

Gender Inequality and the Social Consequences of Infertility in Rural Punjab, Pakistan: A Human Rights Perspective

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Abstract

Background: Infertility is an important concern regarding public health and social justice in developing countries as the patriarchal norms in these societies often put disproportionate burden on females. The gender inequality deepens the psycho-social and economic impacts of infertility in rural areas of Pakistan nurturing important worries about the reproductive rights, dignity and an equal access to healthcare.

Objective: The present research investigates how gender inequality constructs the social effects of infertility among rural couples in Central Punjab, Pakistan, from a perspective of human rights.

Methods: This study adopted a quantitative cross-sectional research design. A sample of 457 infertile couples was selected through multistage sampling from four rural districts of Central Punjab (Lahore, Faisalabad, Jhang and Nankana Sahib). The data were collected using interview schedule which further were analyzed on Statistical Package for the Social Sciences through descriptive and inferential statistical techniques.

Results: Findings of the study highlight pervasive gender-based inequalities linked with infertility as 58% respondents reported facing social stigma and 55.6% experienced social exclusion. Almost 68.7% respondents faced pressure from their families to conceive children. 52.1 % females were blamed for infertility and a high level of secondary marital threats (Mean = 3.75) were reported by the respondents reflecting women's discriminating vulnerability within marital relationships. Furthermore, 62.1% respondents reported experiencing anxiety and depression while 70% recognized the high cost of treatment as major hurdles to healthcare access. Apart from this, the perceptions of divine retribution and the evil eye (cultural fatalism and religious beliefs) delayed medical treatment for over 40% respondents.

Conclusion: This research depicts that infertility is not merely a medical condition but a human right and gender justice issue in rural areas. It is essential to address the discriminatory social norms, strengthening legal and social policy protections and improving equitable access to reproductive healthcare to safeguarding the dignity, equality and reproductive rights of infertile couples particularly women.

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INTRODUCTION

Infertility is a multifaceted health issue that is not merely a biological or medical condition but encompasses deep socio-psychological, economic and human rights consequences. As estimated by the World Health Organization (WHO, 2023) almost every sixth individual worldwide faces infertility during the reproductive years, depicting that infertility affects population irrespective of social and economic status, geographical location or cultural background. Despite ARTs (Assisted Reproductive Technologies) and infertility treatment,

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the access to reproductive healthcare is highly unequal especially in low- and middle-income countries. The financial constraints, inadequate healthcare infrastructures and deeply rooted social and cultural beliefs in these countries continue to limit timely diagnosis and treatment (World Health Organization [WHO], 2023). Resultantly, infertility has arisen as a critical issue across the globe with discussions on reproductive justice, gender equality and universal access to healthcare.

Infertility has severe consequences in societies where marriage is closely linked with childbearing and fertility is regarded as a prerequisite for social acceptance and family continuity. The parenthood is considered not only as a personal choice but as a cultural obligation that ensures lineage, inheritance and social status in many Asian and African countries (Inhorn & Patrizio, 2015). Those couples who don't conceive often face social marginalization, community stigma and emotional distress and these consequences are rarely distributed equally between spouses as women disproportionately experience the social burden of infertility because reproductive success is traditionally linked with feminine identity and marital worth (Greil et al., 2010; Starrs et al., 2018). This unequal treatment highlights broader structural inequalities rooted within patriarchal societies where gender norms construct family relationships, access to resources and individual life opportunities.

In developing countries, gender inequality is a vital determinant of the reproductive health experiences. As reported by the United Nations Entity for Gender Equality and the Empowerment of Women (UN Women, 2023), the discriminatory social norms keep restricting the autonomy of women in decisions regarding health, education, employment and reproduction. The expectations regarding reproduction frequently highlight unequal power relations within households where females are expected to fulfil maternal roles prescribed by society regardless of biological realities. In case of failure to conceive, they experience blame, discrimination, psychological abuse, domestic violence, social exclusion and marital instability although infertility stems from male factor (United Nations Population Fund [UNFPA], 2022). This highlights how reproductive capacity becomes a mechanism through which gender inequality is reproduced and normalized within society.

