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# Biopolitics of Reproduction: Involuntary childlessness and Justice in Pakistan

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## Abstract

Although reproductive health is generally accepted as a basic human right, infertility is considered as a personal rather than public health issue. In Pakistan, neglect in childbearing is a serious threat to the wellbeing of people and couples. This is because having children is closely linked with social legitimacy and marital stability. This study employs a qualitative design to explore the perspective and management of infertility by the Pakistani health system under the reproductive health umbrella. This analysis draws on Foucauldian biopower and reproductive justice and is based on in-depth interviews with public health officials and medical practitioners from the policymaking and health care institutions. The findings suggest that infertility is widely acknowledged as an important issue, yet it does not appear on the health agendas and policy priorities for international development. These policies are dominated by family planning, maternal health, and prevention of STIs. Thematic analysis shows entrenched institutional and cultural biases: medical discourses often reinforce gender essentialism through the oblivion of male infertility and the blaming of women. These findings indicate that the exclusion of infertility from the public health system in Pakistan reflects a biopolitical strategy that privileges demographic control over reproductive justice and requires systemic policy reforms and gender-inclusive health care.

**Keywords:** *Bodies, Power, biopolitics, Reproductive Health, Pakistan*

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## Background

Infertility as a public health issue has emerged as a global health problem with distinct effect on the lives of men and women; its burden varies greatly between developed and developing nations (Silva *et al*., 2019). These differentials result from interactions between socio-economic and cultural variables, the health care system and reproductive health outcomes and interventions (Hocaoğlu, 2019). Understanding the complex interplay between socio-economic, cultural, health care system and reproductive health variables is important to guide the development of effective infertility management interventions and policies in resource-poor settings (Mascarenhas et al., 2012). For instance, it has been reported that infertility treatment in developing nations is largely underfunded, and access to In Vitro Fertilization (IVF) and other assisted reproductive technologies is limited (Silberner, 2020).Pakistan has a high infertility rate of 22 percent (Bhatti, 2022) and Pakistan's approach to reproductive health care illustrates the complexities of the country's biopolitics, including the stigmatization of infertility, the availability of infertility treatment, and the involvement of international development organizations in devising population control strategies (Hashmi and Malik, 2023)

This situation is concerning for families in Pakistan where having children is very important for social legitimacy and marital stability; in addition to this, the Government of Pakistan places a high priority on regulating population rather than providing reproductive health care as demonstrated by the decrease in number of births from 1994 to 2024 (UN, 2025). While $100 million has been allocated by the government for family planning, no comparable funding has been dedicated to infertility treatment (World Bank, 2024) and publicly funded health systems do not provide any coverage for infertility care (Hashmi & Malik, 2023), this contradicts the constitutional right to equal access to health care.

Pakistan may be considered one of the world's neglected regions in terms of medically assisted reproduction facilities compared with Western nations, India, or the Middle East. The expense of assisted reproduction is beyond the means of many couples in Pakistan, as it is not covered by public health financing (Collins, 2002). Moreover, couples that are unable to conceive are left to rely on the private sector (operating under lack of comprehensive regulation) or native venues like faith healers and hakeem. This lack of regulations has led to inconsistent care standards and the exploitation of treatment- seeking couples/individuals (Ory *et al*., 2014). Similarly, additional alternatives like adoption and employing advanced treatment are further limited by socioeconomic position, gender dynamics, and religious

and cultural restrictions in Pakistan, which is known as a Muslim country (Jaja, 2013, Mumtaz *et al*, 2013 & Shaheen *et al*., 2010).

This situation indicates towards government's role in regulating infertility in Pakistan, as "passive biopolitics" that influences infertility through institutional neglect as opposed to direct intervention. Moreover, the absence of national data on infertility further exacerbates the situation in the context of Pakistani women, where childlessness is frequently perceived as failure to achieve the glorified status of motherhood which determined woman's social worth and marital relationship security (Qamar, 2018).

