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The wish to
have a baby

Fertility
and sport
in women

Understanding
embryo genetics





UR Mexico City

UR Managua (Nicaragua)



UR Oman

UR Group

Over 35 Years Promoting Life



**Editorial Dr. José Jesús
López Gálvez**

CEO

Grupo UR

Our fertility centers are mostly located in the main hospitals of the biggest cities across Spain. And internationally, we have reproduction centers in Mexico, Nicaragua, and Oman, continuing our expansion with new openings.

We started our work in the world of assisted reproduction over 35 years ago, with an unwavering and innovative commitment to our patients. Unwavering, because our 35 years of experience guarantee the professionalism and accuracy of our work. Innovative, because we have always gone ahead of the pack, investing in education, research, and technology.

This extensive experience has been led by professionals committed to developing the most cutting-edge procedures in this field. These values allow us to carry out the most innovative treatments and techniques backed by science in the area of fertility, achieving the highest success rates, both nationally and internationally. All this is combined with a philosophy based on fundamental pillars: a close relationship between colleagues, a positive attitude among people, and a personalized and professional treatment of our patients.

The need to expand knowledge to provide greater quality and safety to patients places us mostly in hospital settings together with the HLA Hospital Group and other leading institutions in healthcare, and has also led us to provide excellence in terms of our professionals' training and ethics. This is evident in the creation of the Master's Degree in Biology and Genetics of Reproductive Medicine over 19 years

ago, with the participation and training of professionals from all over the world. We are also the Chair of Reproductive Biomedicine of the Miguel Hernández University.

The UR Group is currently located in Spain, with centers in Madrid, Malaga, Valencia, Murcia, Granada, Almería, Cádiz (Jerez de la Frontera), Zaragoza, Asturias, and Ceuta. Our headquarters are located in Alicante. Our international expansion began in 2016 with the opening of the Mexico City Reproduction Unit, then in 2018, the Managua Reproduction Unit (Nicaragua) was inaugurated, and in 2020 we opened our center in downtown Oman.

Our centers employ all the latest fertility techniques and specialize in complex procedures. They have laboratories equipped with time lapse technology and their own genetics department with experts in prenatal and preimplantation diagnosis and DNA analysis. Our Biobank preserves our donors' DNA to preserve a baby's health.

One of the things that makes us stand out from the rest is our success rate, which provides recognition and prestige to our reproduction units, exceeding the standards published by the Spanish Fertility Society. Our results are attributed to the quality of care provided by our specialists and our investment in cutting-edge technology that allows us to customize treatments.

For us, quality is not an end, but rather a means, set forth by our patients' satisfaction. What we do determine is our added value in all processes, as well as in our equipment and facilities, which are always in a state of continuous renovation.

