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Reproductive bodies as politically contested sites:

The Politics of Framing Infertility for the Global Agenda for Sexual and Reproductive Health and Rights

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Abstract

Recent estimates by the World Health Organization show that one in six people globally experience infertility at some point in their lives. Infertility is a fundamental reproductive health concern affecting an individual's human right to freely decide if, when, and how many children to have. A growing body of literature notes infertility's absence from the sexual and reproductive health and rights (SRHR) agenda, at the same time that global demographic anxieties have elevated infertility into a political issue, with resources and access stratifying reproductive possibilities. This thesis addresses the lack of research on the political process of advocating for infertility within the SRHR agenda, by uncovering the framings employed by global experts in their attempt at elevating infertility within SRHR. Based on a frame analysis of qualitative expert interviews, their infertility framings are traced as part of an agenda-setting process, revealing a pragmatic approach that favours politically advantageous framings over explicitly rights-based ones, as experts navigate larger structural frames. This thesis contributes insight into the political process of agenda-setting and the compromises behind infertility advocacy, opening up further inquiry into the institutions and narratives that shape how infertility reaches the SRHR agenda and fundamentally, whose infertility is addressed.

Keywords: Infertility, agenda-setting, global health advocacy, reproductive justice, framing, sexual and reproductive health and rights, expert knowledge

Word count: 14.994

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List of abbreviations

Abbreviation	Definition
ARTs	Assisted Reproductive Technologies
LMICs	Lower-Middle Income Countries
MNCH	Maternal Newborn and Child Health
NGO	Non-Governmental Organisations
PHC	Primary Healthcare
RJ	Reproductive Justice
SRHR	Sexual and Reproductive Health and Rights
SWOP	State of the World Population Report
UHC	Universal Healthcare
UNFPA	The United Nations Population Fund
WHO	World Health Organization

Glossary of terms

Term	Definition
Agenda	"The list of subjects or problems to which governmental officials, and people outside of government closely associated with those officials, are paying some serious attention at any given time." (Kingdon, 2014, p.3).
Framing	"Selecting some aspects of a perceived reality and make[ing] them more salient in a communicating text, in such a way as to promote a particular problem definition, causal interpretation, moral evaluation, and/or treatment recommendation." (Entman, 1993, p.52)
Infertility	"A disease of the male or female reproductive system defined by the failure to achieve a pregnancy after 12 months or more of regular unprotected sexual intercourse." (WHO, 2023, p.ix)
Primary Infertility	"When a pregnancy has never been achieved by a person." (WHO,2023, p.26)
Reproductive Justice	"A political movement that splices reproductive rights with social justice to achieve reproductive justice … where the main principles are (1) the right not to have a child, (2) the right to have a child, (3) the right to parent children in safe and healthy environments, as well as demanding sexual autonomy and gender freedom for every human being .. The heart of the claim is that all fertile persons and persons who reproduce and become parents require a safe and dignified context for these most fundamental human experiences." (Ross & Solinger, 2017, p.9)
Secondary Infertility	"When at least one prior pregnancy has been achieved." (WHO, 2023, p.26)
SRHR	"Sexual and reproductive health is a state of physical, emotional, mental, and social wellbeing in relation to all aspects of sexuality and reproduction, not merely the absence of disease, dysfunction, or infirmity. Achievement of sexual and reproductive health relies on the realisation of sexual and reproductive rights, which are based on the human rights of all individuals to: have their bodily integrity, privacy, and personal autonomy respected; freely define their own sexuality, including sexual orientation and gender identity and expression; decide whether and when to be sexually active; choose their sexual partners; have safe and pleasurable sexual experiences; decide whether, when, and whom to marry; decide whether, when, and by what means to have a child or children, and how many children to have; have access over their lifetimes to the information, resources, services, and support necessary to achieve all the above, free from discrimination, coercion, exploitation, and violence." (Starrs et al., 2018, p.2646)

