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Infertility: Unified Health System and the fundamental right to family planning

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Abstract

The World Health Organization considers infertility a global health problem to be addressed through assisted reproduction procedures. Given this, the question arises as to whether the Unified Health System has supported infertile people to perform the *in vitro* fertilization technique as a means of realizing their fundamental right to family planning. The hypothesis that access to *in vitro* fertilization is difficult and limited is confirmed, with few public centers offering totally free treatment. Lack of adequate investment, shortage of professionals, and long waiting lists also demonstrate the helplessness suffered by infertile people. Although judicialization has sometimes been used, it is not a widely effective solution. Ensuring universal access requires creating comprehensive public policies and efficiently incorporating assisted reproduction services into the Unified Health System.

Keywords: Fertility. Unified Health System. In vitro fertilization.

Resumo

Infertilidade: Sistema Único de Saúde e o direito fundamental ao planejamento familiar

A Organização Mundial da Saúde considera a infertilidade um problema global de saúde a ser enfrentado por meio de procedimentos de reprodução assistida. Diante disso, questiona-se se pessoas inférteis têm sido amparadas pelo Sistema Único de Saúde para a realização da técnica de fertilização *in vitro* como meio para efetivação de seu direito fundamental ao planejamento familiar. É confirmada a hipótese de que o acesso à fertilização *in vitro* é dificultoso e limitado, com escassos centros públicos oferecendo tratamento completamente gratuito. Falta de investimentos adequados, escassez de profissionais e longas listas de espera também demonstram o desamparo sofrido por pessoas inférteis. A judicialização, embora tenha sido utilizada em alguns casos, não é uma solução amplamente efetiva, sendo necessário, para garantir a universalidade do acesso, criar políticas públicas abrangentes e incorporar de forma eficiente serviços de reprodução assistida ao Sistema Único de Saúde.

Palavras-chaves: Fertilidade. Sistema Único de Saúde. Fertilização in vitro.

Resumen

Infertilidad: Sistema Único de Salud y el derecho fundamental a la planificación familiar

La Organización Mundial de la Salud considera la infertilidad un problema mundial de salud que debe afrontarse mediante procedimientos de reproducción asistida. Ante ello, se cuestiona si las personas infértiles han contado con el apoyo del Sistema Único de Salud para realizar la técnica de fertilización *in vitro* como medio para hacer efectivo su derecho fundamental a la planificación familiar. Se confirma la hipótesis de que el acceso a la fertilización *in vitro* es difícil y limitado, ya que pocos centros públicos ofrecen un tratamiento completamente gratuito. La falta de inversiones adecuadas, la escasez de profesionales y las largas listas de espera también demuestran el desamparo que sufren las personas infértiles. La judicialización, si bien se ha utilizado en algunos casos, no es una solución ampliamente efectiva, y, para garantizar el acceso universal, es necesario crear políticas públicas integrales e incorporar eficientemente los servicios de reproducción asistida al Sistema Único de Salud.

Palabras clave: Fertilidad. Sistema Único de Salud. Fertilización in vitro.

The authors declare no conflict of interest.

Infertility as a health problem

According to data from the World Health Organization (WHO)[1], 278 thousand couples face infertility in Brazil, which is equivalent to 15% of all couples of reproductive age. A couple who maintains an active sex life and does not use contraceptive methods has a 20% chance of conceiving a child each month. This means eight out of ten couples can get pregnant within a year. However, the remaining 20% have difficulty conceiving naturally, and around 10% of these will need to resort to assisted reproduction treatments to fulfill their dream of having a child.

According to Resolution 2,294/2021[2] of the Federal Council of Medicine (CFM), infertility is a health problem with medical and psychological implications. Therefore, the legitimacy of the desire to overcome it is recognized. This condition makes family planning difficult, which is seen as an integral part of the right to health, with the formation of a family with children being an instrument for the fulfillment of the human person.

Procedures such as *in vitro* fertilization (IVF) and artificial insemination offer hope to couples facing infertility who wish to have children. IVF is a medical-assisted reproduction procedure that involves combining eggs and sperm in a laboratory to create embryos that are later transferred to the woman's uterus to achieve pregnancy[3].

This treatment is often used by people who have difficulty conceiving due to a variety of medical reasons, such as blocked fallopian tubes, endometriosis, poor sperm quality, and unexplained infertility. However, despite health being a fundamental right of the individual, the discussion about the provision of IVF by the Unified Health System (SUS) is a relevant and controversial topic.