Consequently, women encounter (Ullah *et al*., 2021) unwarranted and negative pressure and discrimination from their families and society (Abdelnabi, 2024). According to Ashraf & Waraich, (2025) & Taebi *et al*. (2021) they are humiliated, threatened with divorce, excluded from social and traditional events, and seen as a sign of bad luck. Significant psychological stress, anxiety, feelings of worthlessness, sexual dysfunction, frustration, sadness, low self-esteem, and social isolation are all brought on by these expected social and familial expectations (Mubashir *et al.,* 2023, Ali et al., 2023). Furthermore, as having children is thought to be restricted to women only, they are held responsible for childlessness irrespective of having or not having infertility (Ashraf & Waraich, ,2025).

Pakistan Vision 2025 contains national development goals that refer to gender equality - these constitutional commitments and feminist advocacy developed by movements like the Aurat March outline issues around bodily autonomy and reproductive rights; however, women's reproductive health will continue to be negatively impacted by patriarchal cultures, misinterpretation of religious texts, restrictive abortion laws and insufficient family planning services (Rafaqat and Shabbir, 2024; Shehzadi et al., 2024). As the fifth most populated country globally, Pakistan has put policies in place to fulfil their international obligations relating to reproductive health, as outlined by ICPD, MDGs, SDGs and FP 2030; reproductive health care laws, maternal and newborn health programs, and community-based programs (i.e., Lady Health Visitors and Traditional Birth Attendants) have been developed to further the implementation of these policies (Hashmi & Malik, 2023). These policies concerning infertility only cover the prevention of menstrual hygiene and infection control but do not include infertility being treated as solely a women's-only issue, often reinforcing myths about infertility being a women's-only issue while ignoring men's reproductive health. Similarly, many provincial healthcare strategies after 18th Amendment (Punjab Health Sector Plan 2018, Punjab Health Sector Strategy 2019-2028) fail

to address infertility, the right to procreate, or male reproductive health creating clear gaps in reproductive justice between international policy commitments and local realities (Hashmi & Malik, 2023).

Policies that specifically target mothers and women of reproductive age while ignoring young boys going through puberty, the transgender community, the elderly, and people with reproductive health issues demonstrate how inaccessible reproductive justice is (Ross and Solinger's 2017). Although it is declared inclusive, universal health coverage is not implemented (Collumbien et al., 2012). To produce evidence for creating inclusive policies that cater to the needs of infertile couples, these omissions necessitate methodical investigation. In addition to exposing governmental blind spots, exclusion from care violates Pakistan's constitutional promise of equal access to healthcare. When infertile people's reproductive objectives conflict with the state's demographic aims, they are further isolated on top of the psychological, social, and financial stress they already face. Considering this, the current study aims to investigate how reproductive health professionals and public health officials view the policy invisibility of infertility and whether they support or contradict current restrictions.

## Theoretical Framework

Using a reproductive justice framework, this research tackles the right to fair treatment for everyone with a focus on the delivery of ethical, competent reproductive healthcare. Reproductive justice is a combination of three separate but interrelated frameworks; social justice, reproductive health, and reproductive rights, as defined by Ross (2020). This combination seeks to illustrate the ways that discrimination prevents the equitable delivery of healthcare services. Historically, population control objectives have directed how Pakistan has delivered reproductive healthcare within its public healthcare system by emphasizing fertility control over the full range of services. Despite provincial and national commitments to provide all individuals with universal access to healthcare services, there is still a lack of access to infertility services from both policy and practice perspectives. The promotion of family planning and contraceptive services through a legislative or regulatory lens creates a discriminatory structure within the public sector while ignoring the needs of those individuals who want to conceive but cannot access the necessary services. In addition to advocating for reproductive rights and services, reproductive justice advocates for the right to procreate, the right to choose not to procreate, and the right to raise children safely, as articulated by Black feminist scholars (Ross & Solinger 2017). This research study

applies this framework by discussing what practitioners and policy makers think about and support in terms of infertility being hidden in the context of Pakistan's reproductive health agenda.

