

SPECIAL ARTICLE

The new WHO infertility guideline: A universal right to equitable, evidence-based fertility care

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Abstract

The WHO 'Guideline for the prevention, diagnosis and treatment of infertility' heralds a significant global shift towards recognizing infertility as a medical condition requiring prevention, diagnosis, treatment and policy support. This recognition is vital for the one in six people with infertility worldwide and for policymakers trying to address the societal consequences of fertility decline. The guideline's 40 recommendations and six good practice statements emphasize pragmatic diagnostic pathways, cost-effective interventions, psychosocial support and shared decision-making. Preventive measures, including fertility education, lifestyle counseling, smoking cessation and early management of sexually transmitted infections, are recommended in routine care to improve future reproductive health outcomes. The guideline aligns closely with the International Federation of Gynecology and Obstetrics (FIGO) vision for equitable, context-specific fertility care. FIGO supports adaptation of fertility services according to local resources while promoting access to fertility services irrespective of marital status, gender, sexual orientation or socioeconomic circumstances. Both WHO and FIGO advocate the incorporation of infertility care within national reproductive health strategies to improve access and affordability, particularly in low- and middle-resource settings. Compared with regional fertility society guidelines, the WHO recommendations prioritize scalable and affordable approaches suitable for diverse health systems. Although important gaps remain, including fertility preservation, third-party reproduction, and expanded guidance on male-factor infertility and endometriosis, this guideline provides a practical framework for clinical uptake across nations. Its greatest contribution is the reframing of infertility from a neglected and stigmatized condition to a public health priority within universal health coverage.

KEYWORDS

infertility, infertility guidelines, reproductive health, World Health Organization

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1 | INTRODUCTION

For too long, infertility has been treated as a predestined condition, with couples finding themselves 'blessed' or 'cursed', based on their ability to have children. This is often a private struggle relegated to the margins of global health priorities. However, WHO's new 'Guideline for the prevention, diagnosis and treatment of infertility' marks a fundamental shift: infertility is now recognized as a medical condition warranting systematic investigation, prevention and evidence-based treatment. By acknowledging that one in six people globally will experience infertility, WHO frames reproductive autonomy as a fundamental human right requiring systematic support.^{1,2}

A defining feature of the WHO guideline is its emphasis on a pragmatic, history-driven, diagnostic approach. Rather than promoting extensive upfront testing, the guideline recommends targeted evaluation based on clinical findings, including selective use of mid-luteal progesterone to confirm ovulation, tubal assessment and structured semen analysis with repeat testing only when abnormal. This approach reinforces cost-effectiveness while maintaining diagnostic rigor.

The guideline explicitly aims to make fertility care 'safer, fairer and more affordable', and it includes 40 recommendations plus six good practice statements spanning prevention, diagnosis and treatment. Importantly, prevention is operationalized through specific, low-cost interventions rather than broad principles alone. The guideline recommends routine provision of fertility education, lifestyle counseling, tobacco cessation and early treatment of sexually transmitted infections, highlighting that even brief clinical interactions can meaningfully reduce infertility risk. Psychosocial support and patient values are placed at the centre of care, reinforcing shared decision-making over purely technology-driven approaches. By providing an evidence-based framework, WHO supports inclusion of fertility care in national health policies, financing plans and essential medicine lists.¹

This is highly aligned with FIGO's vision of context-specific implementation of fertility care across all regions. FIGO advocates for national adaptations that reflects local resource availability, workforce capacity and health system infrastructure. Central to FIGO's position is a commitment to non-discriminatory access, to ensure that eligibility for fertility investigation and treatment is not constrained by marital status, gender or sexual orientation. FIGO also supports equity in socioeconomic access with fertility care affordably embedded within the public sector, rather than solely confined to private, fee-for-service providers. To this end, FIGO advocates that fertility care be formally incorporated into national reproductive health strategies and financing frameworks, rather than considered as an adjunct service, so the WHO guideline's principles translate into durable policy commitments across both high- and low-resource settings.

In many low- and middle-resource settings, fertility care remains predominantly out-of-pocket, with limited public funding allocated to infertility investigation or treatment. Workforce and laboratory

capacity is frequently insufficient to deliver even the conservative recommendations from the WHO infertility guidelines. Legal and eligibility restrictions, such as marital-status requirements or prohibitions on third-party reproduction, further limit access for many individuals despite their clinical need. Furthermore, the lack of Artificial Reproductive Technology (ART) registries in many jurisdictions constrains access to data needed to monitor safety, outcomes and equity of access over time. Alongside implementing the clinical pathways outlined in the WHO infertility guideline, addressing these barriers will require investment in culturally sensitive, non-discriminatory models of care.

