <a href="#">M, Whitty M,</a> <a href="#">Thomas A, Turner</a> <a href="#">J (2019)</a>	Human Fertility · 2019 · Australia	384	51% infertility 12+ months; 28% age >35; 17 Billings clinics 1999-2003	crude pregnancy 62.5%
<a href="#">Frank-Herrmann</a> <a href="#">P, Jacobs C,</a> <a href="#">Jenetzky E, Gnoth</a> <a href="#">C, Pyper C, Baur</a> <a href="#">S, Freundl G,</a> <a href="#">Goeckenjan M,</a> <a href="#">Strowitzki T (2017)</a>	Archives of Gynecology and Obstetrics · 2017 · Germany	187	187 subfertile women trained in the Sensiplan symptothermal method; age 21-47; mean 3.5 yr trying (range 1-8); amenorrhea, known tubal occlusion and severe male factor excluded	adj. cum. conception 38% @8mo

## Methods papers and reviews 4 STUDIES

Study	Journal · Year · Country	n	Population	Outcome
<a href="#">Stanford JB, et al. (2022)</a>	Human Reproduction Open · 2022 · USA/Canada/UK/Poland	834	mean age 34.0; 30% prior live birth; 10 sites, 4 countries	crude pregnancy 57% (methods cohort) <span>Methods paper</span>
<a href="#">Bulletti FM, Giacomucci E, Guido M, Palagiano A, Coccia ME, Bulletti C (2025)</a>	Therapeutic Advances in Reproductive Health · 2025	—	PRISMA systematic review, 145 key articles (from >25,000 titles)	Narrative / systematic review (no single cohort rate) <span>Review</span>
<a href="#">Ganci D, Steeper M, Polyakov A, Sunkara SK, Wilkinson J, Lensen S (2026)</a>	Fertility and Sterility · 2026	—	systematic review: RRM vs ART or medically unassisted conception	Narrative / systematic review (no single cohort rate) <span>Independent review</span>
<a href="#">Kiani AK, Paolacci S, Scanzano P, et al. (2020)</a>	Acta Biomedica (Atenei Parmensis) · 2020 · Italy	—	narrative review of ART complications	Narrative / systematic review (no single cohort rate) <span>Review</span>

**Footnote on intervention scope.** Not every study in the conception and methods groups tested a full medical and surgical RRM protocol. Several evaluated fertility-awareness training alone. Marshall and colleagues 2019 stratified couples by Billings cervical-mucus charting; Frank-Herrmann and colleagues 2017 trained couples in the Sensiplan symptothermal method. Both report conception outcomes from charting-based timing without the targeted diagnostic and treatment component that defines comprehensive NaProTechnology. Read those rates as fertility-awareness training outcomes, not as comprehensive RRM outcomes.

**Footnote on iNEST.** The iNEST paper (Stanford and colleagues 2022) is an enrollment and methods report, not an outcomes cohort. By its own account, clinical sites had missing data for about one-third of participants, and the authors caution that this level of missing data limits generalizability and that differential loss to follow-up may bias outcomes. Treat its 57% any-pregnancy and 44% any-live-birth figures as descriptive feasibility numbers, not as efficacy estimates.

## RRM REPLICATES ACROSS ELEVEN COUNTRIES

International replication: 14 independent studies across 11 countries. Headline rate shown as text, labeled by outcome type.

	STUDIES	HEADLINE RATE (BY OUTCOME TYPE)
<b>Ireland</b>	● ● ● 3 studies	crude LBR 41% to adj. cum. LBR 52.8% @24mo
<b>Spain</b>	● 1 study	crude LBR 35.3%; adj. cum. LBR 50.0% @24mo
<b>Canada</b>	● 1 study	crude LBR 38%; adj. cum. LBR 66.0% @24mo
<b>Ukraine</b>	● 1 study	crude LBR 41.5%; adj. cum. LBR 73.6% @24mo *
<b>Australia</b>	● ● 2 studies	crude LBR 35.4%; adj. cum. 57.4% @24mo; pregnancy 62.5%
<b>Italy</b>	● ● 2 studies	crude conception 40.9% to 51.2% @12mo
<b>France</b>	● 1 study	crude conception 37%
<b>Germany</b>	● 1 study	cum. conception 38% @8mo
<b>USA</b>	● 1 study	adj. cum. LBR 29% @24mo
<b>Multinational</b>	● 1 study	crude any-pregnancy 57% (methods cohort)

● Live-birth outcome      ● Conception / pregnancy outcome      Dots = independent studies (not a rate)

\* Ukraine: non-indexed lower-tier journal.

Italy ART comparator (17.8% per complete cycle) excluded: a different denominator cannot be compared to these rates.

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International replication: 14 independent studies across 11 countries. Each headline rate is shown as text and labeled by outcome type (live-birth versus conception, crude versus adjusted-cumulative) because those denominators are not directly comparable across countries.

## How RRM Compares to IVF and ART

The first direct head-to-head comparison of RRM and IVF outcomes in the same clinical population appeared in 2025. Among 187 couples who committed to RRM treatment at a Dublin clinic (mean age 36.4, 19% with prior IVF, mean 32.2 months trying), 41% achieved a live birth and 52% conceived within 24 months. The paper benchmarked these crude rates against CDC and SART IVF registry data from the same year. In age bands under 43, RRM crude live-birth rates were 42-44%, comparable to the SART and CDC benchmarks of 40-41% for IVF. This is a

single-center retrospective cohort benchmarked against registry aggregates, not a randomized trial. The comparison is informative but not definitive.

For broader scale, the largest published [NaProTechnology cohort to date](#) enrolled 1,310 couples across a five-year single-center study in Madrid. The crude live-birth rate was 35.3%. The adjusted-cumulative rate reached 50% at 22-24 months and plateaued at 62.1% from 31 months onward. These rates come from a cohort with a mean age of 35.0 and 27.5% prior ART. They are not directly comparable to IVF per-cycle benchmarks.

A full course of NaProTechnology-based care typically runs \$2,000 to \$5,000, covering evaluation, targeted diagnostics, and treatment for the underlying conditions driving infertility [\[source\]](#). The right comparison for that number is not a single IVF cycle. It is what IVF costs to reach a baby.