The SUS aims to provide all Brazilian citizens with free and universal medical care. However, currently, the provision of assisted reproduction treatments, such as IVF, is not universally guaranteed, despite there being an understanding that it should be offered as part of reproductive health services, given that infertility affects countless couples in Brazil.

Therefore, few public hospitals in the country offer these services. In most cases, they are not entirely free since patients may be responsible for the costs of medications or associated procedures. Furthermore, in these free public services, there is no regulation regarding the waiting period for starting treatment or specific criteria that patients must meet to be eligible.

Given these problems, the question arises as to whether infertile people have found support in the SUS to undergo IVF as a means of realizing their fundamental right to family planning. The hypothesis is that access to IVF is challenging due to regional unavailability and limited SUS resources, as well as indirect costs for those trying to conceive, long waiting lists, and limited capacity to provide the service.

Using a literature review and the inductive method, this research seeks to understand, firstly, the social evolution regarding the recognition of sexual and reproductive rights, of which family planning is an integral part. Secondly, it will investigate the legal provisions related to IVF in the Brazilian legal system and how it is provided by the SUS to finally verify whether the provision of the service by the public system has supported families diagnosed with infertility.

The research on this topic aims to identify challenges, obstacles, and areas that need improvement. This will improve health policies and resource allocation to ensure a more effective health system.

Fundamental right to health and family planning

Fundamental rights are all legal prerogatives related to people (whether natural or legal, considered individually or collectively) that, according to the perspective of positive constitutional law, were explicitly or implicitly incorporated into the Brazilian Constitution of 1988 and removed from the sphere of availability

of the constituted powers. Furthermore, they encompass all legal prerogatives that, due to their content and importance, can be equated to rights, regardless of whether they are formally enshrined in the Brazilian Constitution [4].

One of the fundamental rights—the right to health—most strikingly demonstrates the connection between its object and the right to life/principle of human dignity. In addition to the connection with the right to life, it is also closely linked to protecting physical and mental integrity, which are equally fundamental in legal terms [4].

The WHO defines health as a complete state of physical, mental, and social well-being, not merely the absence of illnesses and diseases [5]. Law 8,080/1990 [6], which establishes the conditions for the promotion, protection, and recovery of health and the organization and operation of its corresponding services, defines health as a fundamental human right, with the State responsible for providing the conditions necessary for its entire exercise.

Furthermore, the United Nations (UN), in its agenda of goals to be achieved by 2030, emphasizes the importance of health and well-being as a fundamental priority. These rights are highlighted in the third of the UN Sustainable Development Goals, which aim to ensure healthy lives and promote well-being for all, regardless of age [7].

An important point is the need to ensure universal access to sexual and reproductive health services—including family planning, information, and education—and the integration of reproductive health into national strategies and programs. Currently, health is an issue that transcends the mere biological condition of an individual. It is fundamental to citizenship and social justice since both individual health and the health of communities are influenced by economic, social, cultural, political, environmental, and biological aspects [8].

With the enactment of the current Brazilian Federal Constitution [9], access to health became a social right offered by the SUS. Established by Law 8,080/1990 [6], the SUS has as its main guidelines universal access at all levels of health care, equality in care without prejudice or privilege of any kind, comprehensive care, community participation, and political and administrative decentralization. Health care is defined in Art. 196 of the Constitution as *a right of all and a duty of the State and shall be guaranteed by means of social and economic policies aimed at reducing the risk of illness and other hazards and at the universal and equal access to actions and services for its promotion, protection and recovery* [9].

According to the Constitution, access to health care and family formation are universal rights that the State must guarantee to all people in Brazilian territory, including foreigners. In addition, private institutions can offer health services while preserving the rights in the public system. This highlights the importance of universal access to health care and family building in Brazil, with public and private services to meet these needs [9].

In this context, it is necessary to differentiate between sexual and reproductive health: while the former concerns equality and freedom in the exercise of sexuality, the latter refers to equality and freedom in the sphere of reproductive life. Addressing sexuality and reproduction as components of citizenship and, therefore, of democratic life implies considering the interconnection of these two areas. Treating these aspects as separate fields is essential to preserve the autonomy of each sphere of life and, simultaneously, relate them to each other and various other social dimensions [10].