Infertility symbolizes a socially constructed phenomenon whose meaning extends far beyond medical diagnosis from a sociological perspective as interactionists claim that social meanings attached to infertility are created through continuous interactions among individuals, families and communities affecting how infertile couples perceive themselves and are perceived by the others (Blumer, 1969). Similarly, the feminists argue that reproductive expectations are rooted within patriarchal power structures that honor the social positions of men while assigning female primary responsibility for reproduction (Lorber, 2012) and these perspectives illustrate that infertility should not be viewed solely as a biomedical condition but a social experience constructed by unequal gender relations, cultural expectations and institutional practices.

From the lens of the International human rights framework, reproductive health is recognized as an integral component of the right to the highest attainable standard of health as the Article 25 of the Universal Declaration of Human Rights (United Nations, 1948) forms every individual's right to health and well-being, while the International Covenant on

Economic, Social and Cultural Rights lays stress on equitable access to healthcare without discrimination (United Nations, 1966). Similarly, the CEDAW (Convention on the Elimination of All Forms of Discrimination against Women) forces states to abolish discrimination against women in healthcare ensuring equal access to reproductive health services (United Nations, 1979). Moreover, recently the Programme of Action of the International Conference on Population and Development and the Sustainable Development Goals considered reproductive rights as essential components of sustainable development, gender equality and social justice (United Nations, 2015) and all these international commitments highlight that infertility should not be viewed only as a medical problem but as an issue involving dignity, social inclusion and equality.

infertility has complex social implications within Pakistan due to the strong patriarchal family system and collectivist social structure and marriage is widely regarded as incomplete without children. The fertility is considered the primary purpose of marital life. So infertile couples especially females experience persistent family pressure, social criticism and community discrimination that extend beyond the private sphere into broader social relationships (Sami & Ali, 2011). Infertile females in many rural areas are subjected to negative labels, emotional abuse, exclusion from family ceremonies and threats of divorce. The traditional beliefs attributing infertility to divine punishment, supernatural forces or the evil eye further intensify which lead many families to get spiritual or traditional remedies before consulting qualified medical doctors (Ali et al., 2012).

Accessing the treatment of infertility also depicts broader patterns of social inequality as the primarily focus of Pakistan's reproductive healthcare system is on maternal and child health while infertility prevention, diagnosis and treatment receive comparatively limited attention from the policy makers. The major urban centers have specialized fertility services and are often financially inaccessible for rural households which create substantial differences in healthcare utilization (WHO, 2023). The limited public awareness, economic barriers, inadequate counseling services and persistent social stigma discourage many couples to seek timely medical treatment. Consequently, the infertility converts into a chronic social issue characterized by psychological distress, deteriorating marital relationships and reduced quality of life and all these inequalities point out that reproductive healthcare is a question of social justice, equitable health systems and the protection of fundamental human rights.

There exist significant knowledge gaps regarding the intersection of gender inequality, human rights and the lived experiences of infertile couples in rural areas despite the growing body of international literature on infertility as most of the existing researches have focused on clinical management, assisted reproductive technologies or psychological adjustment. Less attention has been given to the structural and institutional factors that shape gender-based discrimination. According to the reports of the studies conducted in South Asia and Sub-Saharan Africa, infertile women face greater social stigma, marital instability and emotional suffering than males and these studies are qualitative or relatively small samples limiting the generalizability of their findings (Mumtaz et al., 2013; Ombelet, 2020; Tabong & Adongo, 2013). Moreover, limited research focused on infertility within a human rights context in spite

of increasing international recognition that reproductive health is inseparable from the principles of dignity, equality and non-discrimination (WHO, 2023).

The empirical research in Pakistan has recognized multiple dimensions of infertility including cultural beliefs, treatment-seeking behavior, psychological distress and family pressure (Ali et al., 2022; Sami & Ali, 2021) but have generally examined infertility either as a medical condition or as a social and cultural phenomenon without systematically digging out how patriarchal gender relations produce unequal social consequences for males and females. Existing studies in Pakistan has also given little attention to infertility as a question of reproductive justice and human rights especially in rural perspective where traditional gender norms affect family decision-making, healthcare utilization and the social status of women. Apart from this, most available studies are geographically limited to single district or urban area. All this left insufficient empirical evidences about rural communities where access to reproductive healthcare is comparatively limited and socio-cultural pressure is often more intense.