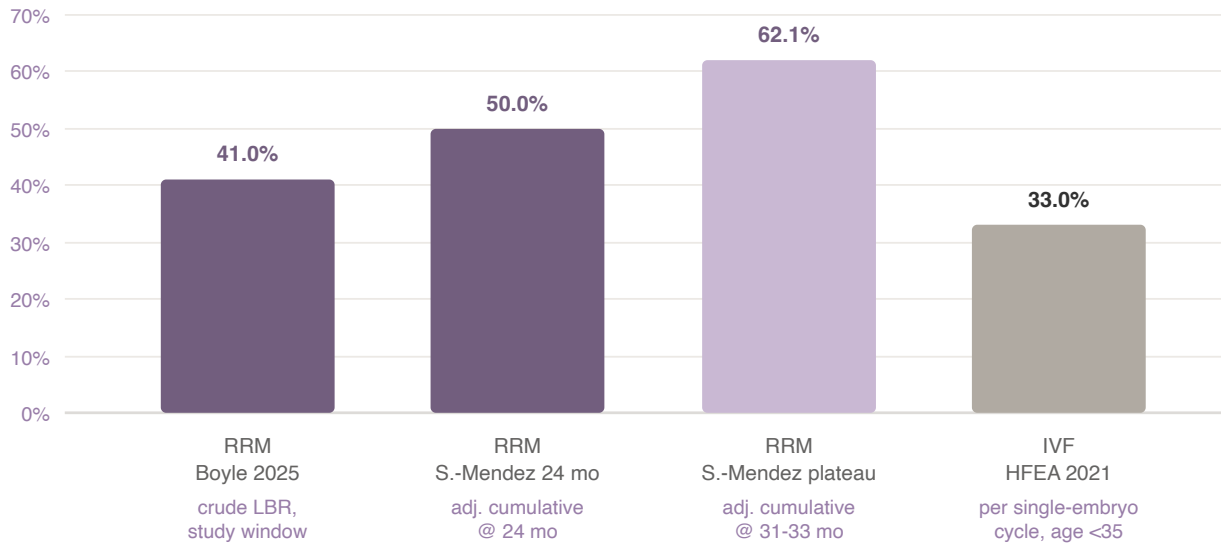
A single IVF cycle in the United States, including medications, runs about \$19,200 [\[source\]](#). Most couples do not succeed in one cycle. A US prospective cohort put the total treatment cost per successful outcome at roughly \$61,000 [\[source\]](#). A more recent patient-reported figure is about \$50,000 across an average of 2.3 cycles [\[source\]](#). A global review figure of \$10,000 to \$15,000 per IVF cycle also exists [\[source\]](#), but that is a worldwide average; it reads low for the US market. The honest comparison is RRM's full course cost to IVF's cumulative cost to a live birth: \$2,000 to \$5,000 for care that diagnoses and treats the problem, versus roughly \$50,000 to \$61,000 for a technology that bypasses it.

The [ART registries and reporting codes page](#) covers how IVF outcomes are measured, categorized, and reported at the population level.

An independent systematic review published in Fertility and Sterility in 2026 assessed [RRM effectiveness and safety compared to ART and medically unassisted conception](#). The Ganci and colleagues review is explicitly skeptical, framing RRM as "frequently promoted as an alternative to ART despite uncertainty" and cautioning that reliance on RRM alone "may delay effective treatment." Readers conducting policy or clinical assessments should read this review alongside the cohort evidence. Disagreement in the literature is part of the evidence picture, and the absence of randomized controlled trial data is a genuine limitation that affects conclusions in both directions.

## RRM VS IVF: LIVE-BIRTH RATES

RRM rates are cumulative over a treatment window; the IVF reference is per single-embryo cycle — different denominators.



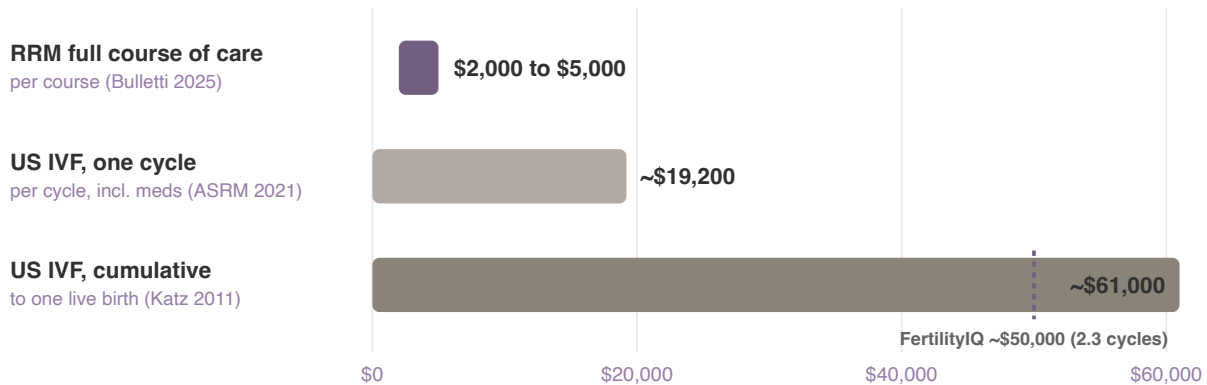
*RRM = restorative reproductive medicine (natural conception). HFEA IVF figure is the live birth rate per embryo transferred, women under 35. A cumulative RRM rate and a per-cycle IVF rate are shown side by side for context, not as a like-for-like ratio.*

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RRM rates (Boyle 2025 crude live birth; Sanchez-Mendez adjusted cumulative) are measured over a treatment window, while the HFEA 2021 IVF reference is the live-birth rate per single-embryo cycle for women under 35. A cumulative rate and a per-cycle rate are different measures shown side by side for context, not a like-for-like ratio.

## TYPICAL COST (US DOLLARS)

An RRM course costs far less than what IVF runs to reach one live birth. Bars use different denominators (labeled).



*Per cycle and cumulative are different denominators and are not interchangeable. The honest comparator to an RRM course is IVF's cumulative cost to a live birth, not one cycle's sticker price.*

*Sources: Bulletti FM et al. 2025; ASRM 2021; Katz et al., Fertility and Sterility, 2011; FertilityIQ 2019.*

rrmacademy.org/rrm-success-rates

Three cost figures on one US-dollar scale, each labeled by its basis: an RRM full course of care (\$2,000 to \$5,000, Bulletti 2025), one US IVF cycle including medications (about \$19,200, ASRM 2021), and the cumulative US cost to one live birth (about \$61,000 per successful outcome, Katz 2011, with FertilityIQ's about \$50,000 across 2.3 cycles marked alongside). Per cycle and cumulative are different denominators and are not interchangeable.