1. Introduction

Infertility has long been a neglected issue on the sexual and reproductive health and rights (SRHR) agenda, despite the fact that as early as 1994, the International Conference on Population and Development's landmark Programme of Action recognised the right to fertility services, and called on signatory countries to make accessible the prevention and treatment of infertility (Zuccala & Horton, 2018; United Nations, 1994; Gipson et al., 2020). Not only has infertility been overlooked, but it is an essential component of SRHR, as it intersects with other core areas such as family planning, HIV/AIDS, gender based violence, female genital mutilation, abortion amongst others (Gerrits et al., 2023; Gerrits et al., 2017; Smith et al., 2025; Nnagbo et al., 2024). In addition, access to fertility care is foundational to ensuring the human right to "*decide freely and responsibly the number, spacing, and timing of children*" (United Nations, 1994, p.60; Barnes & Fledderjohann, 2020). Despite this, the past 30 years have seen little progress (Gerrits et al., 2023; Starrs et al., 2018), and in 2018 the seminal Guttmatcher-Lancet Commission on SRHR similarly noted that infertility has been underprioritised and lacked the visibility that other issues on the agenda enjoy (Starrs et al., 2018; Gipson et al., 2020).

Coinciding with the rise of demographic anxieties and simultaneous fears of overpopulation and underpopulation across the world (UNFPA, 2023; UNFPA, 2025), infertility is poised to become more central to global political, developmental, and health agendas. There is growing reproductive justice informed research on infertility in global health, sociology and anthropology in various contexts across the world, building on top of a larger body of medical research and technological advancements on fertility care from the past four decades (Eskew & Jungheim, 2017). Recent global estimates by the World Health Organisation (WHO) on infertility prevalence and their first ever guidelines on infertility have garnered heightened visibility and urgency, estimating that one in six people worldwide are experiencing infertility (WHO, 2023; WHO, 2025; Shah & Gher, 2023). Despite this visibility, lacking resources and unequal access to care continues to stratify reproductive possibilities (Thoma et al., 2021a). This presents a critical juncture in global infertility advocacy, where visibility and research are increasing but there is a distinct lack of research on the ongoing political process that lies behind putting infertility on the SRHR agenda. Understanding this political process at this crossroads is essential as it allows for

a critical examination of the compromises, power dynamics and strategic trade-offs that will inevitably shape not only whether infertility reaches the agenda, but whose infertility is addressed and at what normative cost.

1.1 Research Aim

In light of the above, this thesis aims to uncover the arguments and calculations behind framings of infertility, particularly among the expert elite as they are shaping global approaches to infertility advocacy and policy. Using a qualitative frame analysis and applying a theoretical framework of agenda-setting, power in SRHR, and normative concepts of reproductive imaginary and stratified reproduction to ten expert interviews, the analysis will uncover the tensions, logics and compromises behind expert framings of infertility, as well how they maneuver larger structural frames in the agenda-setting process. This research aims to contribute to a greater understanding of how infertility is framed in politically advantageous ways through the insights of experts with direct links to major agenda-setting UN agencies which will eventually inform global infertility policy.

1.2 Research Questions

The overarching research question guiding this thesis is:

How is infertility framed within advocacy efforts to include it on the global sexual and reproductive health and rights agenda?

The sub-research questions that will structure the analysis and discussion are as follows:

1. *How do experts frame infertility?*
2. *How do structural frames influence expert framings of infertility?*

1.3 Delimitation

This study has several important delimitations that shaped its inherent scope as a thesis, and answers the research question by examining a narrow set of parameters. It does not interrogate the agenda-setting process as a whole or provide a longitudinal view of agenda-setting infertility, rather it examines one step of this process, namely how experts, whose opinions form the base of agenda-setting policy formation processes, themselves frame infertility. Therefore it does not aim to definitively determine how all experts view infertility, rather it highlights the framing strategies, structural constraints and political calculations of a select group of influential experts, offering an exploratory account of infertility advocacy that intends to open up further inquiry. Lastly, the analysis of the global SRHR agenda and the global experience of experts means that it will stay at the global level, as the structural dynamics and tensions that emerged across experts' accounts were not found to map neatly onto these geographical distinctions. Many experts and much literature address infertility in the Global South, but experts' experiences have also explicitly drawn on their national settings in the Global North. The analysis therefore operates at the global level rather than drawing national or other context-specific cases.

2. Background

This section will outline the causes and prevalence of infertility as well as highlighting seminal publications forming part of the growing agenda-setting process for infertility. These are referenced by experts and contrasted to the study findings in the discussion chapter.