Another important limitation exists that infertility has traditionally been investigated from medical, demographic or psychological viewpoints whereas legal and human rights dimensions have gained less attention. The contemporary debates on reproductive justice stress that access to reproductive healthcare should not be viewed only medically but as a broader issue involving equality before the law, bodily autonomy, freedom from discrimination and equitable participation in social life (Cook et al., 2003; UN Women, 2023). Resultantly, observing infertility through a socio-legal and human rights context gives a more comprehensive understanding of how structural inequalities construct reproductive experiences and affect the quality of life of affected individuals.

This study fulfills these gaps by incorporating sociological theory with human rights principles to explore gender inequality and the social consequences of infertility among rural couples in Central Punjab, Pakistan. Using feminism and symbolic interactionism, it theorizes infertility as a socially constructed experience in which cultural expectations surrounding parenthood create unequal burden for females within patriarchal family systems. The human rights perspective enables an observation of infertility as an issue extending beyond health consequences including dignity, equality, social participation and access to justice and this interdisciplinary approach contributes to the growing international discourse that acknowledges reproductive health as both a public health concern and a matter of social justice.

Empirical contribution of this study is also vital as unlike many previous investigations that relied on qualitative evidences, this study uses quantitative data collected from a sample of 457 infertile rural couples residing in Lahore, Jhang, Faisalabad and Nankana Sahib through a multistage sampling technique. The large sample from multiple districts increases the reliability and representativeness of the findings and statistical analysis using the SPSS generates robust empirical evidences regarding gender discrimination, social stigma, family pressure, marital instability, financial barriers to infertility treatment, psychological well-being and the impact of cultural beliefs on healthcare utilization.

Findings of the study are expected to make various theoretical, practical and policy contributions as theoretically, this study encompasses sociological understanding of infertility by illustrating that reproductive experiences are constructed not only by biological factors but also by unequal gender relations, cultural norms and institutional inequality. From a practical perspective, the research gives evidences that may help healthcare policymakers and professionals in formulating gender-sensitive counseling services, psychological support mechanisms and culturally appropriate infertility interventions for rural people. At the policy level, the findings provide useful guidelines for government agencies and civil society organizations for reproductive health policies, improve equitable access to infertility services, reduce gender-based discrimination and promote awareness regarding shared responsibility for infertility within marriage.

The study has international relevance as well as gender-based discrimination linked with infertility has been documented across many low- and middle-income countries where patriarchal social system shapes reproductive expectations. As a result, the evidences created from rural Punjab contribute to comparative discussion on reproductive rights, gender equality and healthcare accessibility in similar social and cultural contexts throughout South Asia, the Middle East and Sub-Saharan Africa. By associating empirical quantitative evidences with international human rights principles, this research contributes to global efforts intended to achieve the Sustainable Development Goals particularly SDG 3 (Good Health and Well-being), SDG 5 (Gender Equality) and SDG 10 (Reduced Inequalities) (United Nations, 2015) and therefore it is not only locally relevant but also internationally significant for scholars, policymakers and practitioners concerned with reproductive justice and social equity. Based on these considerations, the aim of this study is to explore how gender inequality shapes the social consequences of infertility among infertile couples in rural Punjab, Pakistan, from a human rights perspective.

METHOD

By employing a quantitative cross-sectional research design, this study aims at examining the relationship between gender inequality and social consequences of infertility among infertile couples in rural areas of Punjab, Pakistan as quantitative approach enabled the systematic measurement of respondents' experiences and facilitated statistical analysis of the social, cultural, psychological and economic dimensions linked with infertility. Cross-sectional design further provided a comprehensive understanding of the prevailing experiences of infertile couples within their social and cultural context.