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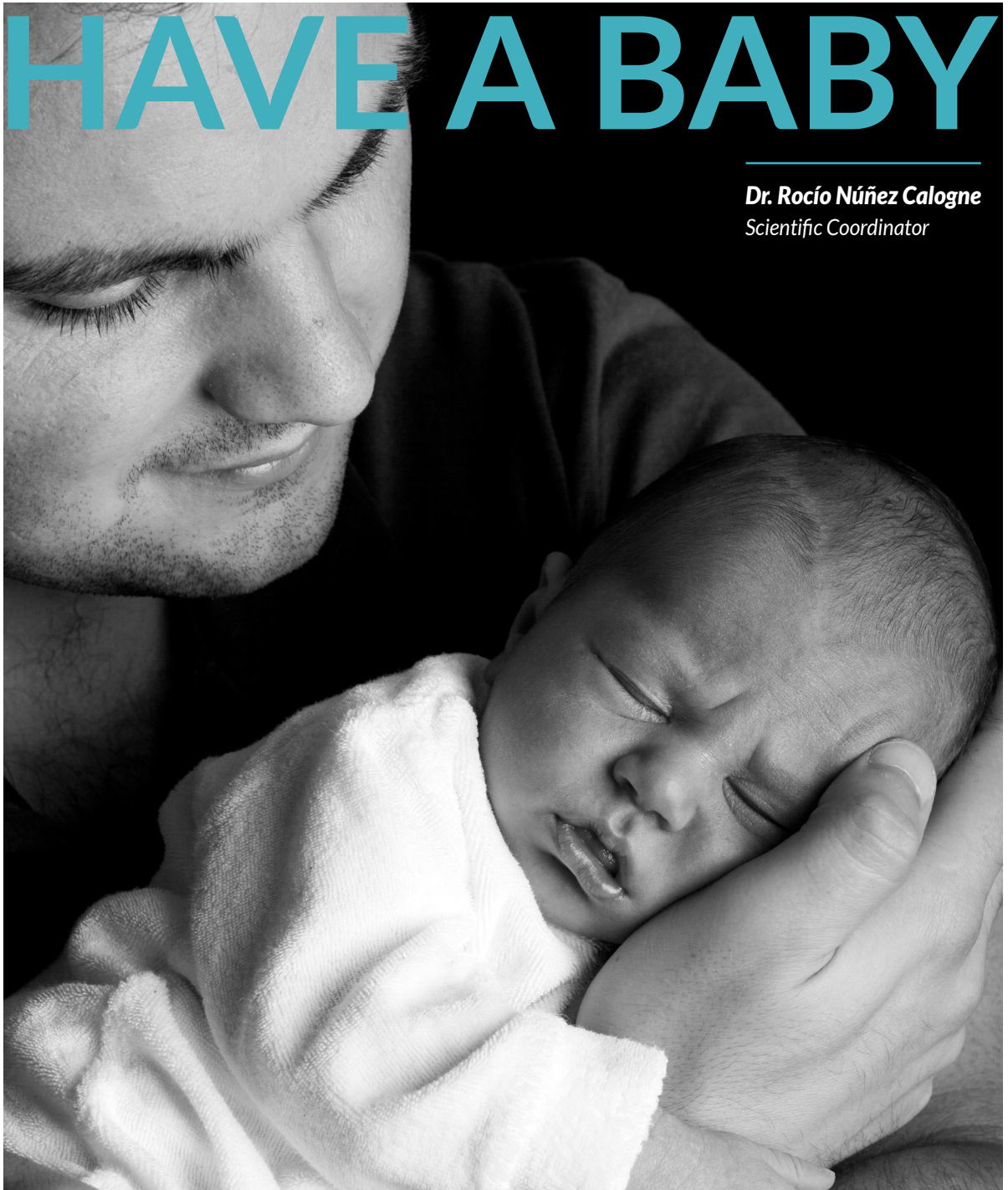
The assessment of the fertility test allows us to draw up a guaranteed, customized, and affordable plan

Miguel Barea Gómez

The wish to

HAVE A BABY

Dr. Rocío Núñez Calogne
Scientific Coordinator



Assisted reproduction has undergone enormous technological advances in recent years. Issues like the genetic editing of embryos or the anonymity of gamete donations are highly topical these days, and professionals hold conferences, meetings, seminars, etc., where leading experts present their views.

In most cases, these professionals address technical issues, where the fundamental question is “how”: which diagnostic techniques are best suited for each patient (“personalized medicine” is very popular right now), how to carry out treatments, and how, in short, to achieve pregnancy. At best, the questions are legal in nature: is it allowed? But we rarely ask ourselves whether it “should be”. And this is what ethics is all about: building values, or, in other words, duties.

As professionals, we tend to focus on our means, because they are what we manage and because we want to know how conflicts raised by new techniques can be solved, but we are less concerned about the ends. And let’s not forget that the ultimate goal is not just to achieve gestation, but to obtain a healthy child. The actions of reproductive medicine professionals focus on one aspect that many people are especially sensitive about: **their desire to reproduce**. Exceedingly high expectations fueled by technological advances, the uncertainty of results, the openness to medicine for the sake of satisfying desires,

etc., may give rise to tensions that require in-depth analysis.