Biopower is a key concept in understanding the power that contemporary governments exert over citizens. This includes controlling the population through the regulation of reproduction, family, and health, as Foucault noted (1978) and (2003). Some countries do this by enacting laws, such as the pro-natalist legal framework in Romania and Israel, or through population controls such as in China and Japan (Soare 2013; Stopler 2008). However, biopower also works through the omission of services and resources. Fertility treatments are regularly not available to citizens in most low- and middle-income countries (LMICs), including Muslim-majority countries and most South Asian nations. Governments use justifications such as `overpopulation' and `not enough resources' to exclude fertility services from publicly funded health programs; as a result, infertile couples are denied the right to reproduce (Ombelet 2024; WHO 2025).

International population control initiatives, limited resources and the prioritization of private clinics at exorbitant prices are all explicitly stated as reasons for restricting access to affordable fertility services in several low income countries( Zaake *et al*., 2026).The fact that infertility is not globally recognized as a disease; insufficient funding for fertility services and sociocultural factors continue to be major barriers for individuals seeking treatment; coupled with a limited number of countries offering any form of public or government funded treatment significantly limits access to fertility services. Pakistan parallels these patterns exactly: by denying the availability of infertility treatment in public healthcare facilities, the state is not only overtly lacking in facilitating reproductive health, but they are exercising biopower in these circumstances; they establish standards for determining which individuals are entitled to have an institutional response to their reproductive challenges and those individuals who are not entitled benefits from such an institutional response.

According to feminist researchers, biopower exacerbates patriarchal hierarchies by politicizing and medicalizing reproduction, which disproportionately affects women (Onwuachi-Saunders et al., 2019). Women experience systemic control over their sexuality and fertility(Wood et al., 2023; Moulton er al., 2021). While poor males and marginalized communities also experience biopolitical governance, women in the Global South are disproportionately disciplined by coercive population policies, restricted access to reproductive care, and the stigmatization of infertility (Ginsburg & Rapp, 1995; Mohanty, 2005; Inhorn, 2003).This study uses the concepts of reproductive justice and biopower to argue that rather than depoliticizing infertility to achieve their

demographic and economic goals, couples who experience involuntary childlessness especially women are more likely to face social and economic consequences should be considered when creating inclusive reproductive health care policies.

Feminist lens guides that biopower enforces patriarchal inequity through governing reproduction and the control of women's sexuality and reproductive capacity (Wood et al., 2023; Moulton et al., 2021). Women particularly in the Global South have an increased likelihood of being impacted by restrictive policies surrounding reproduction, their lack of access to healthcare and being stigmatized for being infertile (Mohanty, 2005; Inhorn, 2003). The author emphasizes the need to explore infertility as a social and political issue rather than simply as a demographic and economic problem using both the concepts of reproductive justice and biopower. Furthermore, it is vital that the development of reproductive health policies, be done with consideration of the potential social and economic impacts of involuntary childlessness upon women.

### Objectives

- To apprehend the public health official stance and medical practitioner position about the status of involuntary childlessness/infertility
- To comprehend the potential factors shaping public health official and practitioners' attitude towards involuntary childlessness

## Method

### Research Design

To better understand the state and requirements of involuntary childlessness in relation to the public reproductive health services offered in the Punjab province, this study used qualitative research approach to understand the stance of public health officials and reproductive health professionals employed in tertiary care hospitals in the provincial capital. A basic qualitative research design provides the foundation for this study (Tisdell et al., 2025), which is used to find out how individuals perceive a phenomenon within their professional context.

### Population, Sample and Sampling

The most populated province in Pakistan, Punjab, has a vast network of tehsil, district, teaching, and rural health institutions. This study was carried out there. Punjab was in charge of carrying out devolved programs after the 18th Amendment, which made health a provincial matter (Khan et al., 2014). Many infertilities and Assisted Reproductive Technology centers are available in Lahore, the provincial capital and

center of research and technology, drawing patients from all around Punjab for both state and private reproductive treatment. Key government representatives involved in health policy and service delivery were accessible in this setting. Three important government agencies participated in this study: the Planning and Development Board, the Punjab Health Department, and the Punjab Population Welfare Department. Five government officials with expertise in healthcare planning or policy design from the primary and secondary healthcare, tertiary/specialized healthcare, and planning sectors took part. Nine reproductive health specialists (five women and four men) from tertiary care hospitals in Lahore were also included as respondents. Each specialist had worked for more than ten years. The demographic information of participants is presented in table 1 and 2, which are attached as annexure

## Data Collection Tool

The researchers employed semi-structured interviews. The interview protocol was generated by taking the guidelines from previous literature.