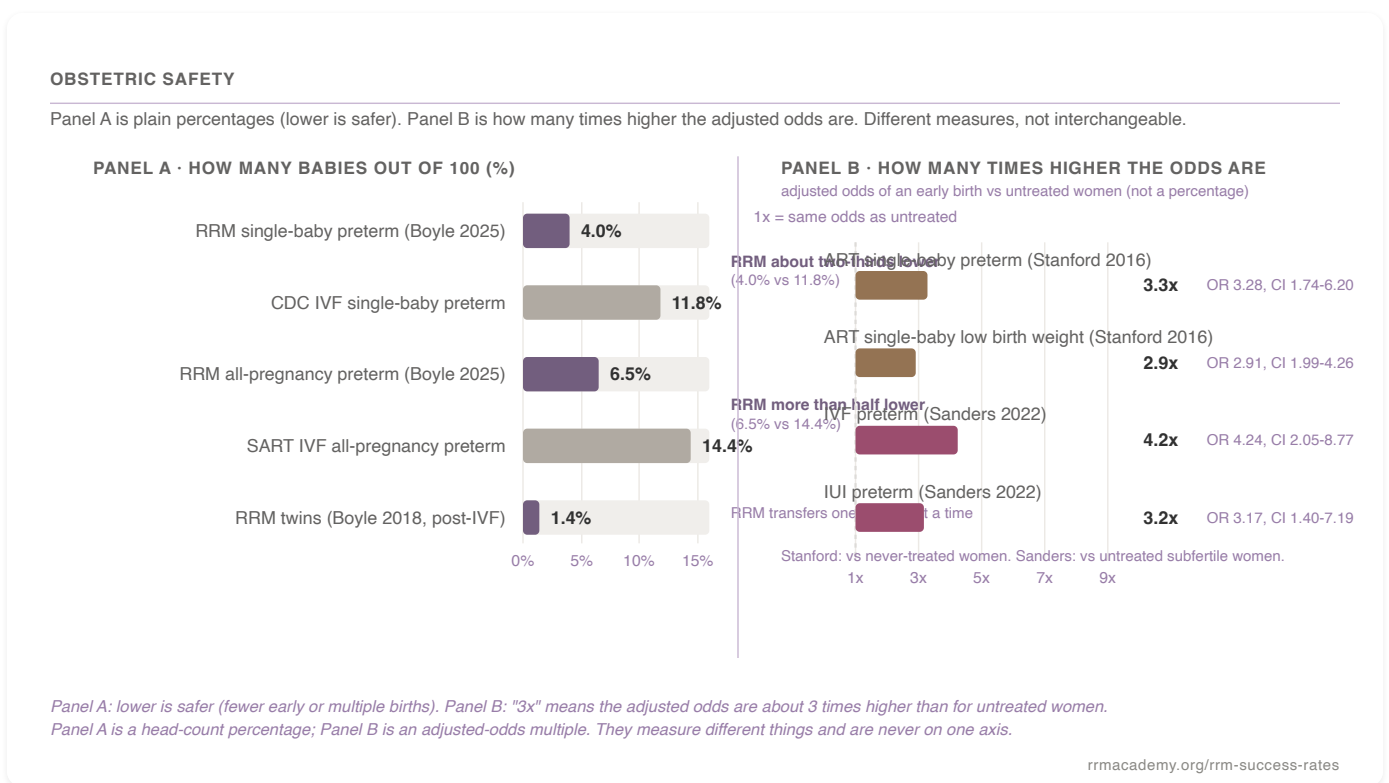
## Obstetric Safety

The clearest safety signal in the RRM outcomes data is not an odds ratio. It is two straightforward percentages. In the Boyle 2025 head-to-head cohort, 4.0% of RRM singleton babies were born preterm. The CDC benchmark for IVF singleton births that same year was 11.8%. That is roughly two-thirds fewer early births in the RRM group [\[source\]](#). Across all RRM pregnancies, the preterm rate was 6.5%, against 14.4% in the SART IVF benchmark: more than half the rate [\[source\]](#). RRM twins are rare to begin with. In the Boyle 2018 post-IVF-failure cohort, only one of 74 RRM live births was a twin pregnancy (1.4%) [\[source\]](#).

The comparison papers for ART-treated populations report the data differently. Neither published a per-group preterm percentage for singleton pregnancies; they published adjusted odds ratios. The plain reading: for single babies, the adjusted odds of an early birth were about 3 times higher after ART versus women who never used fertility treatment (OR 3.28, 95% CI 1.74 to 6.20)

[source]. Among women who were already subfertile, the adjusted odds of an early birth were about 4 times higher after IVF and about 3 times higher after IUI, compared with subfertile women who went untreated that cycle (IVF OR 4.24, 95% CI 2.05 to 8.77; IUI OR 3.17, 95% CI 1.40 to 7.19) [source].

One honest caveat belongs here. RRM safety data come from cohorts without matched controls. The difference is mechanistically plausible: RRM achieves conception without transferring multiple embryos, which is the primary driver of multiple births, and multiples drive the majority of preterm births and NICU admissions in ART populations. But plausible is not the same as proven. Randomized data do not exist for this comparison. What the existing evidence supports is a consistent picture: RRM birth outcomes, particularly on prematurity and multiples, look substantially better than ART benchmarks. That picture is worth taking seriously, even before the science is definitive.



Panel A reports RRM versus IVF preterm and twin outcomes as plain percentages (Boyle 2018 and 2025): RRM single-baby preterm is about two-thirds lower (4.0% vs 11.8%) and all-pregnancy preterm more than half lower (6.5% vs 14.4%) than the IVF benchmarks, keeping singleton and all-pregnancy denominators separate. Panel B shows how many times higher the adjusted odds of an early birth are with fertility treatment versus untreated women (Stanford 2016, Sanders 2022); these are adjusted odds, not a head-count percentage, so they are shown as a "times higher" multiple, kept on a separate scale and never plotted on the same axis as the Panel A percentages.