2.1 Causes of infertility

Infertility is commonly understood as the failure to achieve pregnancy (Díaz & Watkins, 2025). Different disciplines, such as epidemiology or demography have varying definitions as well (Bell et al., 2025), but for the purposes of this paper, the WHO definition is used alongside the distinction between primary and secondary infertility, by virtue of the UN and WHO's authority in the health and development sector (Gostin et al., 2015). Infertility in both male and females is often associated with congenital causes present at birth, such as genetic abnormalities, and developmental abnormalities in the genital tract, or acquired causes such as urogenital infections,

malignancies, endocrine disturbances and gonadotoxic exposures to mention a few (WHO, 2025). Underlying risks of infertility can range from biomedical factors affecting reproductive systems, or factors such as postpartum infections, unsafe abortions and some sexually transmitted infections, to possible environmental factors (WHO, 2025; Díaz & Watkins, 2025). Importantly, male factor infertility contributes to 45.1% of infertility cases, and many infertility cases also have unexplained causes, with more research needed to estimate the proportions of male, female, and unexplained factors causing infertility among the reproductive age population (WHO, 2025).

2.2 Global infertility prevalence

The WHO is the only international agency that collects and publishes data on infertility prevalence globally. A WHO report from 2023 estimated for the first time the global prevalence of infertility based on data from 1990 to 2021, revealing that approximately one in six people globally have experienced infertility at some stage in their lives. The report measures infertility in two ways, first is lifetime prevalence, which refers to the proportion of the population who have ever experienced infertility, and period prevalence, which refers to the proportion of the population with infertility at any given point in time (WHO, 2023). Lifetime prevalence of infertility is 17.5% globally, while period prevalence is 12.6% (WHO, 2025). Lifetime prevalence was the highest in the WHO Western Pacific Region, and period prevalence was the highest in the WHO African Region (WHO, 2025).

2.3 Seminal Publications

The emerging global health and SRHR focus on infertility is marked by the publishing of the United Population Fund's (UNFPA) 2025 State of the World Population (SWOP) Report focusing on the fertility crisis and reproductive agency, as well as the WHOs first ever Guideline for the Prevention, Diagnosis and Treatment of Infertility in 2025. These documents signal an increasing emphasis on infertility as a global, reproductive health issue by two leading UN agencies, in other words, it can be seen as part of the effort to establish infertility within the SRHR agenda. UNFPA's annual SWOP report is a policy-shaping document that often reflects evolving SRHR norms, evidence and advocacy. It frames infertility as an issue of reproductive autonomy and rights to decide if, when and how many children to have (UNFPA, 2025). It also

emphasised the social aspects of infertility, such as the stigma, gender norms and social exclusion that particularly women face. In contrast, the WHO guideline is a more technical and epidemiological intervention that aims to standardise the field of infertility services and care by outlining evidence-based recommendations that countries can use. It also underscores that it aims to address inequities in the access, availability and quality of infertility services.

3. Literature Review

This chapter provides an outline of the current research (Bhattacherjee, 2012c) on agenda-setting in SRHR and on infertility in SRHR and illuminates the research gap in the field that this thesis will address. Using a narrative literature review, a qualitative summary of research relevant to the research question is presented which is fitting for new and emerging fields (Khatri et al., 2026), such as the study of infertility within SRHR. Due to the novelty of this research area, this review reveals an analytical understanding of the ongoing discussions and gaps of infertility within SRHR and global health. It is thematically categorised into four sections and structured as a funnel, closing in on my research question. This literature review moves from (1) general agenda-setting dynamics in SRHR to the specific case of infertility, (2) examining its marginalisation, (3) its intersections with inequality and reproductive justice (RJ), and (4) the advocacy efforts seeking to bring it onto the SRHR agenda.

Academic articles were searched for the databases JSTOR, PubMed, The Lancet, Science Direct, Google Scholar and Lund University's online library search tool FINN. Keywords and search strings used are outlined in the table below:

Categories	**Keywords**
Field of research	Global health, SRHR
Topic	Infertility, fertility, involuntary childlessness, subfecundity
Research focus	Agenda-setting, advocacy, understandings of, framings of, definitions of, social condition, access, services, care, global

Table 1: Overview of key words

Articles were filtered by reviewing abstracts and were excluded if they focused exclusively on biomedical or clinical dimensions of infertility, did not address policy, advocacy or social dimensions, if they investigated individual patient experience without broader structural or political relevance or if they did not engage with the SRHR or global health agenda or the political dimensions of infertility. A total of 25 articles have been selected for review.