## Procedure

All ethical guidelines were followed regarding data collection (anonymity, informed consent, debriefing) and storage. The pilot study was conducted to mitigate potential research loopholes. All steps suggested by Shenton (2004) were followed to ensure the reliability and rigor of the findings (member-checking, audit trail, detailed description). All interviews were conducted in person by the researcher. The average recorded interview times were 1 h and 30 min. Interviews with medical practitioners were conducted in hospitals and their clinics whereas 2 interviews with public health officials were conducted telephonically due to their busy schedule and the rest of the three interviews were conducted in their public offices. All interviews were electronically recorded after taking their informed consent.

## Analysis

The recorded interviews were transcribed, and after reading the transcripts, the respondents were contacted again to confirm any unclear points. The main themes were generated after extracting the codes and connecting themes from the final transcripts. The interviews were analyzed thematically by using the six-steps framework developed by Braun and Clarke (2021). The analysis of health officials and reproductive health practitioners revealed three main themes consisting of five

connecting themes. The themes revealed their positionality, factors shaping government and health sector's attitude, and prospects of involuntary childlessness.

## Findings

### Theme 1: Perception of Involuntary Childlessness

This main theme has two subthemes which reveal perception of public health officials and medical experts about involuntary childlessness.

### Subtheme: Stigmatized, Gendered and Biopower

Some of the respondents labeled involuntary childlessness as stigmatized identity with gender and biopower dimensions while sharing their perceptions about involuntary childlessness. According to male public health official at the Department of Population Welfare:

> *"In my opinion stigma attached with infertility in our society makes it unacceptable especially for women… which makes it more than a medical condition. Everybody wants to have children who can look after them in their old age"*

Similarly, one female medical practitioner shared,

> *"I will say that in our medical language it is a medical condition, but our societal negative attitude made infertility a social problem which unfortunately women have to face more. It is still not acceptable"*

This perspective demonstrates how pronatalist aspirations and the social value of children are maintained by culturally redefining infertility from a medical condition into a moralized identity. Utilizing Foucault's lens, the use of certain words serves to create a normative understanding of the "productive" body vs. the nonproductive person in terms of biopower's hidden form of population management through social constructs rather than through explicit laws.

### Subtheme: Invisibility yet Recognition

Some respondents were quite aware about the prevalence of involuntary childlessness in society; however, they acknowledged that it is absent from policy and public health services. For instance, one male public official from health care acknowledged the prevalence in the society, however, indicated as missing policy agenda and state's priorities.

> *"We usually refer infertility cases to tertiary care or private fertility clinics. I am familiar with the social*

> *dynamics of our society, but I can tell you that infertility is not a state's priority due to the pressure of population growth and, to be honest, the government does not have a budget for this because usually infertility treatments are expensive; therefore, the private sector caters deals it"*

A male official from the development and planning board revealed,

> *"You know…Government takes international agreements such as the SDGs and the FP 2030 as guidelines to design projects. To propose any new project to the government, my team needs numbers to justify the extent of the problem. Infertility has not yet been reported as a major population or health concern. This might be a reason it has not been included in policies and programs."*

The relationship between infertility, biological governance, and the state's authority in relation to infertility within the Pakistani context creates a multidimensional space for the condition of being infertile. This quote highlights that statistical representation is now an essential part of biopolitics, as though infertility had no impact upon society, then it would not have been so poorly represented within government priorities; however, as shown here, although infertility is understood, it remains outside of policy and is only used for reference or prevention (through reference to infectious disease, particularly when there is a history of high mortality rates, for unsafe deliveries due to improper menstrual hygiene).

**Theme 2: Factors shaping attitude towards involuntary childlessness**

This theme has three connecting themes which explain the factors shaping attitude of state and medical experts towards involuntary childlessness.