## Effectiveness by Condition

Published evidence covers several diagnostic subgroups. What follows draws from the cohort data available; it is not a clinical guide, and approaches vary across RRM clinicians and named methods.

**Endometriosis.** In the largest NaProTechnology cohort, couples with an endometriosis diagnosis had a crude live-birth rate of 27.9% (87 of 312). This was among the lower crude rates by diagnostic subgroup, consistent with endometriosis being a mechanically and hormonally disruptive condition. The diagnostic-reassignment chart from the 2025 Dublin cohort shows that endometriosis prevalence rose from 10% pre-workup to 25% post-workup, indicating that thorough evaluation identifies the disease more frequently than prior assessments had. The endometriosis condition page covers the full evidence base on diagnosis, staging, and disease burden.

**PCOS.** The Madrid cohort included couples with a PCOS diagnosis at 12% prevalence pre- and post-workup. No condition-specific live-birth subgroup data for PCOS are published from this cohort's primary report. The ovulatory dysfunction diagnostic category, at 76% prevalence post-workup (up from 19% pre-workup in the Dublin cohort), encompasses the hormonal dysregulation patterns relevant to PCOS. Outcomes within that broader category are not broken out by specific PCOS diagnosis in currently available data. The PCOS condition page covers the diagnosis criteria, hormonal patterns, and clinical background for this condition.

**Recurrent miscarriage.** A 2012 Canadian cohort enrolled 108 couples pursuing NaProTechnology for infertility; 19 of these (18%) had two or more prior unexplained miscarriages. The cohort's adjusted-cumulative live-birth rate was 66% at 24 months, with all births singleton. The recurrent-miscarriage subgroup outcomes were not separately reported in the abstract but the cohort's inclusion of this group is documented. A 2020 Ukrainian cohort explicitly enrolled couples with both infertility and recurrent miscarriage; that cohort achieved an adjusted-cumulative live-birth rate of 73.6% and an adjusted-cumulative conception rate of 77.7% at 24 months, though it was published in a lower-tier journal and carries limitations accordingly. This 73.6% is the highest adjusted-cumulative live-birth rate in the corpus and should be read as an outlier from the most prognostically favorable cohort: the paper names younger age, shorter time trying, and good compliance as its favorable predictors of live birth, and the cohort sits at the low

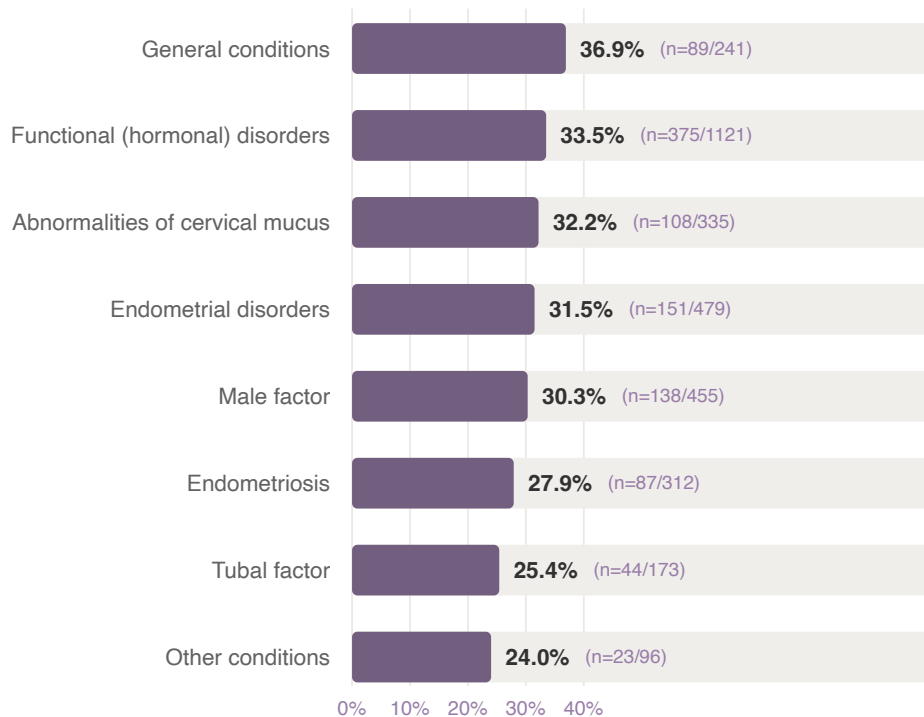
end of the corpus for prior ART exposure. It is not representative of the older, more treatment-experienced populations that most other cohorts on this page enrolled. The [recurrent miscarriage condition page](#) covers the clinical definitions, known causes, and diagnostic framework for pregnancy loss.

**Post-failed IVF.** The 2018 Frontiers in Medicine cohort enrolled [403 couples who had all previously undergone IVF without a live birth \(average 2.1 IVF cycles, only 5% with any prior IVF live birth\)](#). The adjusted-cumulative live-birth rate in this population was 32.1% (crude 18.4%). Age subgroups: women aged 35-38 reached an adjusted rate of 37.5% (crude 23.6%); women over 40 reached 27.4% (crude 16.0%). This cohort is clinically significant because it enrolled couples who had already been evaluated and treated under an ART framework without success, making the diagnostic workup and outcomes particularly informative about what prior evaluation had and had not captured.

**Male factor.** A 2025 Italian multicenter cohort enrolled [1,014 couples presenting with primary infertility and received systematic andrological evaluation alongside gynecological workup](#). Isolated male factor accounted for 23% of couples; combined male and female factor, 45%. After targeted treatment of identified causes, the crude spontaneous pregnancy rate among 919 treated couples was 40.9% at 12 months minimum follow-up. Among the isolated male-factor subgroup, 32.5% achieved spontaneous pregnancy. The comprehensive diagnostic approach reduced the fraction carrying an idiopathic label from the typical 30-50% range to 8% of the total cohort. Male factor is not a secondary consideration in RRM: it is evaluated from the outset as a primary contributing cause.

## LIVE-BIRTH RATE BY DIAGNOSIS

Crude take-home-baby rate within each diagnostic subgroup (Sanchez-Mendez 2025). Couples may carry multiple diagnoses.