3.1 Agenda-setting SRHR issues

Beginning with an overview of literature on general agenda-setting dynamics in SRHR, Edouard (2023) outlines several aspects of agenda-setting in reproductive health to take into consideration, arguing that prioritisation is often influenced by political and historical pressures and discusses the role and risk of religious and private sector actors providing health services, common in many contexts. He stresses that prioritising within the agenda must be based on evidence of effective interventions rather than disease burden alone, and underscores the need for a rights based approach.

More specifically, Joachim (2003) examines these political and structural factors of agenda-setting with a specific case, tracing how non-governmental organisations influenced governments to adopt women's rights issues onto UN agendas through the adoption of the ICPD's 1994 Platform of Action on Population. The author outlines the agenda-setting process of women's rights NGOs by showing the importance of a conducive political opportunity structure and powerful allies as well as the role of their own experts and internal entrepreneurs. Smith and Rodriguez (2016) examine how the previously neglected issue of maternal health and mortality became a central part of the SRHR agenda through its inclusion in the Millenium Development Goals in part due to framing strategies that associated it closely with newborn and child health. In addition, the rise of a diverse network of actors with political capital beyond the technical experts and the creation of alliances was key in advocacy efforts.

Similarly, McDougall (2016) outlines the creation of the Global Strategy for Women's and Children's Health and the negotiations between the SRHR and the maternal, newborn and child health (MNCH) advocacy coalitions. Debates between the coalitions resulted in both sides

adjusting their framings to gain political attention without sacrificing their core beliefs, providing insight into the policy-making process and the prioritisations coalitions must make in their advocacy. In contrast to the research above, Danquah and Koray (2025) explicitly use Kingdon's agenda-setting theory to map out strategies for policy change to support contraceptive access in Ghana, identifying constraints and opportunities in agenda-setting. They give concrete recommendations such as strengthening data systems for an improved evidence base and identifying actors with political capital to advocate for this issue. Although these studies are not specifically related to infertility, they provide key insights into the process and factors around agenda-setting other SRHR issues. This has placed infertility advocacy within a larger context of earlier successful agenda-setting processes in SRHR.

3.2 Infertility as a neglected SRHR issue

Turning towards infertility on the SRHR agenda, there is a broad consensus in the literature that infertility is neglected. Scholars such as Ombelet et al. (2008), point to its neglect within primary health care (PHC) and family planning and notably also mention political factors around this, explaining that "*the idea of infertility treatment in developing countries often evokes a feeling of discomfort and disbelief*" (p. 609). Articles by Zuccala & Horton (2018) as well as Mburu et al. (2023), add to this advocacy by explicitly linking it as an essential part of achieving the Sustainable Development Goals. Mburu et al. (2023) argue among other things that contraception and fertility care are two sides of the same coin that can and should be addressed in tandem. This is a unique framing in the literature, as other authors have used contraception and family planning as examples on the field's overemphasis on family planning and reducing fertility (Ombelet et al., 2008; Ombelet, 2011).

Additionally, Fauser et al. 's (2024) narrative review of literature on declining fertility rates creates a similar framing of infertility, arguing that it should be addressed within approaches to 'family building'. It aims to align family planning with family building, where the latter recognises diverse family configurations and encompasses the many methods to achieve this, having a more holistic approach than traditional 'family planning' is associated with. Gipson et al. (2020) echo the previous authors in recognizing infertility as a neglected component of SRHR, but instead frame infertility as part of a 'double burden' faced by many Global South

countries, who are also struggling with high rates of unintended pregnancy. It goes further than Mburu et al. (2023) by arguing that not only should infertility be addressed alongside an unmet need for contraception, but that the reproductive lifecourse approach should integrate efforts to address this double burden with a strong focus on human rights.

