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Abstract

The main objective of the present paper is to evaluate the perception of women concerning the barriers and access to infertility consultations. Socio cultural and economic access to infertility consultations is detached and three municipalities of the northwest of Portugal were chosen as an example of a peripheral country. A quantitative/qualitative study was done with 60 women. Three dimensions were evaluated: geographic and structural and functional access; economic access; and sociocultural access. The main barriers were mainly identified in the last two dimensions. The economic access was the less well evaluated by women being the cost of treatment (medication, and concentration of costs in a short period) difficult to bear. This can justify a greater involvement of the Portuguese Government, by developing policies for the reimbursement of part of the costs. Also, some changes in structural and functional access must be done with special regard to the separation of the infertility consultations from the reproductive medicine section. The setting of the teams, with a follow-up by the same team of health professionals is also needed.

Keywords: Infertility; Perception; Women; Care; Access; Equity.

1. INTRODUCTION

Infertility is an important issue in a couple's wellbeing and has relevant implications for individual and public health [1] and is considered as a serious public health problem

[2]. Emotional, physical and financial costs for the couples can be detached when we deal with the concept of infertility [3, 4]. This cost can be huge as the desire to have children is still widespread [5, 6] and the pressure to have children can be high [7].

Many conditions caused by genetic abnormalities, infectious agents, environmental agents and behaviours have been affecting human fertility. The recent postponing age at first pregnancy has highlighted that natural aging processes are an important limit to human fertility [3] and the main causes of tubal infertility are sexually transmitted diseases, unsafe abortion and post-partum pelvic infections [8]. This has been an important factor for the development and use of medical technology to overcome such limits [5].

It is difficult to assess the epidemiology of infertility [9]. One of the facts is the lack of a standard definition of infertility for research purposes. In the US, the common clinical definition of infertility is the failure to conceive for 12 months [9]. In fact, infertility currently affects approximately 10% of couples [10, 11, 12]. Ombelet [13] estimated that 60 to 80 million couples worldwide had fertility problems confirming the 80 million cases highlighted by Cousineau and Domar [3]. It ranges from less than 5% to over 30%, estimating approximately one in ten couples [14]. At the same time, technological treatment solutions have been increasing giving hope to couples, even if there are some barriers, such as financial costs of treatment and health insurance policies that limit reimbursement [3]. In the United States, approximately 12% of women between the ages of 15 and 44 reported having received care related to their infertility (assessment and/or treatment), indicating that 7.4 million women and their partners are confronted with fertility problems [15]. However, the stress associated with infertility treatment, time consuming, can be expensive and frustrating at the same time [16].

Studies developed in the United States concluded that infertility disproportionately affect the less privileged. This results from assumed social and racial disparities in health status and in the frequency of certain risk factors. For example, sexually transmitted infections (that may lead to infertility if untreated) could be more relevant in the populations less privileged such as black women [5, 9]. The access, the utilization and the outcomes are increasingly in the public debate [5, 17]. Besides the identification of risk factors in infertility, the ethical and financial implications of medically assisted reproduction, the risks and benefits of the technologies used [5], disparities in access to

care continues to address public and individual attention.

In what concerns the access to health care, we can conclude that it is a complex concept [18], multidimensional and multifaceted [19]. It must be considered as a basic human right and a social goal [20]. So, universal access must be faced as a priority [21]. It can be defined as “those dimensions which describe the potential and actual entry of a given population group to the health care delivery system” [19] and that can help people to obtain the types of care needed to obtain an optimal health outcome [20]. Although a good access is not easy to define, it must, therefore, be obtained within the needed time, meaning that patients can get the right service at the right time and in the right place [22]. In other words, it is essential to obtain quality care at the right place and at the right time. On the other hand, access equity, a concept related to access as a potential determinant of inequalities, can be considered "when services are distributed based on people's need for them" [19]. For that, the promotion of access to infertility treatments must be faced as a priority to national and regional policies and in the management of health systems [23].