*RRM produces broadly comparable live-birth rates across diverse diagnoses — it treats the underlying cause rather than bypassing it.*  
Source: Sanchez-Mendez et al. 2025 (Table 1). Subgroups are not mutually exclusive. [rrmacademy.org/rrm-success-rates](http://rrmacademy.org/rrm-success-rates)

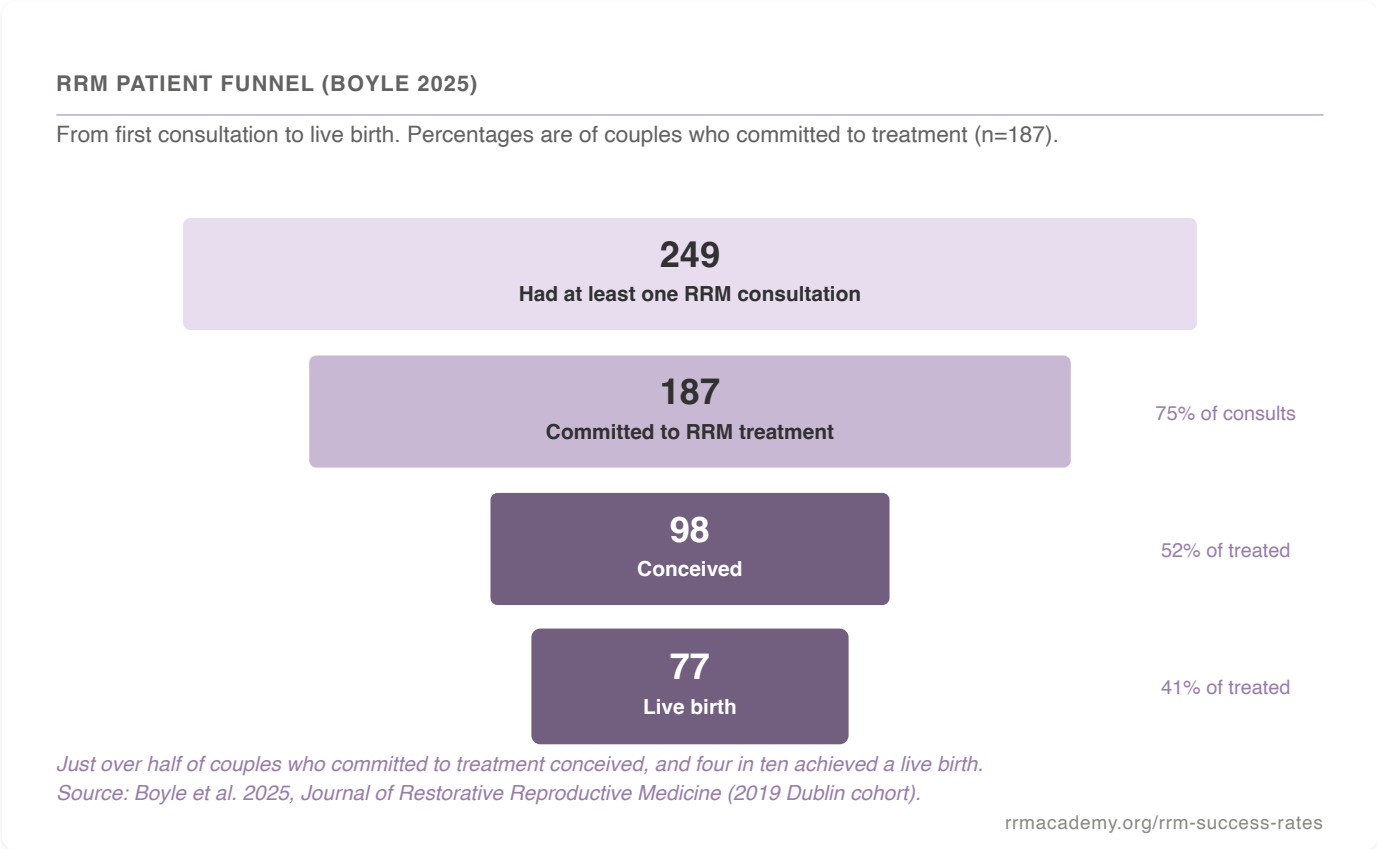
Crude take-home-baby rate within each diagnostic subgroup from Sanchez-Mendez et al. 2025 (Table 1). Couples may carry more than one diagnosis, so the subgroups are not mutually exclusive.

## Spotlight Studies

The 2025 Dublin cohort published in the Journal of Restorative Reproductive Medicine offers the first direct comparison of RRM outcomes against contemporaneous IVF registry data. Of 249 couples who had at least one RRM consultation, 187 committed to treatment and met inclusion criteria. Of those 187, 98 (52%) conceived and 77 (41%) achieved a documented live birth within 24 months. The mean age was 36.4 and 19% had prior IVF. The funnel from consultation to live birth is reported transparently, which is relevant: the 41% crude live-birth rate uses the 187 committed-to-treatment couples as the denominator, not the 249 who consulted, and not a smaller per-cycle denominator.

The diagnostic reassignment findings in this cohort are clinically significant independent of the outcome rates. Before RRM evaluation, 24% of couples carried a label of "unexplained infertility." After full workup, that figure fell to 1%. Labels that were absent pre-workup and appeared post-workup include corpus luteum deficiency (0% to 71%), endometriosis (10% to 25%), hypothyroidism (7% to 24%), hypoandrogenism (0% to 31%), and endometritis (0% to 17%). These are not statistical artifacts: they represent diagnoses that RRM evaluation identified and prior assessment did not.