**Subtheme: Gender-Biased Facilities and Practitioner Attitudes**

This theme shows that infertility care in Pakistan is very much influenced by the fact that men receive no attention when it comes to their reproductive health, whereas women are heavily medicalized regarding their bodies. Healthcare practitioners observed that partners often resist having examinations, blaming the wife for infertility, justifying remarriage through medical evidence (even when the husband is thought to be infertile). For instance, one female medical expert shared,

> *"Many couples come to see me just for medical confirmation, so that, in situations where there are fewer chances of success, husbands can blame their wives for not being able to conceive and get married again. We refer to these couples for test tubes, but since most of them*

> *cannot afford them, they interpret this as a failure and, rather than seeking treatment, some choose to marry again, ultimately women have to suffer"*

By linking masculinity to the denial of reproductive incapacity, such practices perpetuate patriarchal norms that stigmatize male infertility and subject women to intrusive, ongoing examination. Another female practitioner shared:

> *"In my experience, usually husbands do not come for medical examinations, particularly when their wives' reports are acceptable." They refuse to be checked out because it is easy for them to blame their wives. Even men who have azoospermia choose to get married again rather than receiving other treatments."*

These accounts demonstrate how women's social and medical vulnerability is increased when the onus of diagnosis and treatment is placed on them. Another female respondent described the range of services offered for male and female reproductive health and emphasized the cultural constraints that make discussing reproductive health issues a taboo and not a domain of men. Having a medical condition or seeking assistance could make a man feel insecure about his masculinity because all reproductive and biological treatments are performed on female bodies in accordance with dominant gender norms.

> *"Unfortunately, the treatment services start with female only usually in medical practices of Pakistan... I believe this is because infertility is typically seen as a feminine domain... not considered macho."*

Utilizing these converging narratives illustrates how the medicalization of male infertility is largely ignored or taboo; while female bodies are highly visible in the diagnostic/testing process. This perpetuates hegemonic norms around masculinity, creates diagnostic costs borne by women, and embeds gender-based blame.

All the male health experts agreed that the current availability of both facilities and qualified staff for managing men's reproductive health such as infertility is insufficient because of the widespread lack of knowledge among medical professionals regarding men's reproductive health issues especially infertility in Pakistan. This lack of understanding has resulted in men being limited in their ability access to reproductive health services. To seek assistance for reproductive health issues, men are forced to contact urologists, since there are no separate departments for treating male

infertility. Health care workers in tertiary care facilities have also expressed similar views.

> *"In my experience men have more reproductive issues but they do not like to report or seek help, and we also do not have proper set ups in public hospitals to address their concerns"*

This evidence shows the ways an institution preserves hegemonic masculinity by allowing men to avoid a medical diagnosis and keeping men able to preserve their social honor. The health needs of men are marginalized by bias in the way in which men's needs are discussed within the medical system; however, women are penalized at a disproportionate rate. Disparities in health between men and women are instances of reproductive injustice.

**Subtheme: Restrictions due to Cost and Culture**

Both groups express concern about the high cost of infertility treatments; however, the severity of this issue is seen in tertiary care settings where couples refuse to continue with their treatments. For instance, one of the male medical experts shared the following:

> *"Patients who often present to hospitals with this problem are frequently unable to complete their treatments due to the high cost of tests, scans, medication, treatment and necessary follow-up. Some of them turn to non-medical which sometimes cause other health problems."*

Another medical expert said,

> *"In our society, the option of genetic engineering is limited in fertility treatment area, and to be honest, it is extremely expensive even for state, therefore advanced fertility treatments and specialized staff in tertiary care health departments are missing, and owing to government disinterest, we lack the resources for them. Therefore, private sector caters infertility related advanced treatment within permissible boundary"*

Another female medical practitioner shared,

> *"Government has its own limitations due to religion and culture norms. The state can monitor private clinics and faith healers to protect patients but cannot allow surrogacy or involvement of a third party which is generally popular practice in western countries.*

High costs, inadequate capacity in government services, and cultural barriers restrict access to assisted reproductive technologies (ARTs) in Pakistan.