This research was carried out in four rural districts of Central Punjab, Pakistan, named as Lahore, Faisalabad, Jhang and Nankana Sahib. The selection of these districts was based on purposive sampling because they represent diverse rural communities characterized by traditional cultural values, strong patriarchal family structures and varying level of access to reproductive healthcare services. Choosing Rural Punjab gives an appropriate setting for exploring infertility because childbearing is widely viewed as a fundamental expectation of marriage. The childlessness in rural areas of Punjab often carries substantial socio- cultural consequences especially for females. The married infertile couples were the target population

of the study who were residing in the selected rural districts and eligibility criteria included couples married for at least five years, had faced primary or secondary infertility as defined by the World Health Organization and were permanent residents of these four selected districts rural communities. Moreover, those couples who adopted children or declined to have participation were excluded from the research. A sample of 457 respondents was selected using a multistage sampling technique to ensure adequate geographical representation of the study population as at the first stage, four districts of Central Punjab were purposively chosen. Then at the second stage, rural villages within each district were identified and eligible infertile couples were accessed with the help of local healthcare facilities, Lady Health Workers (LHWs) and community networks operating within the selected villages. Those respondents who were meeting the inclusion criteria were selected until the required sample size was gained and this multistage approach increased the representativeness of the sample while ensuring coverage of different rural communities across Central Punjab.

The primary data were gathered using structured face-to-face interviews by a standardized interview schedule developed after review of relevant literature on infertility, gender inequality, reproductive health and social stigma. The tool had closed-ended questions designed to measure respondents' socio-demographic characteristics, experiences of social stigma, gender-based discrimination, psychological well-being, family pressure, healthcare accessibility, financial barriers, treatment-seeking behaviour and cultural beliefs. This instrument was carefully reviewed by subject experts and pilot-tested among 20 respondents outside the study area to assess its clarity, relevance and comprehensibility prior to the main survey. Necessary revisions were made before starting formal data collection. The process of data collection was completed using personal interviews because majority of the respondents had limited educational background and discussing infertility needed sensitivity, privacy and confidentiality. Moreover, the trained interviewers elaborated the objectives of the study, got informed consent from each respondent and conducted interviews in a respectful and culturally appropriate manner. Apart from this, minimizing response bias, the respondents were made assured to keep their personal information confidential and would be used only for academic research purpose. Data were analyzed through Statistical Package for the Social Sciences Version 26 and both descriptive statistical techniques and inferential statistical analyses were used to observe the association among selected variables and to determine the statistical significance of observed differences. The tables as well as narrative explanations have been used for the presentation of results facilitate interpretation and to address the research objectives comprehensively.

This study also followed internationally accepted ethical principles governing research involving human participants as prior to data collection, ethical approval was got from the relevant institutional authority and all participants voluntarily participated after a clear briefing of the objectives and procedures of the study. A written informed consent was achieved before each interview. The confidentiality and anonymity were strictly followed by removing all personally identifiable information from the dataset. Collected data was used exclusively for academic and research purposes. A special care was taken to respect the dignity, privacy and emotional well-being of respondents throughout the research process keeping in mind the sensitive nature of infertility and its related social experiences.

RESULTS

Results of this study are framed on the basis of quantitative data gathered from a sample of 457 infertile couples who are residing in four rural districts (Lahore, Faisalabad, Jhang and Nankana Sahib) of Central Punjab, Pakistan. The findings of the study have been organized regarding the objectives of the study. These findings focus on respondents' demographic characteristics, gender inequality, social stigma, family pressure, psychological consequences, healthcare accessibility and cultural beliefs linked with infertility. Moreover, the descriptive statistical techniques (frequencies, percentages, means and standard deviation) were applied to summarize the empirical evidences achieved from the participants.