Despite the negative impact of infertility on the couple's lives, access to technology is often difficult and unequal, largely limited by the availability of specialized services, the high financial cost of treatments, and sociocultural barriers. Legal barriers to access are added in some countries. In this article, we consider that access to infertility care should be considered as a fundamental right of all couples regardless of economic circumstances. This includes the geographic, the economic and social access [17, 24].

The concept of accessibility involves the following dimensions: i) geographic (location of resources, time and means of transport), ii) organizational (e.g., obstacles that arise in the organization of health care resources); iii) sociocultural (the assessment of the phenomena that determine the demand for health care and iv) economic [25]. Since the 1980's, international studies have rarely considered the aspect related to socio-cultural accessibility, but instead have predominantly evaluated the geographic and socioeconomic accessibility aspect [17, 26, 27]. Cultural factors can be important barriers to health care adherence. This is linked to the professional relationship of health/client and the use of a suitable language, among others. Socio cultural accessibility is one of the areas where more can be invested as it continues to be neglected by health professionals. It can be relevant to the degree of satisfaction of the patient with health care.

WHO [28] pointed out that Portugal presents some inequalities in access to health care,

presenting inequalities in access to specialized medical care. The same entity mentions that it is imperative to correct the lack of specialist doctors and nurses in the most distant areas of large urban centres. Since 2006 Portugal has implemented several measures to improve access to infertility treatments. Among these measures, we highlight the approval of Law 32/2006 of July 26th, which established the regulation of Medically Assisted Procreation (MAP) techniques and their mode of use, partnerships with the private sector, referencing the couples in a waiting list in the National Health Service (NHS), to reduce waiting times and the creation of new assisted reproduction units and the increase of the reimbursement to 69%. However, despite the favourable developments in recent years, specially the inclusion of more favourable medicines, the supply of the NHS is concentrated in a limited number of services and proves to be insufficient [29]. Likewise, private care is geographically concentrated in large cities, following the standard of the NHS, and they are very expensive.

Despite the growth in the number of specialized centres, equipment and human resources within the framework of the MAP since 2009, these are heavily geographically concentrated, penalizing users residing in more distant areas, both economically and in terms of distance/time [6]. The Graduate Medical Education National Advisory Committee (ERS) [30] recommends about a 30 minutes' distance as appropriate proximity to health services.

The reduction of these inequalities is obtained by acting on the barriers that determine them, among which the limited supply of MAP Centres, distributed unevenly in the national territory (physical barrier), which therefore forces high expenses to be borne by infertile couples (economic barrier), since those residing in areas farthest from the centres must travel to access services and endure extensive waiting periods to start treatments (structural and functional barriers).

The present paper is concerned with the perceptions of women concerning the barriers and the access to infertility consultations in a European country such as Portugal, traditionally considered as a peripheral country. And, to identify possible solutions to improve the access to this type of consultations.

We hope that the article, and the discussion that it raises, will create the momentum necessary to develop a more holistic way to analyse the access to infertility consultations in European peripheral countries. These types of studies are especially useful to health

policy makers, planners and researchers hoping to alert health professionals to the need of a more empathic approach with the couples during consultations. Finally, the national and regional authorities must be aware of the need that the public health system must be more effectively organized by contributing to solve in a more efficient manner the existing problems.

The present article is structured in five sections. The first, Introduction, deals with some aspects related to the concept of infertility and access. The second concerns the methods used in the research, followed by the main results from some discussions. Finally, we will have the main conclusions.

2. METHODS

Our study was quantitative in nature even if some qualitative analysis was also possible. A questionnaire composed of eight sections was submitted to 60 women between July and August 2013. Participants in the study were women in various stages of infertility treatment: those who were undergoing exams, those who were taking medication/injections to produce eggs and/or whose partner was improving sperm, those who were performing some infertility technique (Artificial insemination / FIV / ICSI / Other) and those that were on the waiting list to undergo a MAP technique. Given that we could not refer to all dimensions of access included in the questionnaire, it was decided not to include women in the sample who were conducting the first consultation at the MAP Centre (Alto Ave Hospital Centre), one of the most important public Centres in the country. The Alto Ave Hospital Centre, located in the municipality of Guimarães, has an area of influence of about 400 thousand inhabitants. In 2001 it became a referenced hospital in terms of diagnosis and treatment of infertility.