On the other hand, the doctor-patient relationship, or the relationship between the reproductive professional and the patient, the so-called clinical relationship, is transforming, as a result of a number of dynamic factors that have emerged in recent times and which present it in a different light. Until not so long ago, a clinical relationship revolved around the doctor as the central figure. This relationship was based on the idea that the doctor, as the one responsible for curing patients’ ailments, worked from a place of professional knowledge, which placed them in a position of superiority when making decisions in the pursuit of their patients’ well-being. However, in recent years, we have added to the principle of “do no harm”, as set forth by the Hippocratic oath and later translated into ethical standards, the principle of autonomy as a key component to understand the doctor-patient relationship.



The clinical relationship has been transformed in such a way that there has to be a flow of information from the medical team to the patient, who will ultimately make the decisions. In this relationship, there are therefore two moral agents: the medical team and the patient. Both sides, through dialogue and exchange of ideas and information, agree on the

use of a medical technique for a specific purpose. But in reproductive medicine, this is more complex, as another moral agent intervenes, perhaps the most important of all: the future child.

And this is where conflict may be found if we limit ourselves to being “principlists”, that is, to base our decisions only on the four principles. It may occur that some ethical principles involved in assisted reproduction may be at odds with each other. The principle of doing no harm compels professionals to maximize patient care over potential harm. In the context of prenatal ethics, a professional has a clear duty to care for both mother and future child, when the child is presented as a patient. The principle of autonomy compels the professional to respect the **patient’s right to self-determination**, guided by their desires, preferences, and values.

Principle-based theory is widespread among health and biomedical research professionals and is being applied to inform any of the conflicting areas in the clinical relationship. It originated when the United States Congress created a National Commission responsible for identifying the basic ethical principles that should guide human research in behavioral sciences and biomedicine (1974). In 1978, as the final result of four years of work, the members of the committee produced the document known as the Belmont Report, which contained the three principles: autonomy or respect for people, for their opinions and choices; beneficence, or the obligation to do no harm and maximize benefits and minimize risks; and justice or impartiality in the distribution of risks and benefits.

However, the canonical expression of the principles is found in the book written in 1979 by Beauchamp and Childress; the former had been a member of the Commission. It accepted the three principles of the Belmont report, which they now called **autonomy, beneficence, and justice**, but they added a fourth, the principle of non-maleficence, giving them all a sufficiently broad definition so that they may govern not only in experimentation with humans, but also in clinical practice and care. The first level (the one comprised by the principles of non-maleficence

and justice) refers to what’s right or wrong, while the second level (the principles of autonomy and beneficence) refers to what’s good or bad.

If a person needs assisted reproduction to have a child, this necessarily implies that a professional will have a hand in what may result in offspring. As a result, **professionals must exercise their moral responsibility to decide whether to agree or refuse to use such techniques**. The issue of potential harm to offspring raises questions about the moral role of the professional. In this case, the doctor’s autonomy clashes head-on with the patient’s autonomy. Beneficence based on obligation therefore requires professionals to recognize the limits of the patient’s autonomy when they request medically inappropriate techniques that may jeopardize their health and that of potential children. Therefore, it is also necessary to take into account the set of values that are implicated in each case.

It would be naive, therefore, to think that with a set of principles all ethical problems can be solved. Principles must be, by definition, general, and ethical issues are specific, particular. Clinical ethics was not in vain born as a discipline meant to solve specific situations, and it therefore becomes a decision-making procedure.

Never before have so many complex ethical issues been posed to medical professionals, and even more so in assisted reproduction. **This is why responsible and prudent action is needed, based on values and not only on codes of ethics and legal norms.**

In the words of Diego Gracia, one of the world’s leading proponents of bioethics:

“The answer has to be given at two levels, at the public level or the ethics of minimums, and at the private level of ethics of maximums. These are the two levels of every person’s moral life and therefore also the two levels of professional ethics.”