Table # 1: Social and Demographic Characteristics of the Respondents (N = 457)

Variable	Category	Frequency	Percentage (%)
Gender	Male	228	49.8
	Female	229	50.2
District	Lahore	115	25.2
	Faisalabad	114	24.9
	Jhang	114	24.9
	Nankana Sahib	114	24.9
Marital Status	Married	457	100
Residence	Rural	457	100

The above table depicts the socio-demographic characteristics of respondents. Out of 457 infertile individuals, 228 respondents were males (49.8%) and 229 respondents were females (50.2%), reflecting an almost equal representation of both spouses. Participants were chosen from four rural districts of Central Punjab as Lahore (25.2%), Faisalabad (24.9%), Jhang (24.9%) and Nankana Sahib (24.9%) and this balanced geographical distribution increases the representativeness of the sample and provides a broader understanding of infertility experiences within rural Punjab.

Table # 2: Gender Inequality and Family Pressure

Variables	Response	Frequency	Percentage (%)
Women blamed for infertility	Yes	238	52.1
	No	219	47.9

Family pressure to have children	Yes	314	68.7
	No	143	31.3
Secondary marital threats	Mean Score	3.75	SD = 0.91

Table # 2 elaborates that gender inequality is a dominant feature of infertility experiences in rural areas of Punjab as almost half of the participants (52.1%) reported that women were primarily blamed for infertility despite the possibility of infertility affecting either spouse. Furthermore, 68.7% respondents highlighted facing considerable pressure from their family members to produce children. The respondents also pointed out a relatively high level of secondary marital threats indicating by a mean score of 3.75 suggesting that infertility substantially influences marital stability and family relationships.

Table # 3: Social Stigma Experienced by Infertile Couples

Variables	Response	Frequency	Percentage (%)
Experienced social stigma	Yes	265	58.0
	No	192	42.0
Experienced social exclusion	Yes	254	55.6
	No	203	44.4

Table # 3 reveals that infertility continues to be linked with substantial social stigma within rural communities as majority of infertile individuals (**58.0%**) reported experiencing stigmatizing attitudes because of their inability to have children, while **55.6%** faced various forms of social exclusion including avoidance by relatives, reduced participation in community gatherings and negative social labeling.

Table # 4: Psychological Consequences of Infertility

Variable	Response	Frequency	Percentage (%)
Anxiety and depression	Yes	284	62.1
	No	173	37.9

This table illustrates that infertility is accompanied by considerable psychological distress as almost 62.1% respondents reported facing anxiety and depression associated with childlessness. These findings indicate that infertility extends beyond reproductive health and substantially affects respondents' emotional and psychological well-being.

Table # 5: Healthcare Accessibility and Financial Barriers

Variable	Response	Frequency	Percentage (%)
Treatment financially inaccessible	Yes	320	70.0
	No	137	30.0

According to table 5, the greatest challenges experienced by the infertile couples seeking treatment were the financial barriers as 70.0% respondents identified the high cost of infertility diagnosis and treatment as a major obstacle to accessing appropriate reproductive healthcare services. These findings reflect that economic inequality substantially limits healthcare utilization among rural infertile couples.

Table # 6: Impact of Cultural Beliefs on Healthcare-Seeking Behaviour

Variable	Response	Frequency	Percentage (%)
Treatment delayed because of cultural or religious beliefs	Yes	183	40.0
	No	274	60.0

Table 6 indicates that cultural and religious beliefs has a great influence on healthcare-seeking behaviour among infertile couples as approximately 40% participants highlighted delaying medical treatment because infertility was attributed to divine punishment, fate, spiritual causes or the evil eye. Such beliefs lead towards the postponement of professional medical consultation and increased dependence on traditional or spiritual healing practices before seeking clinical treatment.

DISCUSSION

The findings of this research illustrate that infertility in rural Punjab, Pakistan, is not only a medical problem but a complex social and human rights issue constructed by gender inequality, patriarchal cultural norms and limited access to reproductive healthcare. The females continue to face an unequal share of the social effects of infertility despite the fact that infertility may affect either spouse. The family pressure, social stigma and blame directed toward women highlights deeply rooted patriarchal beliefs that linked motherhood with feminine identity and marital success. These findings align with Feminist Theory argue that reproductive expectations reinforce unequal gender relations and place greater responsibility for childbearing on women (Lorber, 2012). Almost same patterns have been recognized in South Asia and Africa where infertile women face discrimination, emotional abuse and marital insecurity (Inhorn & Patrizio, 2015; Ombelet, 2020).