The guideline provides a practical framework for implementation, underscoring the need to integrate infertility into national health systems through policy inclusion, provider training, essential medicine lists and data systems such as ART registries. This operational focus distinguishes the WHO guidance from many fertility society guidelines by addressing not only what to do, but how to deliver care at scale.

The guideline also addresses the deep-seated stigma surrounding infertility. Women are disproportionately blamed for childlessness and face increased risk of intimate partner violence in the context of infertility.³ By formalizing the diagnosis of male-factor infertility and mandating evaluation of both partners, the guideline promotes shared responsibility in reproductive health.

2 | COMPARISON WITH REGIONAL GUIDELINES

Whereas guidelines tailored for higher-resource settings, such as those of the American Society for Reproductive Medicine (ASRM), the European Society of Human Reproduction and Embryology (ESHRE) and the Asia Pacific Initiative on Reproduction (ASPIRE), address contexts with broad access to advanced reproductive technologies, the WHO guideline is designed to be adaptable across diverse health systems, regardless of economic status. The emphasis falls less on advanced, high-cost technologies and more on cost-effective diagnostic and treatment pathways. For example, letrozole is recommended as first-line ovulation induction for anovulatory disorders such as polycystic ovarian syndrome (PCOS), and expectant management or stimulated intrauterine insemination (IUI) is favored for unexplained infertility before progression to in vitro fertilization (IVF).^{1,4} This stepwise approach prioritizes effective, lower-cost options.

Although many recommendations are conditional and supported by low- or very low-certainty evidence, this reflects the reality of limited high-quality data in diverse global settings rather than a lack of clinical relevance. The guideline therefore appropriately integrates available evidence with expert consensus to provide actionable recommendations across varied resource contexts.

Where IVF and intracytoplasmic sperm injection (ICSI) are affordable and accessible, regional guidelines place greater emphasis on ovarian reserve assessment, including antral follicle count

(AFC) and anti-Müllerian hormone (AMH) measurement, to guide treatment timing, gonadotropin dosing and decisions about fertility preservation. Where IVF is readily available, guidelines place less emphasis on IUI and surgical varicocele repair.

3 | WHAT THE WHO GUIDELINE DOES NOT YET ADDRESS

The guideline does not yet cover all domains of infertility care. WHO acknowledges that future editions must address fertility preservation, third-party reproduction and the impact of pre-existing medical conditions on fertility. Several fertility societies (e.g., ASRM, the Australian and New Zealand Society of Reproductive Endocrinology and Infertility [ANZSREI]) have adopted updated definitions of infertility that do not rely on coital frequency or duration. These broader definitions enable more equitable access to fertility services for people requiring surrogacy (e.g., those with Mayer-Rokitansky-Küster-Hauser [MRKH] syndrome), gamete donation (e.g., same-sex couples or single women) or other third-party reproduction, regardless of relationship status or family structure.

Ovarian reserve testing, particularly antral follicle count, enables clinicians to plan treatment timing and to counsel women with diminished ovarian reserve or those at risk of premature ovarian insufficiency about the limited window for fertility treatment. This is particularly relevant in some low-resource settings, for example, in India, where the mean age of menopause is approximately 46 years compared with 51–52 years in Australia, Europe and the USA, implying an earlier decline in ovarian reserve.^{5,6}

The guideline's coverage of male-factor infertility is limited. Growing evidence links lifestyle factors, metabolic syndrome and conditions such as obstructive sleep apnea and post-COVID-19 sequelae to impaired male reproductive function, none of which are addressed in this first edition.

Endometriosis, a major contributor to infertility, traditionally diagnosed only at surgery, deserves particular attention. Specialist transvaginal ultrasound can now identify endometriomas and deep infiltrating endometriosis with high specificity and is recommended by most gynecological societies as a first-line diagnostic tool.⁷ Where such expertise exists, the proportion of infertility labeled as unexplained falls substantially, enabling targeted treatment and reducing the stigma of a diagnosis without a known cause.

4 | SUMMARY

WHO acknowledges that future editions should incorporate refinements. As countries implement these recommendations, infertility should transition from a source of shame, social isolation and financial hardship to a recognized medical condition supported within national health systems. Ultimately, the strength of this guideline lies not only in its recommended pathways to improve

treatment access, but in its reframing of infertility care as a broader public health concern requiring attention to prevention, early diagnosis and reproductive health awareness. This guideline signals that fertility care is not an optional extra but a core element of reproductive health and universal health coverage.

AUTHOR CONTRIBUTIONS

MLH, KTB and SCN synthesized WHO guidelines, drafted paper and conceptualized content. AS conceptualized and edited the paper. NCP and EGT edited the draft and finalized content.

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DATA AVAILABILITY STATEMENT

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APPENDIX A

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