Understanding EMBRYO GENETICS

Juan Manuel Moreno

Manager Laboratory UR Group

The key to obtaining the ultimate guarantee of success

Currently, we may consider chromosomal abnormalities (aneuploidy) a common feature in human embryos. A high percentage generate aneuploid cell lines at some point in their development, and these are maintained if they are unable to activate their repair mechanisms.

The detection and selection of embryos with the normal number of chromosomes (euploids) for transfer has become standard practice in centers that wish to offer their patients maximum guarantees of success. But, despite the use of powerful diagnostic technology (PGT-A) in our laboratories, a significant percentage of transferred euploid embryos do not achieve the expected results.

There are recent articles that suggest that PGT-A contributes nothing, and that it may even do more harm than good. Obviously, the lack of adequate criteria for indication during consultation, the incorrect use of the embryo biopsy technique in the lab, and the lack of a reliable genetic diagnostic platform will provide results that are quite discouraging, but if we select and address cases accordingly, we will get the most out of the technique.

A recently published study found that patients over the age of 37 whose embryos underwent chromosome screening significantly improved their implantation rate, lowered their chances of miscarriage, and lowered the time needed to achieve pregnancy after cumulative transfer, compared to patients of the same age who chose not to be screened. Therefore, scientifically speaking, we are prepared to state the clear benefit of PGT-A in cases of advanced maternal age, that is, as long as we use robust genetic screening tools, such as an array CGH, and also have good genetic advice.

Let's now discuss the technique: when should the screening take place? On day 3, 5, or even 6 of culture? Obviously, we will always try to take the embryos to the blastocyst stage (day 5 or 6), where we will have a greater amount of DNA that will allow us to have a more reliable diagnosis, but the final decision will be made depending on their quality, number, and development in the lab. During this period of uncertainty, it's essential for the lab to remain in constant contact with the patients, so as to be able to provide all the information regarding the evolution and quality of their embryos.

And what is the minimum number of embryos that need to be screened? Although several authors have discussed this issue, there is no serious work that has determined the minimum number of embryos we must have to clearly benefit from the PGT-A technique. Therefore, this information will be addressed in the consultation, and the decision will be made depending on the circumstances presented by each case.



FERTILITY AND SPORT

in women

Bernardo Fernández Martos

Head of Nursing Area Grupo UR

In recent decades, there has been a significant increase in interest in physical exercise among men and women. This interest can be seen both in occasional recreational practice and in the practice of competitive sports. For example, marathon running was always considered the panacea of endurance

sports, as only a few athletes among the world's elite were able to finish one. Today, however, thousands of marathons are held every year around the world, with hundreds of thousands of participants completing them one way or another—40% of these being women. This represents an increase of

around 35% in female participation in recent years. Social changes, legislation, medical controls, and popular culture have helped to provide new and better opportunities for women to participate in many different sports disciplines. There is no doubt that physical exercise provides important health benefits; however, **there is some concern that excessive activity may have negative effects on fertility.**

Therefore, with a more active practice of recreational sports, and the increase in participation in both training and regulated competitions, it is necessary to evaluate the impact that this may have on reproduction.

Exercise is a highly beneficial activity for most women, which certainly improves their quality of life.

However, with intense physical activity, adverse effects may occur in relation to their reproductive capacity.

The physiological mechanism responsible for this seems to be the generation of a deficit of metabolic resources, which forces the body to have a catabolic reaction that optimizes the bodily systems necessary for maintaining health to the detriment of the reproductive system, thus resulting in a sterility that is easily reversible through the adequate replenishment of energy resources in a timely manner.