Inhorn and Patrizio (2015) agree that infertility has been globally overlooked in large part due to a disproportionate focus on suppressing fertility by increasing access to contraception and decreasing unintended pregnancies, but dives deeper into Central and Sub-Saharan Africa's 'infertility belt' arguing that infertility has been historically neglected due to strong overpopulation narratives and has been a low priority due to the burden of life-threatening HIV/AIDS epidemic. Development narratives of the 'demographic dividend' that emphasise lower fertility for greater economic growth are framed as tacit eugenic narratives of reproduction in the Global South, engaging more directly with foundational beliefs and interests in the field of SRHR than previous authors. This literature reveals the neglect of infertility on the agenda, as an emerging but still marginal concern as other SRHR priorities remain dominant.

3.3 Infertility as an issue of inequality and reproductive justice

Many authors discussing infertility explicitly invoke a RJ approach in their research and analysis when focusing on overlooked infertile populations. Gerrits et al. (2017) raise awareness of the unequal burden of infertility by discussing how it carries gendered stigma, violence and economic hardship in many communities particularly in the Global South. Morshed-Berhabani et al. (2020) conduct a comparative infertility policy analysis across countries of varying income levels, finding that infertility was not a policy priority in lower income countries managing limited resources and a burden of infectious diseases and mortality. In higher income countries, infertility policy was directly tied to pronatal policy writ large, where support for these policies came from demographic anxiety of declining fertility rates and aging populations, although there was no thorough engagement with these narratives themselves.

Ombelet (2011) couples the geographical focus of infertility in the Global South directly with a human rights and RJ lens, uncovering similar narratives as those Inhorn and Patrizio (2015) engaged with in the section above. The author also points to two overarching narratives that have

resisted infertility treatment in a development context, namely overpopulation and limited resources. The narrative of uncontrolled growth in developing countries is questioned, by showing that this is mainly due to increasing life expectancies and not necessarily high fertility rates. A rights-based argument is made for infertility services in the Global South, emphasizing culturally appropriate and equitable interventions, particularly when it comes to the introduction of assisted reproductive technology (ARTs). This situates infertility not only in a global health debate, but also a political debate.

Whittaker et al. (2024) interrogate fertility professional's views on access to ARTs in Sub-Saharan Africa, in which affordability and availability of services, as well as the structural and systemic changes this necessitates, is highlighted. The focus here, similar to Ombelet (2011), is on equitable distribution of these technologies in the political economy of healthcare, which in this region position poor women as the targets of intersecting forms of oppression. The lens of RJ is specifically invoked, in line with the overarching trend of activistic and advocacy-focused global health literature on the subject. Another aspect of infertility in lower-middle income countries (LMICs), namely gendered stigmatisation, is examined by Gerrits et al. (2023) through a scoping review that finds limited interventions addressing infertility stigma and gathers insights on stigmatisation. They argue this lack of interventions is problematic, as dominant notions of masculinity discourage men from seeking infertility care, and as cultures with patrilineal kinship systems negatively impact women experiencing infertility and increases their risk of intimate partner violence and social exclusion. The gendered aspect of infertility is highlighted, and is echoed by all authors included in this review. Interestingly, ARTs are mentioned as a possible way to destigmatise and increase awareness and education, pointing to a promising overlap in two of the most illuminated issues within infertility.

Nnagbo et al. (2024) focus on another issue within the gendered aspects of infertility in LMICs, which is the intersection between son preference, the social and cultural preference for male children, and infertile couples at fertility clinics in Nigeria. It also reveals that some women are not only under pressure to have children, but to specifically have sons, and that this motivation was a primary driver for couples seeking fertility care. This shows that infertility is culturally defined in varying ways depending on the context, in this case a lack of male children. The

positioning of infertility ‘beyond the body’ and the biomedical is clear in Díaz and Watkins (2025) article on social, structural and environmental infertility, opening up a larger political discussion of the disease itself as markers of inequity, such as impacts of pollution and climate crisis, gender inequalities and social precarity and norms. Again, their RJ lens views infertility as a collective issue impacted by the political and socio-cultural context, often creating restrictive environments for the realisation of fertility desires.

Fledderjohann and Roberts (2018) focus not on a specific community, but on the tools and methods used to document infertility in LMICs, interrogating how sex and gender are enacted and reproduced through large-scale surveys, revealing the influence of researchers and experts' own gendered understandings of infertility on the framing of their data collection. They attempt to recenter infertility away from women and female bodies to instead be about all bodies and all factors limiting the ability to have a live birth, arguing that the dominant narratives of infertility invisibilise men and places the “*burden of reproductive blame*” on women (Fledderjohann & Roberts, 2018, p. 76).