The study was approved by the Ethics Committee of a Hospital Centre in the north of Portugal. A pre-test was performed in June 2013 to four women. The questionnaire was composed of 45 questions and divided into eight sections. The first one dealt with some demographic data questions (age of the woman and of the partner, place of residence; civil status, education and profession). The second one concerned clinical data (8 questions) while the third section included geographic access (6 questions). The fourth section focused on the structural and functional access to treatments (11 questions), and the fifth section with economic access (7 questions). Finally, the sixth section focused on

socio cultural access (4 questions) and the seventh section the legal access (3 questions). The income and the suggestions were in the final section.

The contact with the women occurred individually, always after a first contact initiated by some of the doctors or by the nurses. All the women were available to participate in the study, obtaining a zero rate of refusals. The questionnaire was delivered to each woman while waiting for the doctor's call or at the end of the consultation and was always completed in a medical office or in a meeting room provided for this purpose. In almost all cases, the woman was accompanied by her partner/spouse, which enriched the information, since in some cases the partner/spouse shared his opinion. From the notes made when sharing information, we highlighted the fact that some participants emphasized the importance of this type of study, which allowed them to tell and share the difficulties they face during treatment. Although study was based on a questionnaire, the final section was a comment or suggestion question that had not been considered in the questionnaire itself and to which respondents assumed to be important for improving access to infertility care (question 46 - In your opinion, is there anything that could facilitate or improve the situation of women/infertile couples in Portugal? What other difficulties have been felt during the process and which have not been mentioned in this questionnaire?). Each questionnaire, as well as all the information and experiences that were being counted and shared, were analysed by using SPSS software and content analysis per Bardin [31].

A descriptive statistical analysis of the variables was carried out. Some statistical tests were applied, such as the Spearman test and the Chi-Square test.

3. RESULTS

3.1. Characterization of the sample

Table 1 presents some demographic characteristics of the women surveyed. The mean age was 34 years with a standard deviation of 3.64. The minimum age was 25 and the maximum was 40 years. There was a high number of women (86.6%) aged over 30 (age at which reproductive decline begins) attending consultations.

The majority have the secondary level (43.3%) or the upper level of schooling (38.3%).

In 17% of cases, women have up to 6 years of schooling. Regarding marital status, 86.7% were married while 13% lived in a non-marital partnership. Regarding the professions carried out by the respondents, classified as per the National Classification of Professions of the Institute of Employment and Professional Training (INE - Instituto de Emprego e Formação Profissional [32]) the most representative group, with 27% of the cases, were specialists in the intellectual and scientific professions, followed by the group of female workers, craftsmen and similar workers with 23% of respondents. The family income of the respondents was concentrated in two classes: from 510 to 1.000 euros (40%) and from 1.001 to 2.500 euros (58.3%). Less than 2% of the respondents had family incomes of more than 2.500 euros. These results confirm that the sample was composed of middle class couples. Most of the respondents live in the municipalities of Braga and Guimarães (26.7% and 23.3%, respectively), municipalities in the reference area of the most populous PMA Centre, with a higher rate of urbanization.

Table 1 – Sociodemographic characteristics of the women

| | N | % |
|--|----|------|
| Education | | |
| Up to 4 years | 1 | 1.7 |
| Up to 6 years | 10 | 16.7 |
| Secondary | 26 | 43.3 |
| University degree | 23 | 38.3 |
| Civil status | | |
| Married | 52 | 86.7 |
| Non-marital partnership | 8 | 13.3 |
| Profession | | |
| Senior Staff of Public Administration, Executives and Chief Executives | 2 | 3.3 |
| Specialists in the intellectual and scientific professions | 16 | 26.7 |
| Technicians and Professionals of Intermediate Level | 7 | 11.7 |
| Administrative Personnel and Similar | 7 | 11.7 |
| Service Staff and Salespersons | 10 | 16.7 |
| Farm Workers and Qualified Staff in Agriculture and Fishing Industry | - | - |
| Female workers, craftsmen and similar workers | 14 | 23.3 |
| Unskilled Workers | 2 | 3.3 |
| Unemployed | 2 | 3.3 |
| Income | | |
| 510 to 1000 € | 24 | 40.0 |
| 1001 to 2500 € | 35 | 58.3 |
| 2501 to 3000 € | 1 | 1.7 |