The main clinical manifestations include menstrual disorders, as well as ovulatory dysfunction and possible negative effects on oocyte quality. These negative effects are highly variable depending on the intensity, volume, and type of physical activity carried out. And so, in sports where one must carry their own weight, where thinness is given great importance, this is where there is a higher prevalence of fertility-related disorders. In some disciplines, such as cycling or swimming, it occurs less frequently, although twice as often as in the general population that does not practice intense physical exercise.

In this regard, there are numerous studies that show a higher prevalence of reproductive alterations among female athletes when compared to those who are not (or do not play sports). However, other studies show the importance of physical exercise aimed at lowering the body mass index in patients with obesity and Polycystic Ovary Syndrome (PCOS), with higher success rates following assisted reproduction treatments, with a higher rate of embryo implantation, increased likelihood of pregnancy, and lower risk of miscarriage, among these patients. Also, in women with PCOS, reproductive function can be improved to the point of spontaneous ovulation, thus increasing the possibility of pregnancy without having to resort to reproductive techniques.

Another very important aspect to keep in mind is that the practice of high intensity sports among adolescents and young women may lead to different metabolic and psychological alterations of important clinical relevance. The most common manifestations are primary amenorrhea (no onset of menstruation during puberty) and secondary amenorrhea (they cease to menstruate), lower bone density, and eating disorders, such as anorexia, bulimia, or inappropriate dieting. The appearance of these three manifestations concomitantly is what has been called the “Athlete Triad”.

A lack of periods in adolescent athletes is a manifestation of the combination between intense physical exercise, a high degree of emotional stress, and/or decreased food intake. The short-term consequences may include infertility and, in the long term, osteoporosis.

The primary treatment goal for these athletes should be the prevention of any of the three components of the triad, by educating athletes, coaches, parents, and health professionals on the importance of proper nutrition and a safe training program. With the application of the appropriate preventive measures, the long-term prognosis is good; however, the occurrence of long-term alterations may present health consequences for these young people in the future.



OBESITY reduces fertility

Ana Aragonés

UR Embryologist Vistahermosa - Alicante

Obesity has a significantly negative effect on reproduction, affecting both women who seek gestation spontaneously and those who undergo assisted reproductive techniques.

In clinical practice, the simplest way to estimate the degree of obesity is based on the Body Mass Index (BMI), which is calculated by dividing a person's weight in kilograms by the square of their height in meters. A person with a BMI between 18.5 and 25.9 Kg/m² has an adequate weight, between 25.9 and

29.9 Kg/m² is considered overweight, and when the BMI is equal to or greater than 30, they are considered obese.

Women with a BMI that is greater than 30 Kg/m² have been observed to have three times more changes in their menstrual cycle than those with an adequate weight. This is because **obesity produces a deregulation in the hypothalamic-pituitary-adrenal axis**, altering the pulsatile secretion of GnRH and producing a preferential increase in LH with respect

to FSH. This leads, on the one hand, to excessive secretion of testosterone and, on the other hand, to follicular arrest, ultimately leading to anovulation and amenorrhea. This clinical picture is usually typical in patients with polycystic ovary syndrome (PCOS), present in 75% of overweight women.

Obesity not only produces anovulatory problems but also has a direct harmful effect on oocytes, the subsequent development of embryos, and consequent implantation in the endometrium.

In assisted reproductive treatments, this translates into the need to apply a higher dose of gonadotropins, a higher percentage of cycles canceled as a result of poor response and, ultimately, a low success rate.

Despite some discrepancies between studies regarding the ratio of weight loss to rate of live births, it is apparent that a 5 to 10% weight loss causes a

significant improvement at the endocrine level, thus achieving more regular menstrual cycles. It also means a lower dose of medication required, higher proportion of mature oocytes, better quality of embryos to be transferred, lower rate of miscarriage and pre-eclampsia, and the need for fewer cycles.

Therefore, weight loss should be the first therapeutic priority in these patients. And this should not only be the case in women, but should also apply to men, as existing studies today indicate that obesity also affects spermatogenesis, and with it, semen parameters (volume, concentration, vitality, mobility, and morphology).