**Subtheme: Private Matter, Data Deficits, and Governance Dependencies**

A male respondent's remarks were significant because they demonstrated that most experts continue to believe that infertility is still not a matter requiring any public investment. This represents a major systemic flaw in the medical system. In addition, over half of the respondents also felt that there is no systematic collection of data regarding infertility. One male health official highlighted the dependency and limitations of the government,

> *"The government is dependent on international funding to design and execute health projects. Before launching policies or programs, the government needs data. The level of infertility (due to genetic and environmental causes) in modern societies is unknown, and we do not even have this indicator in our health or demographic surveys, I am even not sure if we have record of refereed cases …"*

Another male respondent said,

> *"Advanced infertility treatments are expensive; our government cannot support them due to financial constraints." In Pakistan where international donors are funding us to control the population, I don't' think they would be concerned about infertility in Pakistan; to be honest it is considered concern of developed countries, they have money and expertise"*

Because infertility is not statistically represented in health and demographic surveys, public policy authorities stressed that it is not included in governmental priorities. They contend that measurable metrics that support the allocation of resources and foreign funding are necessary for policy inclusion. They further claimed that improved treatments are "a preoccupation of wealthy countries," framing infertility as financially impossible for government intervention. They did this by tacitly endorsing the view that infertility remains a private matter that does not involve state responsibility. Conversely, medical practitioners focus on actual impacts associated with being ignored. They noted systemic negligence at tertiary facilities, and a lack of referral records, all of which hinder infertility from being acknowledged as a serious medical concern. Practitioners saw how patients resorted to private or unregulated providers, increasing their

health risks, when faced with exorbitant charges and no public alternatives.

**Theme 3 : Prospects, State Assistance, Ethics, Awareness, Records**

The reproductive justice paradigm, which emphasizes the freedom to procreate not just to avoid pregnancy as central to equitable and responsible health systems, is in line with the practical measures that respondents highlighted to make infertility visible and manageable within Pakistan's health system. These measures include state funding for basic infertility care, capacity-building for medical professionals, ethical oversight through transparent counseling and reporting of success rates, policy revisions and public awareness campaigns, and the development of referral records and survey indicators. Medical experts emphasized the necessity of structural and budgetary measures. One male practitioner suggested,

> *"We have the health card model; state-subsidized support can be supplied to them in the future after determining specific conditions (e.g., couples with primary infertility and who have higher medical prospects to conceive through IVF with financial concerns)."*

Another female medical expert suggested,

> *"I would suggest that the government needs to give funding to upgrade public hospitals' facilities for infertility treatment. Besides this, we also need to change those mindsets that target infertile couples,"*

Multiple approaches have been suggested like reducing stigma requires technological solutions as well as cultural transformation. To this end, many public health leaders are focusing their attention on issues related to accountability and to governance.

> *"First, we need to build indicators in our health surveys and demographic surveys to quantify the prevalence of this problem; we need data to design projects and urge the state to allocate funds for that,"* (representative of the planning and development board)

A respondent from Tertiary healthcare emphasized the importance of ethical regulation of the private sector.

> *" Private sector should following all medical ethics and not taking advantage of the weakness of infertile couples when arranging their expensive advanced treatment,"*

The two main components of this strategy are: developing the capability of states to provide better services for men and women with infertility and developing the ability to use data from infertility to build and use laws and regulations to increase the level of attention to infertility on national health agendas. A comprehensive view of how to achieve reproductive justice is not only about having resources and knowledge but also having moral protections and a transformation in society.

## Discussion

The results show that ignoring infertility on Pakistan's reproductive health agenda is not only an oversight or lack of services. It reflects, instead, a political hierarchy of priorities for reproductive health services. According to Foucault (2014,1991), the state's strategic investment into certain reproductive outcomes and lack of investment into others shows how reproductive governance works by recognizing and supporting different groups of people through a biopower lens. In the example of infertility, infertility is consistently seen as peripheral to public health accountability, although infertility has tremendous social implications and impacts in a society where childbearing is an essential component of the stability of marriages, legitimacy of gender, and social belonging for members of that society.