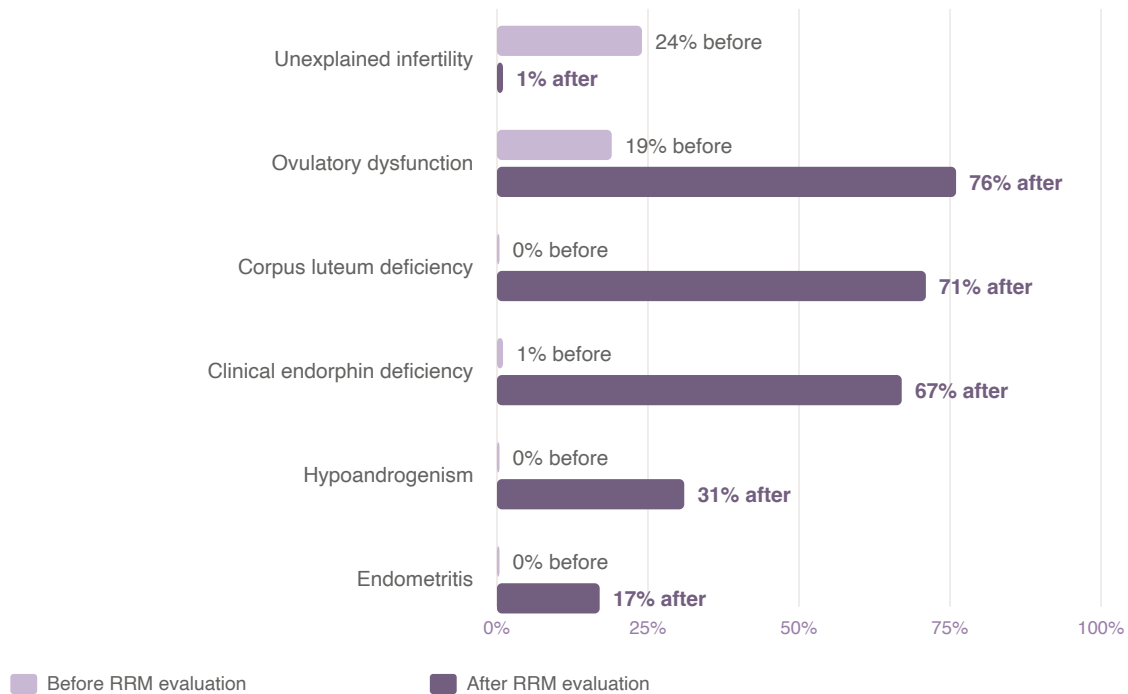
On obstetric outcomes, singleton preterm birth in the RRM cohort was 4.0%, against a CDC IVF singleton benchmark of 11.8%. All-pregnancy preterm was 6.5%, against 14.4% for SART IVF. Twin pregnancies were rare. This cohort is a single-center retrospective study benchmarked against registry aggregates rather than a randomized trial. It establishes that comparable live-birth rates with lower preterm rates are achievable in a documented population. Whether that holds across clinical settings requires further study.



Boyle et al. 2025 (2019 Dublin cohort): the patient funnel from first consultation to live birth. The conception (52%) and live-birth (41%) percentages are computed against the 187 couples who committed to treatment, not the 249 who only consulted.

## DIAGNOSES BEFORE VS AFTER RRM EVALUATION

% of cohort carrying each diagnosis, before vs after RRM work-up (Boyle 2025). Specific causes replace "unexplained".



RRM converts vague "unexplained infertility" into specific, treatable diagnoses.

Source: Boyle et al. 2025 (Table 4). Couples may carry multiple diagnoses, so columns do not sum to 100%.

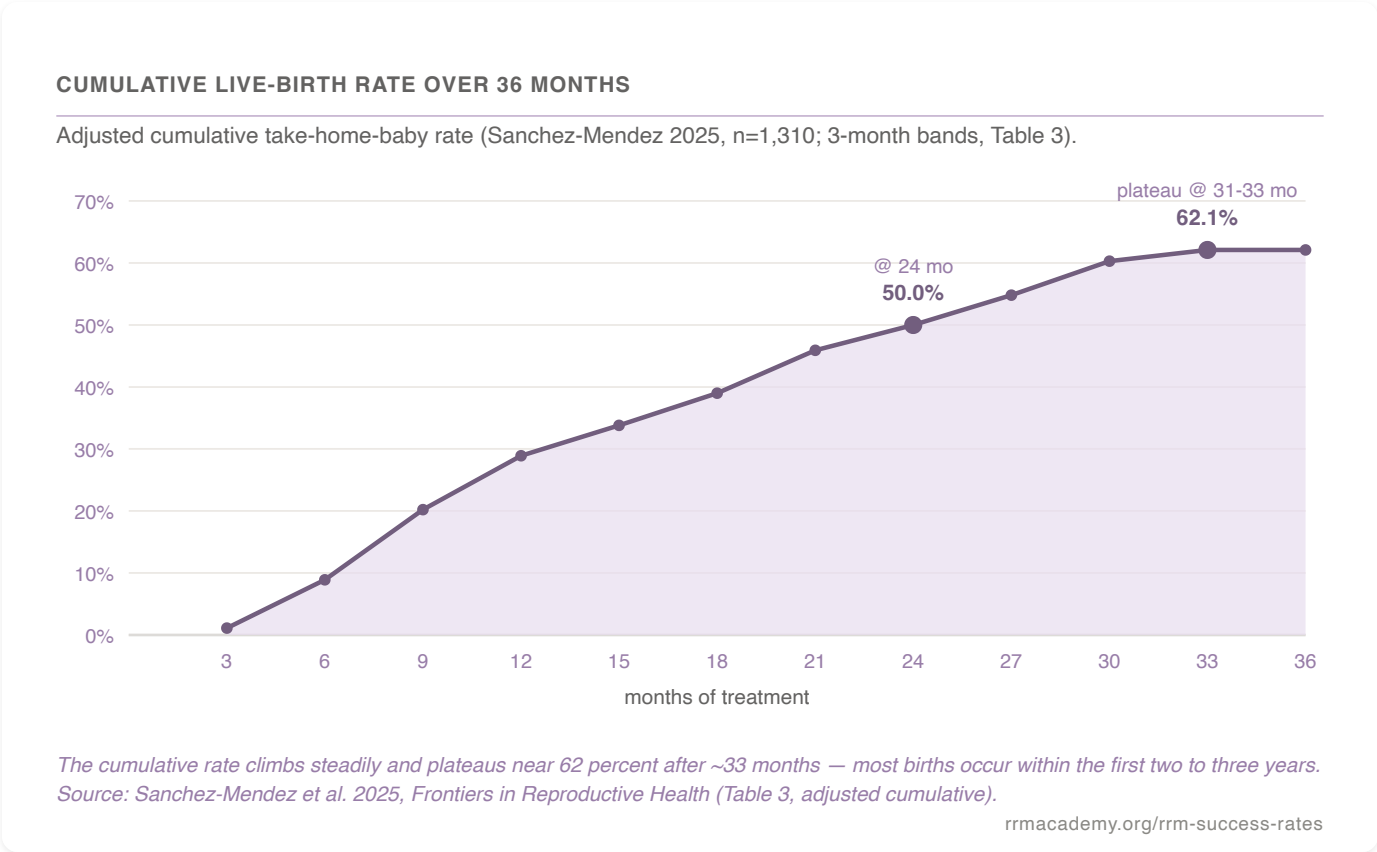
rrmacademy.org/rrm-success-rates

Boyle et al. 2025 (Table 4): the share of the cohort carrying each diagnosis before versus after the RRM work-up. Couples may carry several diagnoses, so the columns do not sum to 100%.