The cause seems to be multifactorial in nature: excessive peripheral aromatization of testosterone to estradiol, insulin resistance, increased temperature in gonads, erectile dysfunction, reactive oxygen species (ROS), etc.

DIET

If in addition to achieving a suitable BMI, a healthy diet is also followed, fertility will be pleasantly favored. The following chart shows a list of nutrient-rich foods that promote fertility:

On the other hand, foods that should be avoided are:

- **Animal proteins** (red meat)
- **Saturated fats** (pork, veal, bacon, yogurt, butter, chocolate)
- **High glycemic index/fast digesting carbohydrates** (white bread, sweets, sugary soft drinks, honey, potatoes)
- **Alcoholic beverages**
- **Coffee**
- **Soy**

Vitamin A	Milk, oranges, carrots
Vitamin B	Eggs, cereals, bananas, lamb
Vitamin C	Kiwi, red pepper, broccoli
Vitamin E	Sunflower oil, hazelnuts, almonds
Folic acid	Spinach, asparagus, broccoli, chard, lettuce
Polyunsaturated fatty acids (Omega 3)	Salmon, tuna, sardines
Monounsaturated fatty acids	Olive oil, avocado, olives
Plant-based proteins	Lentils, chickpeas, beans, nuts
Slow-releasing carbohydrates rich in fiber	Wholegrain cereals/bread, strawberries, oranges, pears, lentils, chickpeas
Calcium	Dairy products
Iron	Cockles, clams, lentils
Zinc	Oysters, celery, eggplant

Assisted reproduction cycles grow in Spain due to unprecedented increase in infertility

José Félix García España

Director UR El Ángel - Málaga

Infertility currently affects one in five couples; next year, it will do so in one in four, according to the Spanish Fertility Society. Approximately 10% of births that occur every year in Spain are possible thanks to assisted reproduction, either due to infertility or subfertility, that is, when gestations are achieved after more than a year of attempts.

Age is a determining factor when conceiving a child. A woman is born with a number of oocytes that she uses up during her life and has no ability to regenerate them. In males, spermatogenesis is maintained; a man generates new sperm every 90 to 120 days, but the quality of semen also declines with age, especially from the age of 45.

If a woman wants to be a mother at a later age, the vitrification of oocytes is recommended. This increases her chances of being a mother in the future, as from age 40, the chances of achieving pregnancy decrease. Assisted reproductive techniques have evolved immensely, making multiple pregnancy

less common. **Approximately 73% of our patients in 2018 received only one embryo per transfer and only two twin pregnancies occurred.** In our Reproduction Unit in the HLA El Ángel Hospital, we conduct a detailed study of each case, which allows us to apply the technique that is best suited to each particular circumstance.

Since its opening in 2011, the Reproduction Unit at the HLA El Ángel Hospital has treated nearly 2,500 patients. In 2018, 84% of couples under the age of 35, 69.14% between the ages of 35 to 39, and 39.39% over 40 achieved pregnancy following in vitro fertilization. 77.77% of patients who had in vitro fertilization with donor oocytes achieved pregnancy.

In the Women's Unit of the HLA El Ángel Hospital, we offer comprehensive advice to women, from the moment they start contemplating the idea of being a mother to the end of the process with the birth of the child, providing both psychological and emotional care.



If you choose to delay motherhood **PRESERVE YOUR FERTILITY**

María Jesús Franco

Gynecologist UR Montpellier - Zaragoza

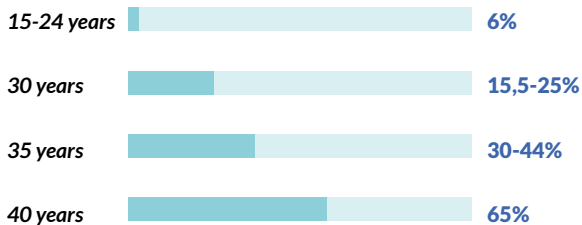
The impact of age on ovarian functioning has a quantitative and a qualitative component. In the 20th week of pregnancy, the ovaries of the fetus contain between 6 and 7 million oocytes. At birth, there are only 1 or 2 million oocytes, of which only between 300,000 and 500,000 will reach maturity and only 400 to 500 will be ovulated over the course of a woman's reproductive stage. A woman's reproductive ability begins to decline about ten years before menopause even if the woman continues