The study further explores that infertility is closely associated with social exclusion and psychological distress as many respondents reported anxiety, depression and reduced

social participation due to persistent societal expectations regarding parenthood. The infertility gets negative social meanings through interactions within families and communities resulting in stigmatization and diminished self-esteem as mentioned by interactionists (Blumer, 1969). These findings are aligned with previous research illustrating that infertility significantly affects individuals' emotional well-being and quality of life (Greil et al., 2010; WHO, 2023). The financial hurdles were another major barrier to infertility care as the high cost of diagnosis and treatment limits access to reproductive healthcare for many rural couples indicating broader inequalities within the healthcare system. Moreover, cultural beliefs and religious interpretations such as divine punishment and the evil eye delayed medical consultation. These findings depict that healthcare-seeking behaviour is affected not only by economic resources but also by cultural perceptions surrounding infertility. Increasing public awareness, improving reproductive health literacy and involving community and religious leaders in health promotion initiatives could be helpful in reducing misconceptions and support timely medical treatment. The findings highlight that infertility should be recognized as an issue of equality, dignity and access to healthcare rather than only a reproductive health problem from a human rights perspective. Persistent gender discrimination, social stigma and unequal access to infertility services internationally acknowledged reproductive rights and reflect the need for stronger legal and social policy interventions. All this needs expanding affordable infertility services, integrating infertility care into public reproductive health programmes, promoting gender-sensitive counseling and strengthening legal protection against discrimination to improve the well-being of infertile couples and advancing reproductive justice.

Despite its contributions, this research has some limitations as cross-sectional design restricts the causal interpretation. Moreover, the findings are confined to rural areas of Central Punjab. Future studies should use longitudinal or mixed-methods approaches including additional provinces and investigate variables such as legal awareness, healthcare quality and coping strategies. However, this study indicates that addressing infertility requires an interdisciplinary approach combining healthcare services, legal protection, public awareness and gender-sensitive social policies to ensure the dignity, equality and reproductive rights of infertile couples.

CONCLUSION

This study indicates that infertility in rural Punjab, Pakistan, extends beyond a reproductive health condition and should be understood as a multidimensional problem constructed by gender inequality, cultural norms, patriarchal social structures and unequal access to healthcare. By observing infertility through the combined perspectives of sociology and human rights, the study illustrates that women unequally face social stigma, family pressure, psychological distress, marital insecurity and discrimination, despite infertility being a condition that may affect both gender equally. These findings argue that infertility is not only a medical issue but also a matter of social justice, equality, dignity and reproductive rights. Feminism, Symbolic Interactionism and Human Rights approaches gives a comprehensive explanation of how unequal gender relations and socially constructed beliefs formulate the lived experiences of infertile couples within rural communities. Moreover, this

interdisciplinary perspective represents the principal academic contribution of the study by expanding existing sociological research beyond traditional medical and psychological interpretations of infertility. It also presents important practical and policy implications by highlighting the need for gender-responsive reproductive health policies, affordable infertility diagnosis and treatment services, psychosocial counseling, and community-based awareness programmes that challenge misconceptions about infertility and promote shared responsibility between spouses. Moreover, the policymakers should reinforce the legal and institutional mechanism that protects infertile individuals from discrimination and ensure equitable access to reproductive healthcare, particularly in underserved rural areas. Such kind of interventions would lead to improve the quality of life of infertile couples while supporting Pakistan's commitment to reproductive justice, gender equality, and universal health coverage.

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AUTHOR CONTRIBUTION STATEMENT

Dr. Khizar Hayat designed the study, developed the research framework and methodology, conducted the data collection, performed statistical analysis, interpreted the findings and prepared the original manuscript. Dr. Ayesha Chaudhary contributed to the conceptual development of the study, provided methodological guidance and academic supervision, critically reviewed the manuscript for important intellectual content and contributed to the interpretation of the findings and revision of the final draft. Both authors reviewed, approved the final version of the manuscript and agree to be accountable for all aspects of the work.

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