The connection between health and reproductive and sexual rights must be seen based on the needs that arise from the reproductive experience and the exercise of sexuality, i.e., the two dimensions need to be considered distinct areas in public health policy. Pregnancy, childbirth, puerperium, breastfeeding, conception, contraception, abortion, sexually transmitted diseases, and sexual violence are issues of utmost importance that are currently at the center of health policy concerns. This implies that public authorities must guarantee the necessary resources to promote well-being,

prevent morbidity and mortality, and provide necessary treatment and care in these domains [10].

Family planning, which is the decision to have children or not, is included within the scope of reproductive rights, supported by the principles of human dignity and responsible parenthood. The State is responsible for providing educational and scientific resources to exercise this right. Any coercive attempt by official or private institutions is illegal [11].

Concerning issues of filiation, it is essential to remember that family planning is a guaranteed right on which neither the State nor society can impose limits or conditions, as established in art. 226, §7, of the Federal Constitution [9]. The free choice to form a family is an achievement of men and, mainly, of women over the years [12].

The aforementioned constitutional section is regulated by Law 9,263/1996 [13], the Family Planning Law, which guarantees all citizens, not just couples, the right to family planning, covering methods and techniques of conception and contraception, establishing penalties, and providing other measures. Through this law, the "Family Planning" program was created, whose main elements are actions and guidelines related to fertility, which guarantee all citizens rights similar to those established in the Federal Constitution. The program allows anyone to have control over the size of their offspring, being able to decide whether or not to increase it according to their choices and needs [14].

The program's promotional approach is based on preventive and educational measures to ensure equitable access to information, resources, methods, and techniques available for regulating fertility in a non-coercive manner [15]. Furthermore, CFM Resolution 2,294/2021 [2] regulates the use of assisted reproduction techniques aimed mainly at people with infertility or as a way to prevent the transmission of genetic diseases.

In vitro fertilization technique as a path to fertility

The American Society for Reproductive Medicine [16] defines infertility as the inability to become pregnant after 12 months of frequent sexual intercourse (two to three times per week) without the use of contraceptive methods. In some cases, this evaluation may be recommended earlier, especially if there are clinical reasons for it. In any situation, it is essential for couples facing infertility problems to seek medical investigations before receiving a definitive diagnosis [3].

The WHO recognizes infertility as a public health problem that affects 8% to 12% of couples worldwide. However, it should not be categorized as a conventional disease since it does not always involve symptoms such as pain, hospitalization, or risk to life. Even so, it triggers a series of psychological disturbances, being perceived as a threatening situation that provokes various emotional conflicts [17].

Even if physical integrity is not compromised or there is no risk to life, its negative influence on the psychological health of the couple and, often, of the family itself cannot be denied. Infertility can produce frustration, demotivation, and other harmful effects. It should be treated as a public health problem to be faced with other reproductive problems, such as contraception and sexually transmitted infections (STI) [18].

Infertility can become the main challenge in the lives of many women, who begin to see pregnancy as their primary goal, which results in significant psychological suffering. In addition, another essential aspect to be considered is that the cause of conjugal infertility is often attributed to women, which can lead them to feel more responsible for their inability to conceive and blame themselves before their partners [19]. However, just as a person is not born a woman for the unconscious, neither is a mother born – whether through natural conception, assisted fertilization, or adoption, women assume their condition as mothers through the symbolic representations they can perform [20].

The history of artificial reproduction began in 1332 with the Arabs, who used it rudimentarily to inseminate horses for war. In 1777, the Italian abbot Lazzaro Spallanzani successfully inseminated a female dog, producing three

puppies. The technique has since expanded, mainly for economic purposes, allowing the selection of more efficient animals for work and food [21].

In 2010, the International Federation of Fertility Societies surveyed 103 countries to assess the presence or absence of legislation related to assisted reproduction. Among these countries, 42 (40.7%) indicated that they had specific legislation; 26 (25.2%) reported having reference guidelines or non-specific laws, which could include resolutions, recommendations, situations provided for in the Constitution, or laws that, although not exclusive to assisted reproduction, in some way regulated the practice; and 35 (35%) operated without any specific legislation or guidelines [22].