to have regular menstruation cycles every month. As the number of follicles in the ovary decreases, their quality also worsens and the rate of oocytes with genetic alterations increases; studies confirm that these alterations are less than 10% in women under 30 and close to 100% in women over the age of 45. This also makes miscarriage more common in these women with figures of 7-15% in women under 30, compared to rates above 34% in women over 40.

The number of eggs is directly related to a wo-

man's ability to conceive. Over the course of a year, 6% of women between the ages of 15 and 24 who wish to get pregnant will fail to do so; when a woman reaches 30, these figures go up to 15.5-25%; at 35, they rise to 30-44%, and at 40, the percentage of failure is as high as 65%. If a couple consults for infertility, assisted reproductive techniques would only raise their chances by 50% up to 30-35 years of age, and only a by a third if the pregnancy is postponed until 35-40 years of age.

Age and failure probabilities



With these numbers in mind, it's necessary for women to understand that the optimal age for pregnancy is between 25 and 30 years of age. This is increasingly complicated due to the current social situation, so it's necessary to raise awareness among women of the importance of preserving their fertility.

Factors affecting ovarian reserve:

- **Genetic**
- **Immunological**
- **Environmental:** smoking; chemicals such as herbicides, insecticides, and industrial products; radiation; chemotherapy; overweight or stress.
- **Social:** the development and advances in medicine or hygiene have resulted in a higher life expectancy for humans and especially women. In our current society, women's life expectancy is around 88 years. By contrast, the age in which a woman reaches menopause has hardly changed and remains around 52 years of age, from which we may easily deduce that the increase in life expectancy is not associated with an increase in the number of childbearing years.



The incorporation of women into the workforce on equal footing with men has increasingly delayed the ideal time for motherhood because it leads to a decline in their professional development and includes the fear of losing their jobs because of a pregnancy. Today, the average age in which women have their first baby is 31 years old.

On the other hand, the emergence of assisted reproductive techniques has led couples to trust that these methods will guarantee a pregnancy; however, even if these techniques manage to help many couples achieve their desired pregnancy, the results obtained also decrease as the age of the woman demanding these services increases.

In conclusion, given the negative effect that a woman's age has on her reproductive capacity, it is necessary to raise awareness of the fact that it's not good to delay maternity. The optimal period of fertility in women is between 25 and 30 years of age, and if the social and employment situation does not allow it, we propose the preservation of oocytes between these ages in order to improve the chances of future gestation.

“The assessment of the fertility test allows us to draw up a guaranteed, customized, and affordable plan”

Miguel Barea Gomez

Director UR IMED Valencia.



Dedication to their patients, **concern** for those asking for help in order to have a child, and **hard work** until the desired outcome is achieved are fundamental pillars that guide Dr. Miguel Barea in his work.

“The assessment of the fertility test allows us to draw up a guaranteed, customized, and affordable plan.”

The most important thing for the director of the Reproduction Unit of the IMED in Valencia is to be able to combine clinical care and practice with teaching, health education, and research in the public and private sectors. “The satisfaction we feel after an achievement is short-lived. What really motivates me is being able to help my patients fulfill their reproductive wishes, because the ability to have children is an essential aspect in quality of life. There are many visits, disappointments and joys that we share and, in the end, a baby that we feel is our own.”