The Sánchez-Méndez and colleagues 2025 study is the largest published NaProTechnology cohort to date, enrolling 1,310 couples at a single center in Madrid over five years. The crude take-home-baby (live birth) rate was 35.3% (463 of 1,310). The adjusted-cumulative rate tracked upward over time: 20.2% at 9 months, 28.9% at 12 months, 39.0% at 18 months, 50.0% at 22-24 months, and a plateau of 62.1% from 31-33 months onward. This time-curve matters: couples or clinicians looking at a 12-month rate alone would see 28.9%, missing the additional pregnancies that accrued over the subsequent year and a half.

The age gradient in this cohort is steep and clinically important. Adjusted-cumulative live-birth rates by age band: 83.7% for women aged 18-30, 63.2% for ages 31-35, 53.3% for ages 36-40, and 24.4% for women over 40. Age is the strongest predictor of outcome. The mean cohort age of 35.0 means the overall rate sits between the 31-35 and 36-40 age bands, and readers evaluating these numbers for their own situation should weight the age-specific figures accordingly.

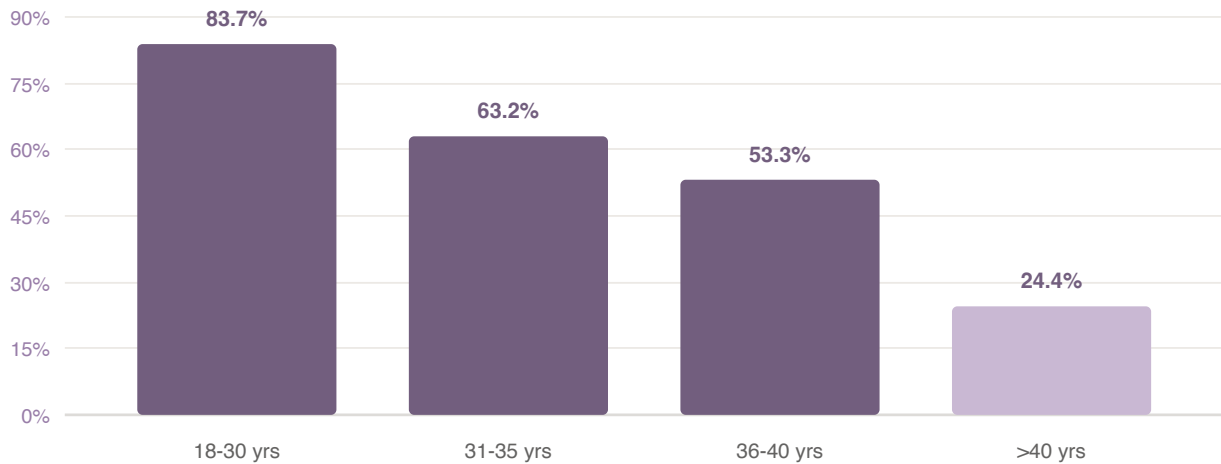
The cohort also enrolled 27.5% of couples with prior ART. Among that subgroup, the crude take-home-baby rate was 25.3%, still meaningful in a population that had already pursued ART without a live birth. And what was "unexplained" before workup became diagnosable: fewer than 2% of couples completed evaluation without receiving at least one specific diagnosis. The study does not report the full diagnostic reassignment table, but the near-elimination of the "unexplained" category across 1,310 couples documents what systematic evaluation finds when it is applied systematically.



Sanchez-Mendez et al. 2025 (Table 3, adjusted cumulative): the cumulative take-home-baby rate by 3-month treatment band for the 1,310-couple cohort, reaching 50.0% at 24 months and plateauing at 62.1% from the 31-to-33-month band onward.

## CUMULATIVE LIVE-BIRTH RATE BY MATERNAL AGE

Adjusted cumulative take-home-baby rate by age band (Sanchez-Mendez 2025, n=1,310; p<0.001 across bands).



Success declines with maternal age, as with all fertility care — but cumulative rates remain meaningful into the late 30s.  
Source: Sanchez-Mendez et al. 2025 (Figure 2B, adjusted cumulative).

[rrmacademy.org/rrm-success-rates](https://rrmacademy.org/rrm-success-rates)

Sanchez-Mendez et al. 2025 (Figure 2B, adjusted cumulative): adjusted cumulative take-home-baby rate by maternal age band for the 1,310-couple cohort, with a significant decline across bands (p<0.001).

## How to Read These Numbers

**Crude vs. adjusted-cumulative rates describe different things.** A crude rate divides live births by all enrolled couples, treating every dropout as a non-live-birth. An adjusted-cumulative (life-table) rate censors withdrawals and estimates what fraction of couples would succeed given the full follow-up window. These can differ by 10 to 25 percentage points in the same cohort. Neither is wrong; they answer different questions. This page reports both and labels which is which.

**Per-couple and per-cycle denominators are not interchangeable.** RRM studies predominantly report per-couple rates: one outcome per enrolled couple over a defined period. IVF registries predominantly report per-cycle or per-embryo-transferred rates: one outcome per individual treatment attempt. A couple who transfers three embryos across three IVF cycles has contributed three observations to the per-cycle rate and one observation to a per-couple rate. Comparing a 36-month per-couple RRM rate to a single-transfer-attempt IVF rate treats fundamentally different denominators as equivalent.

**Selection effects are real and not fully correctable.** Couples who seek RRM typically arrive with prior medical encounters, previous diagnoses, and often prior treatment failures. They are not the same population as couples pursuing first-line ART, and they are not the same as the general population of subfertile couples. This means RRM cohort rates cannot be straightforwardly generalized, and they cannot be straightforwardly dismissed on the grounds of selection either. The studies are honest about their populations; readers should be honest about the inference limits.