Source: Questionnaire applied between July and August 2013.

When questioned on the understanding of the cause of their infertility, all women could respond. The male cause was pointed by 30% of respondents, 30% mentioned the female cause as the origin of infertility, 10% mentioned the mixed cause and idiopathic (unknown) infertility was pointed out by 30% of the women.

The practice of some professions/occupations seems to be related to some cases of infertility, especially regarding the profession of the man [6, 33]. Thus, it was decided to include in the study information on the professional status of the respondents' partners. It was verified that 30% of the cases were in the group of workers, craftsmen and similar workers, followed by the group of specialists in the scientific and scientific professions (13.3%) and the group of technicians and professionals of intermediate level (13.3%). Specifically, we found chemical operators (two men), pastry cooks (two men), drivers (three men), textile workers (six men) and electrical engineers (one man). These are professions that require the individual to remain seated for a long time, which involve the handling of glues, solvents and benzene and that are exposed to intense heat sources. And, in fact, it was verified that some of the partners who practiced these professions corresponded to cases of male infertility (eight men).

The percentages found of female and male infertility meet the values referenced by the Reproductive Medicine Society and the Portuguese Fertility Association. Information about the cause of infertility was supplemented with the help of the team of reproductive medicine. We are pleased to note that respondents' responses coincided with the responses of health professionals.

3.2. Geographic and structural and functional access

In the Portuguese infertility health care the organizational barriers that stand out most are the (extensive) waiting lists of the public sector. The specialized services in reproduction medicine belonging to the National Health System have waiting lists that are around 2/3 years old [34]. Being the age a fundamental aspect in this type of treatment, these waiting years are crucial for women who have already surpassed the age group of 30 years.

The waiting lists of public infertility services are not considered a priority because there are always more serious patients and sectors more important to attend to and solve than couples who cannot have children [35]. These couples wait to get a first consultation,

wait for the booking of the exams and even more to be able to start the treatment itself. One of the solutions is the use of the private sector where waiting lists are generally shorter than those in the public sector. However, since treatment costs are extremely high, only couples with a higher socioeconomic status can opt for the private sector solution.

Few problems of geographic access were detected in our sample. Six questions were posed to obtain some information about geographic access. In fact, only 7% of the respondents had to travel more than 40 km to go to the consultations and/or to carry out the treatments. Most travelled less than 20 km: 36.7% between 11 and 20 km and 28.3% between 1 and 10 km.

The results suggest that the Centre seems to mainly receive people from municipalities contiguous to the parish of Creixomil, which is where the PMA Centre is located. Nevertheless, the analysis of this result deserves some care in its analysis. The municipalities located less than 20 km are those with the largest number of inhabitants, which may justify this concentration of users. On the other hand, the fact that the sample includes only women in treatment tends to devalue the problems of physical access, since infertile women from remote municipalities may not even try to access it.

More than half of the women (53.3%) reported spending between 10 and 29 minutes to reach the PMA Centre. More than 73% of respondents reported a travel time of less than 30 minutes, which is recommended by the Graduate Medical Education National Advisory Committee [30]. There were no travel times longer than 60 minutes.

Asked about the means of transportation used to travel to the PMA Centre, all the participants answered that they used their own vehicle. Of these, only three women reported using the bus sporadically, especially on days when they were traveling alone, since in most situations they were accompanied by their partner.