Advances in reproductive technology have improved results and allow us to work in conditions that are increasingly adapted to the embryo’s physiology and need for homeostasis. “The reproduction units of the UR International Group to which we belong use cutting-edge technology, with all the proven advances used today in clinical, genetic, and laboratory reproduction techniques. To this, we must add our friendly and warm treatment towards patients,” stresses Dr Barea Gómez.

The specialist acknowledges that the procedures used in assisted reproduction are very stressful and overwhelming, and therefore an extra level of support is required in each consultation, with the help of a team, something that patients notice from their first contact with the clinic. A key factor, he explains, “is that we work within the framework of a hospital organization. This provides security and confidence in case of any eventuality that may arise from reproduction treatments.”



The Achievements of Reproductive Medicine

Infertility in the population has grown in recent years from affecting 10% of the couples of childbearing age, to 20% today. Fortunately, thanks to the great advances in reproductive medicine and the means available today, only a very small percentage of couples do not become parents. “Today, we can help and achieve positive results in those situations where circumstances such as infections, endocrine diseases, autoimmune or genetic alterations, to name a few, have prevented couples from fulfilling

their dream of achieving a pregnancy and having a healthy baby.”

The stress of today’s life, an inadequate diet, alcohol and coffee consumption, smoking, and environmental toxins are a direct cause of this rise in infertility. But the delay in becoming a mother and the decrease in semen quality are responsible for 70% of the consultations in fertility clinics. “We must help women preserve their fertility so that their children are biologically their own,” says Dr. Miguel Barea, and for this he considers it urgent and necessary to “carry out an informative and educational social program that contributes to improving birth rates in patients with difficulties so they may be able to chart a reproductive plan in time.”

The Spirit and Ambition to Overcome

Besides the technology and the appropriate facilities, Dr. Barea Gómez firmly states that the team is the key to success, both in the IMED Valencia reproduction unit that he leads, and in the other fertility clinics of the UR International Group. “The professionals who work with me have freedom and autonomy, and they know that I am there to support them. Our work differs not in the things we do, but rather how we do them, following an essential protocol: **commitment** to our patients; **pride** in helping the couples who come to our center; **responsibility** for our results; and **comprehensive care**. All this reflects a spirit and ambition to overcome with the goal of leading the sector in our country.”

The doctor is proud to have in his Valencia IMED reproduction unit a highly qualified team comprised of professionals from several levels, such as gynecologists, biologists, nurses, and administration department staff. “Since I don’t want to leave anyone out, I’ll name them all: Adolfo de Prados, Juan Íñiguez, Marta Masip, María José García, María José Giménez, Sandra Lozano and Claudio Reig. A team that seeks professional development and is non-conformist, upholds the values of honesty and companionship,



“**COMMITMENT, PRIDE,
RESPONSIBILITY,
COMPREHENSIVE CARE**”

and meets the requirements that are bringing us very good results.”

The reproduction units of the UR International Group are at the service of their patients from the first call, whether this is the first time they’ve faced assisted reproductive treatment or they’re coming from failed attempts at other clinics. Upon their first contact with our teams, a medical action plan is developed to deepen our knowledge of the case as much as possible and thus decide which is the most appropriate treatment to achieve our goal.

The International Department of the UR International Group carries out commendable work in putting a staff of interpreters at the service of foreign patients, whose goal is for the patient to not feel alone and feel accompanied for the duration of the treatment, coordinating assistance, lodging, hospitalization, and travel. Their actions are part of a different type of approach, one that requires reactivity and precision on the part of the medical and paramedical team.



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Hospitalario



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The best private hospital in the province of Alicante 2018 and 2019, according to the Health Reputation Monitor (MRS).



ACKNOWLEDGEMENTS



Dr. Rocío Núñez Calogne



Dr. Juan Manuel Moreno



Dr. Bernardo Fernández Martos



Dr. Ana Aragonés



Dr. José Félix García España



Dr. María Jesús Franco



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“ There’s nothing more rewarding
than helping you ensure a healthy pregnancy
and a healthy baby. ”

Dr. José López Gálvez

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