Infertility's place as a marginalized issue within health policy shows that the exclusion of those unable to conceive is not just the result of a lack of concern for their situation, but also demonstrates the social standards, norms, and constructs that define social responsibility for members of various communities (Sherman, 2015).

When the state does not meaningfully include infertility data into its health data systems, public priorities, and budgetary frameworks, there are systemic institutional barriers to the state's recognition of infertility as a valid domain of intervention. The failure to account for infertility in health policy and provision is neither coincidental nor happens in isolation; instead, it illustrates political arrangements ordering reproductive issues in which donor priorities, demographic objectives, and population management strategies consistently outweigh claims for reproductive justice (Briggs, 2002; Ginsburg & Rapp, 1995; Stopler, 2015). In this regard, infertility is not simply an area of neglect, but a displacement created by reproductive policy that has greater focus on controlling fertility than providing equal assistance to those who want to become parents. The results of this research demonstrate that demographic governance could regulate both excessive birth rates, as well as making

statistically insignificant the institution of involuntarily childless individuals.

The gendered nature of infertility treatment was demonstrated by participant descriptions of the diagnostic process where women are routinely tested and held accountable for their infertility while men can usually escape testing and avoid the assessment from a clinician. This fits with Connell (2005) who describes hegemonic masculinity as a concept used to examine how male reproduction becomes tied symbolically to power/authority/social worth, therefore testing for male infertility can threaten the concept of masculinity.

The concept of gender performativity, as discussed by Butler (1990), makes clearer the point that reproductive responsibility is not an inherently biological characteristic, but rather one that is an outcome of repeated social expectations for women to be held responsible for reproductive failure. Thus, when women's bodies get medicalized, this is one way in which patriarchal norms are perpetuated in clinical settings.

Previous research has shown that women's infertility is more frequently investigated than men's, even when the cause of infertility may come from the male partner (Ahmadi et al., 2011; Fathalla, 1998; Petok, 2015). Additionally, male reproductive health is often devalued by stigma, a lack of communication about men's reproductive issues, and negative cultural beliefs about men in the context of infertility; this lack of emphasis about male reproductive health creates barriers for men to pursue testing and reinforces the gendered attribution of blame for infertility (Arya & Dibb, 2016; Goodman, 2022; Roudsari et al., 2023). The importance of the mentioned pattern is not only that the clinical practices within it are unequal and in addition, there is a wider social construction of blame, particularly on women and their bodies in medical and household environments, and then, in comparison, men's reproductive condition is also socially protected in a manner, and this provides the basis for a diagnostic double standard which reproduces both gender inequity as well as an unequal emotional burden.

The results highlight the way access to fertility treatment is impacted by economic and geographic disparities. Access to care is often dependent on finances or where care is provided, but access to treatment can also come at a cost in the privatized market for services and pose a greater risk to people of lower socio-economic status. The rationale for viewing access to fertility treatment in this context then, is that indirectly indicates the extent to which infertility exists because of the economic conditions limiting access to treatment or causing issues in treatment (Shanner & Nisker 2001). In terms of reproductive justice, access to fertility treatments

is only possible if there are equal and fair opportunities to become pregnant under appropriate socio-economic circumstances.

The structural inequalities described above are also connected to wider patterns of reproductive selection found globally and post-colonially. The fact that contraceptive and fertility control are prioritized over infertility treatment reflects an historically established logic about how reproductive health interventions are funded in the Global South. Reproductive health interventions that demonstrate the ability to assist with demographic management goals are more often funded than those that do not (Asemota & Klatsky, 2015; Briggs, 2002; Ginsburg & Rapp, 1995; Wang, 2022). Therefore, based on these findings, infertility often gets relegated to being considered secondary and elite compared to the goals of governmental policies involved with population control. This has been documented as part of the larger criticism of neoliberal forms of reproductive governance whereby economic productivity, cost-effectiveness and donor alignment determine what constitutes a legitimate priority within the field of reproductive health (Bharadwaj, 2016; Inhorn & Patrizio, 2015; Ombelet, 2020). The marginalization of infertility within the Pakistani context cannot be understood as an isolated national problem; rather, it is part of a larger political economic system whereby certain reproductive paths and futures are valued by political and economic systems while others continue to be devalued.