Regarding satisfaction with the geographical location of the Centre, women's opinion was largely positive, varying between satisfied (60%) and very satisfied (30%). Only 10% of the respondents had a negative assessment. As expected, satisfaction with location tends to decrease as the distance to the Centre increases. The Spearman rho coefficient (-0.642) indicates a strong (negative) correlation between the level of satisfaction and distance travelled (the p value that was accepted as being statistically significant was $p < 0.05$). The association is statistically significant at conventional levels of significance ($p \approx 0,000$). In

other words, the respondents from more distant locations tended to consider the location as less satisfactory.

In what concerns the structural and functional access, eight questions were posed. Considering the waiting period to obtain the first consultation in the PMA Centre, the most frequent waiting period (41.7%) for obtaining an initial consultation was 4 to 6 months. Only 26.7% of respondents indicated a waiting period of up to 3 months. It should be noted that 5% of the respondents waited about 13 to 18 months for a first consultation.

For most participants, the opinion on the waiting period for an initial consultation in the PMA was "Reasonable" (63.3%) or "Good" (16.7%). On the contrary, 13.3% of the women considered the waiting period "Bad" (Table 2).

Table 2 - Statement about waiting period to obtain the first consultation at the PMA Centre

| Waiting Period | N | % |
|-----------------------|----------|----------|
| Bad | 8 | 13.3 |
| Reasonable | 38 | 63.3 |
| Good | 10 | 16.7 |
| Very Good | 2 | 3.3 |
| Unanswered | 2 | 3.3 |
| Total | 60 | 100.0 |

Source: Questionnaire applied between July and August 2013.

As expected, as the waiting period for the first query increased, the opinion on this waiting period tended to be less satisfactory. The Spearman rho coefficient (-, 564) indicates a strong (negative) correlation between the waiting period for the first consultation and the opinion on this waiting period. The estimated correlation is statistically significant at the conventional levels of significance ($\rho \approx 0.000$).

The correlation coefficient of Spearman was estimated by trying to see if there was any statistical relationship between the waiting period to obtain a first consultation at the PMA Centre and the age of the woman, which would indicate a prioritization of the care per age. The coefficient indicates a positive but moderate correlation ($\rho =$, 282). The association found is, however, statistically significant, at a significance level of 5%. That is, older women tend to report a longer waiting period for the first consultation at the

PMA Centre. This may be considered as a service efficiency perspective, since infertility treatment techniques are more likely to succeed in younger women.

3.3. Economic access

Six questions were used to cover the economic access aspect. The economic barrier seemed to be the main difficulty towards access. The costs inherent to the entire process of treating infertility, especially those related to medication, appear to be a serious obstacle for women and difficult to overcome by those who have a lower monthly income.

Some of the respondents, as well as their partners, have stated that the cost of treatment is difficult to bear, specially the costs associated with medication, as well as the fact that many of these costs are concentrated in a short period. Only 30% of the respondents said the recent increase in co-payment is enough to support the costs of medication. However, most the women, the equivalent of 70%, disagree.

Couples ask for a greater involvement of the Government, mainly regarding policies on reimbursement of medicines, to increase public participation.

According to the narratives of the respondents:

Above all, there is still not much political will for infertility. There must be political will for insurers to begin to share treatment cycles, otherwise there will still be failures in treatment access, couples will still have to give up the dream of being parents and there will continue to be a part of the population that will not be able to contribute to the birth rate of the country (Q5, partner of 36 years, university degree, economist).

The costs are hard to bear, the medication should be more reimbursed, the government should support us more (Q30, 37-year-old woman, 6 years of education, unemployed).

Last week we spent 300 euros on medication in one day. There are couples who do not have this money (Q47, companion of 35 years, 12 years of education, pastry cook).

Regarding treatment costs, it was found that, in terms of medication, the amounts spent by the respondents ranged from 300 to 500 euros, some of them reaching 700 to 1,000 euros within the space of a few weeks. And transport costs must be added. It is mainly the women who have pointed to values between 300 and 400 euros with transportation. Some respondents were even able to estimate that, in average, for each treatment cycle they would have already spent on drugs between 1,000 and 2,500 euros.