Assisted human reproduction is a type of fertilization performed using advanced techniques that handle human gametes to facilitate reproduction. Among the best-known techniques are the transfer of gametes into the fallopian tube (gamete intrafallopian transfer – GIFT), the transfer of the zygote into the fallopian tube (zygote intrafallopian transfer – ZIFT), the intracytoplasmic sperm injection (ICSI), and, last but perhaps most importantly, IVF, the subject of this study [21].

Initially implemented in the United Kingdom in 1978, IVF arrived in Brazil in 1983 and has made progress since then. However, there are still barriers to its access, especially for low-income populations [18]. The IVF technique consists of four distinct stages: first, controlled ovarian stimulation occurs, which aims to promote the development of ovarian follicles; then, oocytes are collected; after that, the eggs are fertilized, and the embryos subsequently grow; finally, the embryos are transferred to the uterus.

In the context of IVF, the embryo transfer stage is often associated with debates and controversies since IVF increases the likelihood of multiple pregnancies by approximately 25%, which can lead to complications for both the mother and the fetus [3]. The technique is considerably invasive, as it requires hormonal stimulation to extract the egg from the female reproductive system, followed by surgical intervention to collect the egg to facilitate fertilization in a laboratory environment [21].

In Brazil, no specific law addresses assisted human reproduction in a comprehensive or detailed manner, and all attempts to create such legislation have so far yet to be successful. The first bill (PL) related to assisted human reproduction was introduced in 1993, almost a decade after the first successful reports of this practice in South America. Since then, several bills have been proposed—PL 1,135/2003 [23], PL 1,184/2003 [24], PL 2,061/2003 [25], PL 4,892/2012 [26], and PL 115/2015 [27]—but none have moved forward.

Senate Bill 90/1999, authored by former Senator Lúcio Alcântara and currently numbered 1,184/2003, appears to have been the most successful so far. The Senate approved it and has been awaiting a vote in the Chamber of Deputies since January 8, 2007 [28].

Law 9,263/1996 [13] addresses the right to assistance with conception, establishing that new reproductive technologies, such as artificial insemination and others, must be accessible through the SUS. Despite the provisions mentioned, the legislation does not define criteria for access to these new techniques, which generates debates mainly related to scope.

On March 22, 2005, the Ministry of Health (MS) instituted the National Policy of Comprehensive Care in Assisted Human Reproduction within the scope of the SUS, as established by Ordinance MS 426/2005 [29]. This policy targeted both couples with infertility problems and those who would benefit from assisted reproduction techniques to prevent the transmission of diseases, including people with HIV/AIDS [7].

However, even before it was implemented, Ordinance MS 2,048/2009 [30] revoked this policy, justifying the need for an impact assessment and the availability of financial resources. Thus, to date, universal access to new reproductive technologies through the SUS has not been implemented in Brazil [7].

CFM Resolution 2,294/2021 [2] prescribes ethical standards for the use of assisted reproduction

techniques, and it is the deontological device to be followed by Brazilian physicians who perform the procedure. The first resolution that regulated the time was CFM Resolution 1,358/1992, updated in 2010 (CFM 1,957/2010), 2013 (CFM 2,013/2013), and 2015 (CFM 2,121/2015) [28].

Despite the lack of legislative regulation, services related to assisted reproduction are offered in both the public and private systems. In the public system, they are available in a limited number of reference hospitals, while in the private system, there is a wide range of services for those who can afford them. However, considering that Brazilian federal legislation guarantees the right to assistance with conception, including assisted reproduction techniques, these procedures should be accessible in the public system for individuals with infertility or who require measures to prevent the transmission of diseases.

While there are 193 assisted reproduction centers (CRHA) in Brazil, only ten offer treatment through the SUS. Most centers (107) are located in the Southeast region, with 66 units in São Paulo; the smallest number is located in the North, with only five units, two in Amazonas, two in Pará, and one in Tocantins [31]. Of the ten centers that offer assisted reproduction treatment through the SUS, only four perform IVF utterly free of charge: the Assisted Reproduction Center of Brasília Maternal and Child Hospital; the Januário Cicco Maternity School—belonging to the Federal University of Rio Grande do Norte; the Pérola Byington Hospital; and the Clinics Hospital of the School of Medicine of the University of São Paulo (USP), both in São Paulo/SP [32].