The recommendations made by practitioners and government officials suggest a possible alternative framework; specifically, those making these recommendations call for more inclusion of infertility in data collection, more ethical oversight of infertility practices, and an increased role of the public sector in the provision of assistance to couples struggling with infertility. As these stakeholders come to view infertility as a policy issue rather than merely a private problem of failure, these recommendations represent opportunities for moving infertility out of the periphery of reproductive health and into the realm of institutional accountability.

The inclusion of infertility in data and programming systems is especially important, because once the data are collected, they will be much more likely to have governance, funding and visibility from a political standpoint (Hennink et al., 1998). This type of shift would not remove the social stigma associated with infertility; however, this type of change could help challenge the belief that a desire to have children is not an obligation of a public health system.

The conclusion is that the issue of infertility has been largely politically excluded from being included as part of reproductive governance in Pakistan. The difficulty of access to this type of care is not just primarily due to a lack of services but is also due to a selective

distribution of care available that is supportive for some reproductive outcomes but not for others. The issue of infertility needs to be seen as a key point in which the notions of biopower, gender inequity, classism, and reproductive injustice converge (Foucault; 1983, 1991; Ross; 2020).

## Conclusion and Recommendations

Infertility remains an overlooked area of reproductive health in Pakistan. Although infertility has gradually increased as a health concern, maternal health, family planning and population control continue to dominate national and provincial health policies in Pakistan. The selective enforcement of guidelines supports patriarchal norms by imposing heavy restrictions on women undergoing assisted reproduction while neglecting male infertility. Infertility must be integrated into national and provincial reproductive health agendas to ensure reproductive justice in health care. To reduce costs associated with reliance upon expensive treatments, access to culturally appropriate and affordable infertility diagnosis and treatment services within public governments must be expanded to protect the reproductive rights of couples. Increased visibility of infertility data is necessary; infertility should always be recorded in statistics, and Demographic and Health Surveys should include indicators for infertility instances to guide future resources. Additionally, to provide gender-inclusive healthcare, policies must address eliminating patriarchal standards, acknowledging that male reproductive health challenges and eliminating gender prejudices in the medical discourse and practice. In the end, there must be strict ethical oversight for public and private health care providers. Such policies will reduce systemic inequity and expand availability of reproductive health care resources in Pakistan.

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## Annexure 1

**Table 1: Demographics of Public Health Officers**

| Gender | Professional area | Experience | Qualification |
|---|---|---|---|
| **Female** | District Lahore Health Education officer, Health Care Department | 16 years | MPhil Public Health |
| **Male** | Deputy Director, Health Care Department | 10 Years | MBBS |
| **Male** | Program Manager, Planning and Development Board, Punjab | 10 Years | MBBS |
| **Male** | Deputy Director, Punjab Population Welfare Department | 14 Years | Masters' and PPSC |
| **Male** | Tertiary Care and Medical Education Department | 12 Years | Masters, FPSC |

**Table 2: Demographics of Public Health Practitioners serving in tertiary health care**

| Gender | Professional area | Experience |
|---|---|---|
| **Female** | Gynecologist Tertiary Care Public Hospital | 10 Years |
| **Female** | Associate Professor (Gynecologist) Tertiary Care Public Hospital | 21 Years |
| **Female** | Assistant Professor Obstetrician Gynecologist Tertiary Care Public Hospital | 16 Years |
| **Female** | Assistant Professor Obstetrician Gynecologist Tertiary Care Public Hospital | 15 Years |
| **Female** | Associate Professor Obstetrician Gynecologist Tertiary Care Public Hospital | 20 Years |
| **Male** | Urologist, Public Hospital | 10 Years |
| **Male** | Urologist, Assistant Professor Tertiary Care Public Hospital | 16 Years |
| **Male** | Registrar, Urologist, Tertiary Care Public Hospital | 14 Years |
| **Male** | Assistant Professor, Tertiary Care Public Hospital | 15 Years |