Asked about the impact of treatment costs on their budget, 53.3% of the respondents stated that costs have an average impact and 38.3% considered this impact to be high.

The women who earn lower incomes are faced with an increasingly difficult access to treatments. Only 8.3% confirmed a low impact.

The correlation between the distance travelled and the impact of treatment costs on respondents' budgets shows that the Spearman rho coefficient estimated (-, 018) indicates a weak (negative) correlation between the distance travelled and the impact of the costs on the budget. More importantly, the correlation found is not statistically significant at conventional levels of significance ($p=0.894$). It was stated that increasing the distance travelled would result in an increase in the impact of the costs on the budget. The impact of the costs with the treatments verified seems to be mainly related to the expenses with the medication.

3.4. Socio cultural access

Four questions were used to obtain the perceptions from the 60 women on socio cultural access. Most of the respondents considered the comfort of the waiting room as "Reasonable" (60.0%) or "Good" (38.3%). However, some women regretted that the waiting room was shared with users of obstetrical consultations. Women were not comfortable with being in the same waiting room with pregnant women. There was a feeling of some "psychological" discomfort in the waiting room. Let's look at the following convergent narratives, with results found in other studies in the Portuguese territory [36, 37]. The interviewees, in their narratives, also criticize the fact that the public services gather in contiguous spaces, the services of reproductive medicine and the infertile services:

I think the management of services should be more carefully structured and not mix pregnant women with infertile women in the waiting room. For those who cannot have children like us, it hurts us, because that is our dream (Q26, 35-year-old woman, university level, teacher).

In the waiting room, we should not be with the women who are pregnant. It is very frustrating for us as we cannot have children (Q55, 39-year-old woman, secondary education, seamstress).

3.4.1 The patient / health professional relationship

The relationship between users and health professionals is one of the key indicators in assessing access to quality care and satisfaction with health care [29, 38, 39].

Doctor's interest

Regarding the physician's interest, it was found that, for the clear majority of the

respondents, the evaluation was very positive, classifying the physician's interest as "Good" (40.0%) and "Very good" (40.0%). Only 20% of the respondents rated the doctor's interest as "Reasonable". There were no negative classifications in this dimension (Table 3).

Table 3 – Interest of physician

| Interest of physician | N | % |
|------------------------------|----------|----------|
| Reasonable | 12 | 20.0 |
| Good | 24 | 40.0 |
| Very Good | 24 | 40.0 |
| Total | 60 | 100.0 |

Source: Questionnaire applied between July and August 2013.

3.4.2 Availability of time in consultation

Regarding the availability of doctors' time in the consultation, none of the women made a negative assessment and seem to be all satisfied with the time doctors spend in consultations. Of the total number of respondents, 50% consider the time doctors provide in the consultation as "Good" and 23.3% classify it as "Very good" (Table 4).

Table 4 – Availability of doctors' time in the consultation

| Availability of doctors' time in the consultation | N | % |
|--|----------|----------|
| Reasonable | 16 | 26,7 |
| Good | 30 | 50,0 |
| Very Good | 14 | 23,3 |
| Total | 60 | 100,0 |

Source: Questionnaire applied between July and August 2013.

3.4.3 Relationship with the physician

The interpersonal relationship with the doctor was considered "Good" by 46.7% of the participants. This category is considered generally positive, with 35% considering the relationship with the doctor as "Very good" (Table 5).

Table 5 - *Relationship with the physician*

| Relationship with the physician | N | % |
|---------------------------------|----|-------|
| Reasonable | 11 | 18.3 |
| Good | 28 | 46.7 |
| Very Good | 21 | 35.0 |
| Total | 60 | 100.0 |

Source: Questionnaire applied between July and August 2013.

Although the previous category generally obtained positive opinions, in some narratives it was possible to verify the problem of the continuity of the doctors. In other words, some respondents mentioned the need to be attended by the same doctor.

There should be a greater and better explanation of how the whole process will work and always be attended by the same doctor. Several doctors followed the process and none of them knew what the others were saying. Very confused (Q38, 38-year-old woman, college level, nurse).