In the other centers, the patient and/or her family must pay for the medications, which have an average cost of R$5,000. These centers are located in São Paulo, at USP in Ribeirão Preto and the Federal University of São Paulo (UNIFESP); in Porto Alegre, at the Porto Alegre Clinics Hospital and the Fêmina Hospital; in Belo Horizonte, at the Clinics Hospital of the Federal University of Minas Gerais (UFMG); and in Goiânia, at the Clinics Hospital of the Federal University of Goiás (UFG) [32].

The cost, which may be affordable for some, is an obstacle for others, as evidenced in the research by Mesquita et al. [18], which followed up 40 women who qualified to use the Porto Alegre University Hospital system, in which three IVF attempts are possible. Of the participants, 14 did not even start the process, seven for financial reasons. Of the 19 who started and did not get pregnant before exhausting Porto Alegre Clinics Hospital their chances, 37.5% also did not go ahead due to lack of resources.

The Teaching and Research Center for Assisted Reproduction at the Brasília Hospital sees an average of 30 to 35 couples per month for assisted human reproduction (AHR) treatments. The population served has primary infertility (patients who have never had children) or secondary infertility (patients who have had children but are currently facing fertility problems). There are no restrictions on age, financial status, or educational level to access these services, and most patients live in the Federal District or surrounding areas. However, the service is occasionally sought by people from other states [33].

At the Januário Maternity School, the patient must prove the need for treatment and be up to 38 years old. The waiting period is approximately one and a half years. At the Pérola Byington Hospital and the Clinics Hospital of the School of Medicine of USP, the age limit is 37, with an average waiting time of two years [32].

The age limit is another factor that undermines the implementation of the fundamental right to family planning, as a greater number of cycles are required for successful pregnancy rates to occur in older women. According to data updated on October 20, 2022, 3,980 cycles were performed on women under 35 and 8,787 on women over 35, for the same fertilization rate of 74%. Therefore, restricting the age and number of cycles considerably reduces the chances of success [31].

While the number of cycles performed in 2022 was slightly lower than in 2021, with a reduced rate of 15.58%, and there is still no data for 2023, the increase in the number of IVF cycles in the country is undoubtedly a reality [31].

There is currently no quantitative information on couples/women/men who would need the SUS for reproductive assistance. However, in 2021, the waiting list at the SUS for gynecological consultation for infertility was approximately 400 users per month, and the waiting time exceeded 200 days [34]. At this rate, care for infertility cases is non-existent in 72.9% of Brazilian municipalities. Demands greater than 75% are met in only 5.9% of them, with municipalities with the smallest number of inhabitants being those that neglect infertility cases the most [35].

Judicialization of the right to health

Although a waiting plan was established so that treatment could be financed by the SUS, the deficiencies in the system's functioning, the shortage of professionals, and the lack of adequate investments make the process slow and inadequate. This results in a growing waiting list and, consequently, makes the search for infertility treatment a challenging goal to achieve within the scope of universal access [14].

Specialized public services in this area are notably scarce, mainly due to the government transfers intended for assisted human reproduction policies within the scope of the SUS, which only began in 2012 with the publication of Ordinance MS 3,149/2012[36]. Thus, the number of hospitals capable of offering this type of treatment is limited, so couples are often forced to join waiting lists and wait long periods to advance in the process [14]. In some cases, they need to resort to the judicial system to obtain free access to treatment.

Regarding the judicialization of the case, when consulting the case law of the higher courts, using the keywords "in vitro fertilization" and "Unified Health System," eight lawsuits were found in the Federal Supreme Court (STF). In all of them, the appeals were denied because the controversy did not reach constitutional status, and there was no violation of the constitutional precepts indicated on the grounds for appeal.

In turn, in the Superior Court of Justice (STJ), 14 lawsuits were found, and in 12 of them, the appeal filed against the lower court's decision to deny the case was not acknowledged. In Special Appeal 1,845,015-PR [37], in the separation of an ordinary lawsuit filed against the Union, the state of Paraná, and the Municipality of Umuarama/PR, the right to free access, which had already been granted and maintained in the previous courts, was once again consolidated. Therefore, the defendants were required to refer the plaintiffs for care at a hospital accredited by the SUS to undergo assisted human reproduction treatment.

Furthermore, it was agreed that, in the specialized home treatment provided to patients, to preserve the universality of SUS care and avoid discriminatory treatment, the parties would be referred to the nearest SUS care unit for out-of-home treatment (OHT)—also provided for by MS Ordinance 55/1999 [38]—and, alternatively, since OHT is more expensive than treatment in a private clinic, the SUS could use the services offered by the latter [37].