**No randomized controlled trials exist comparing RRM and IVF.** The head-to-head comparison in [Boyle and colleagues 2025](#) is a retrospective cohort benchmarked against registry data, not a randomized trial. The absence of RCTs is frequently cited as a limitation of RRM evidence. It is a genuine limitation. It is also worth noting that IVF's initial expansion into clinical practice occurred largely before any randomized controlled trials existed for it, and that RCTs in reproductive medicine carry distinctive logistical and ethical challenges. The appropriate conclusion is that the evidence is observational, and observational evidence carries the limitations it always does.

**Journal tier matters, and the preprint flag matters.** The studies in this table span journals from indexed general-audience family medicine to specialty journals to one preprint (the [2021 Australian cohort by James and colleagues](#)). Preprints have not completed peer review. Lower-tier journals have less rigorous peer review. This page notes preprint and lower-tier status where applicable. These distinctions matter when weighing the evidence.

**The ranges in the stat cards span genuinely different things.** The 18.4% crude live-birth rate comes from a cohort where 100% of couples had prior failed IVF, average 2.1 cycles, mean age 37.2. The 73.6% adjusted-cumulative rate comes from a mixed cohort with broader inclusion criteria and 24 months of follow-up. These are not contradictory estimates of the same thing. They are measurements of different populations over different periods using different metrics. The range exists because heterogeneous populations produce heterogeneous outcomes.

## Frequently Asked Questions

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## What is the success rate of NaProTechnology? —

In published cohorts, NaProTechnology live-birth rates range from 18.4% (crude, 24-month follow-up, population with 100% prior failed IVF) to 62.1% (adjusted-cumulative plateau reached at the 31 to 33 month band, mixed infertility population) [\[source\]](#) [\[source\]](#). The variation is not measurement error. It reflects genuinely different populations, follow-up windows, and rate-calculation methods.

The most rigorous way to interpret any single figure is to identify: (1) whether it is a crude rate or an adjusted-cumulative life-table rate, (2) the follow-up period it covers, (3) the age profile of the enrolled population, and (4) whether prior treatment failure was an inclusion criterion. A 35-year-old with no prior treatment will have a different expected trajectory than a 39-year-old with two prior IVF cycles. The age-specific data from the 1,310-couple Madrid cohort offers the most useful reference: 83.7% adjusted-cumulative for women 18-30, 63.2% for ages 31-35, 53.3% for ages 36-40, and 24.4% for women over 40 [\[source\]](#).

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## Is RRM more effective than IVF? —

In published observational data, the rates are comparable in age-matched populations, with different risk profiles. The 2025 Dublin cohort reported 42-44% crude live-birth rates in women under 43, against SART and CDC IVF benchmarks of 40-41% for the same age range [\[source\]](#). A 2025 systematic review found RRM success rates of 40-60% versus ART success rates of 30-40% across the reviewed literature [\[source\]](#).

These are observational comparisons, not randomized trials. The populations differ, the denominators differ, and the comparison is not controlled. What the data does not support is the premise that IVF is categorically more effective than RRM for all populations. What it also does not support is an unqualified superiority claim in either direction. An independent systematic review published in *Fertility and Sterility* in 2026 is explicitly skeptical of RRM effectiveness claims and readers engaged in policy or clinical decision-making should read it directly [\[source\]](#). The honest summary: the effectiveness comparison remains open, which is itself a finding worth noting given how long ART has dominated the clinical infrastructure.

## How does RRM compare to IVF on safety?

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The available evidence points in one direction. In the first head-to-head cohort comparing RRM directly against IVF benchmarks, RRM singleton preterm births came in at 4.0%, against 11.8% in the CDC IVF benchmark for the same year: roughly two-thirds lower. Across all pregnancies, the preterm rate was 6.5% for RRM versus 14.4% in the SART IVF benchmark: more than half lower [\[source\]](#). Separate population studies found the adjusted odds of an early birth were about 3 times higher after ART versus never-treated women [\[source\]](#) and about 4 times higher after IVF among subfertile women [\[source\]](#). The mechanism is not mysterious: RRM achieves conception without transferring multiple embryos, so multiple pregnancies are rare, and multiples are the main engine of preterm births and NICU admissions after IVF. These are observational findings, not randomized trial results. But the pattern is consistent and clinically meaningful.

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## Is RRM evidence-based?

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In published literature, yes, with the usual caveats that apply to observational evidence. This page indexes 14 cohort studies and 2 systematic reviews, spanning 2008-2026, across 11 countries, with populations ranging from 41 to 1,310 couples. The studies are predominantly published in indexed peer-reviewed journals. One is a preprint. One review, published in *Fertility and Sterility* in 2026, is explicitly skeptical of the evidence base [\[source\]](#).

The body of evidence is observational. No randomized controlled trials comparing RRM to IVF exist. The individual cohorts use different populations, different follow-up windows, and different rate-calculation methods, which is why the ranges on this page span a wide band. The evidence is sufficient to establish that RRM produces documented live births in defined populations at rates that are clinically meaningful. It is not sufficient to make unqualified effectiveness claims, predict individual outcomes, or rule out selection bias in the cohorts. Evidence-based means the practice is grounded in published literature. It does not mean settled. RRM meets the first standard. The second is a higher bar that reproductive medicine as a field, across all approaches, has not fully reached.

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## Are there randomized controlled trials comparing RRM and IVF?

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No. As of 2026, no randomized controlled trials have been published comparing RRM (or NaProTechnology) to IVF as primary treatments for infertility. The best available comparison is the 2025 Dublin retrospective cohort benchmarked against contemporaneous IVF registry data [\[source\]](#), which is informative but not equivalent to a randomized design.

The absence of RCTs is a real limitation of the RRM evidence base. It is frequently raised in critical reviews of RRM, including the 2026 Fertility and Sterility systematic review [\[source\]](#). At the same time, IVF was adopted at scale and became the dominant infertility treatment before any RCTs existed comparing it to expectant management or other approaches. A Cochrane review documented that only two small RCTs (86 women total) examined IVF versus expectant management. The standard is applied unevenly. That does not resolve the limitation for RRM, but it is relevant context for evaluating what level of evidence is actually available across the field.

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