We should always be followed by the same doctor, because there are different opinions (Q45, 38-year-old woman, secondary level, unemployed).

In the same line of thought, similar results were found in the study of Augusto [34]. Two interviewees, in their speeches, complain about the need for users to be followed by only one doctor "(...) we must always explain the same thing. We go halfway and then go back to the beginning", "(...) I'm talking to them, and they're reading to see what's happened before. "

Our respondents also mentioned that, similarly to those interviewed by Augusto [34], there should be greater humanization from the physicians:

More support, information, more sensitivity and availability from the doctors (Q46, 40-year-old woman, university level, social reinsertion).

4. CONCLUSIONS

In Portugal, the study of couples' access to infertility consultations is still not frequent. Hence the relevance of this study because we need to understand the real difficulties that couples face to access and follow-up these type of consultations.

The present article sought to understand the main barriers faced by couples in accessing infertility care. The results point out that in addition to the suffering of not being

able to have the desired child, couples face numerous physical, structural and functional barriers, as well as economic, sociocultural and legal barriers that make the whole process even more painful.

In a country with one of the lowest fertility rates in world (1.2 average number of children per woman in 2014), and with the increase of sexually transmitted diseases and the cases on infertility, one can think that is needed a greater involvement of the Government, mainly regarding policies on reimbursement of medicines. Furthermore this country is assisting to a decrease of its population as there is a significant number of inhabitants that went to other countries and the capacity to attract immigrants is quite low.

The main problem detected in our study does concern the geographic access dimension. Apparently, few problems of geographic access were detected in our sample, as only 7% of the respondents had to travel more than 40 km to go to the consultations and/or to carry out the treatments, more than 73% of respondents reported a travel time of less than 30 minutes, and 90% were satisfied/very satisfied with the location of the consultations. However, this study cannot be conclusive as we only dealt with women already in treatment and living nearby the hospital, and it is very difficult to get information from remote municipalities where women may not have tried to access it.

The main problems began inside the PMA Centre and are easier to resolve depending only on the organization of the team and of the services. The evaluation was not so positive, particularly in access to economic and social culture. Economic access was less well rated by respondents, since the cost of treatment was hard to bear. The costs associated with the medication, and the concentration of many of these costs in a short period were the main justification. In the year of the investigation we made, the minimum national salary was 485 euros and one can understand the arguments made by women in this dimension. This is a dimension that continues to occur in 2017 as the minimum national salary continues to be very low. This justifies a greater involvement of the Government, by developing policies for the reimbursement of part of the costs.

Also, some changes in structural and functional access must be done with special regard to the separation of the infertility consultations from the reproductive medicine section. The setting of the teams, with a follow-up by the same team of health professionals is also needed.

It is worth mentioning that some changes are needed in both the economic and sociocultural dimensions. As the economic dimension depends on the national intervention of the Government and is more difficult to modify, we suggest the modification, in the short term, of some structural and functional elements in the hospital studied and even at a national level.

On one hand, in the Alto Ave Hospital Centre, infertility consultations should be separated from the reproductive medicine section. As this is not the case limited to this hospital unit, the Directorate-General for Health must draw up rules to be applied in all hospital units throughout the country.

On the other hand, an effort must be made to make the treatments advised by health professionals more transparent and to establish teams, seeking to provide each woman a follow-up with the same team of health professionals. We believe that this action can help increase the humanization of health care.

The present investigation suffers some limitations, such as the fact that even if the team was concerned with an important MPA Centre in Northern region of Portugal, which represents the Centres in one region where lives a quite relevant percentage of the Portuguese population, is needed to investigate if the barriers and access is different if we consider the private MPA Centres. It is known that the Northern region has not a good cover of private MPA Centres, but what is the profile of women that use them and what do they have to tell about their barriers and access?

Concerning further investigation, we think that it is necessary to know what has been the role of men in the whole process of trying to resolve the infertility problem. And what about the rest of the family?

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