In Special Appeal 1,822,814-TO [39], the municipal government agency was ordered to pay for IVF treatment, with the provision of intracytoplasmic injection, for a 38-year-old patient who suffered from habitual miscarriage and female infertility. In its grounds for appeal, the municipality's claim that it was unreasonable to order the payment of a specific and expensive treatment for female fertilization stands out. According to the municipality, this would imply the prestige of individual interests to the detriment of collective interests, especially when considering that infertility does not cause physical harm to the patient's health.

The court emphasized that it should not be forgotten that human infertility is considered a pathology that can generate serious medical and psychological implications, according to the CFM. Furthermore, it was stated that the term health encompasses both the physical and mental aspects of the human being, which is why the intention to obtain treatment for IVF does not deviate from

the principle of guaranteeing health provided by the public authorities [39].

Despite the two decisions of the STJ, in the lower courts, there are numerous cases of denial of the right based on the non-recognition of IVF as an essential medical procedure to ensure or protect health, as well as on the allegation that the public authorities are obliged to provide only the "existential minimum" in health care, and cannot afford costly treatment [40,41].

Although this research deals only with public service, it is essential to highlight that in 2022, the judgment on the merits of Special Appeal 1,822,420/SP [4], and in 2021, the decisions on the merits of Special Appeals 1,822,818/SP [43] and 1,851,062/SP [44] became final and binding. These decisions are paradigms of the repetitive controversy described in Theme 1,067 of the STJ, which establishes the thesis that, *except for an express contractual provision, health plans are not obliged to cover in vitro fertilization medical treatment* [45]. While the STJ's understanding is recent and has taken the path of optionality, it is already outdated, given the overcoming of the exhaustive nature of the list of the National Health Agency (ANS) by the enactment of Law 14,454/2022, which restored the thesis of the exemplary list of ANS with conditions [46].

Final considerations

The fundamental right to health, considered a social right guaranteed by the State, has the SUS as its primary expression in Brazil and is highly linked to the right to life and human dignity. Thus, to make the right to family planning effective, it must be universally and equally accessible to all, including sexual and reproductive health services.

This right, in turn, is protected by Brazilian and international legislation and seeks to ensure that citizens can form their families, with or without children. However, those who, for reasons of infertility, cannot have children naturally can use fertility regulation methods and techniques, including as part of public health policies.

While it is not classified as a conventional disease, infertility is a public health problem that affects millions of couples around the world, triggering significant psychological and emotional disturbances in couples and being the main challenge in the lives of many women. IVF, presented as one of the techniques for people diagnosed with infertility, still has restricted access due to the costs involved, especially for low-income populations. Brazil's lack of specific legislative regulation and the limited access to assisted reproduction services through the SUS stand out in this context.

Although there is an increasing number of IVF cycles performed in the country, many couples face barriers to obtaining the necessary treatment, including age restrictions and long waiting times. In addition, care for infertility cases, as part of family planning, is deficient in many Brazilian municipalities, highlighting the need for improvements in the health system to meet the needs of these couples. The deficiencies in the system's functioning, the lack of adequate investment, and the shortage of professionals make the process slow and inadequate, resulting in a growing waiting list and making seeking treatment a challenging goal to achieve in the context of universal access.

With the shortage of public services specialized in assisted human reproduction, some couples resort to the judicial system to obtain free access to treatment. While there are favorable decisions in some cases, many appeals are rejected based on arguments such as that the refusal to provide these services does not violate constitutional precepts or that the State's budgetary limitations do not allow it.

A public health policy dedicated to the comprehensive promotion of reproductive and sexual rights would be a milestone in democratic evolution, as it would not only strengthen the process of democratization of Brazilian society but would also contribute to reformulating the limits that the State imposes on the private sphere and, consequently, to expanding citizenship into the sphere of everyday life. Several improvements can be proposed, starting with creating more reference public services incorporating assisted reproduction technologies. To this end, economic feasibility studies can support decision-making by managers as long as they are linked to clinical evidence and the efficient organization of health services.

The challenges are significant, given that IVF is an expensive and complex procedure involving high costs for health systems, which need to prioritize and allocate resources despite budgetary limitations. Thus, public policies are urgently needed, given the reality of the SUS, which clearly does not adequately meet the rights guaranteed by national legislation, violating the fundamental right to family planning.

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