Moreover, Barnes and Fledderjohann (2020) invoke RJ’s historical view on control, surveillance and reproduction as a state project, including in the Global North, to argue that there is a reproductive underclass, what they called the ‘*invisible infertile*’. Through the construction of a reproductive imaginary dictating who can and should reproduce, reproduction is and has been a highly stratified process, invisibilizing the needs of marginalised groups experiencing infertility. Infertility’s links to environmental degradation and highly tech-ified expensive treatment have reinforced social hierarchies, and the understanding of infertility as mainly a biomedical disease is deconstructed and questioned. This literature discussed how inequality structures experiences of infertility for globally and locally marginalised populations with strong moral arguments for inclusion.

3.4 Infertility Advocacy

Few articles explore specific aspects of political and civic advocacy for infertility care and services, and three utilise the same case study of The Gambia. Balen (2023) and Afferri et al. (2024) use the case of advocacy work and policy success on infertility in The Gambia as an

example of promoting fertility care in the Global South. Balen (2023) found that establishing and maintaining advocacy networks across regions and disciplines, as well as a wide stakeholder engagement across government and civil society were key in achieving the inclusion of infertility in the country's 10-year National Health Policy, which is novel for the region of Sub-Saharan Africa. Afferri et al. (2024) add to this by arguing that awareness raising, the involvement of men, and data-driven policymaking, among other things, were key in advocating for fertility care in The Gambia. The authors note that their approach conceptualises infertility as more than biomedical, thus needing a broader range of social and educational interventions. Dierickx et al. (2019) conducted an ethnographic study mapping stakeholders as supporters, moderate supporters or moderate opponents to infertility care and services, exploring the arguments behind each position. This mapping identifies actors in a political process but not the process itself.

Lemoine and Ravitsky (2013) argue that infertility should be considered as part of the public health agenda due to its causes such as HIV/AIDS already seen as public health issues, and due to the added benefits of infertility prevention on risky health behaviours such as smoking, obesity and alcohol, arguing that intervention by government-mandated public health functions is necessary in solving infertility, moving away from the dominant individualistic, private sector approaches. Thoma et al.'s (2021b) policy brief on addressing infertility in SRHR through human rights and sustainable development provides more practical, policy and programmatic focused priority areas. It calls for improved data systems, public health infrastructure and regulation, and a strong focus on prevention programmes to address infertility along with increased psychological support programmes. Here authors are formulating arguments for agenda-setting infertility but there is little insight into the political processes and different actors' rationale behind these arguments.

3.5 Research Gap

These four themes cover the literature most relevant to the research questions, moving from the general to the specific. As no existing research connects infertility and agenda-setting directly, the review constructs this bridge by drawing on adjacent bodies of knowledge. It begins by establishing the broader political landscape of SRHR agenda-setting, narrows to infertility as a neglected issue, situates it within structures of gender, race and class through a RJ lens, and

concludes with existing knowledge on infertility advocacy. Together the four themes provide a layered foundation for the analysis that follows.

The literature has examined advantageous arguments for prioritising infertility, with a few investigating the positioning of private and religious actors in relation to infertility advocacy (Edouard, 2023; Whittaker et al., 2024; Lemoine & Ravitsky, 2013) and the constrained political environment around infertility advocacy (Danquah & Koray, 2025; Ombelet et al., 2008; Balen, 2023; Afferri et al., 2024; Dierickx et al., 2019). Nonetheless, no studies have been found which examine experts' own framings of infertility as part of the larger agenda-setting process and how these structural factors shape expert framings of infertility. These experts play a central role in shaping how infertility is framed and addressed moving forward due to their authoritative and influential research and knowledge production. Understanding how global experts frame infertility is essential to mapping the political process of putting infertility on the SRHR agenda, how and why policies and arguments are highlighted and deprioritised, and what implications these choices carry.

4. Theoretical framework

This chapter will outline the theoretical framework of this study and its individual components, which are certain aspects of agenda-setting theory, an understanding of power in SRHR, and the concepts of reproductive imaginaries and stratified reproduction. It will also justify these choices, arguing that although agenda-setting theory is the main perspective, the additional concepts supplement some of the blind spots of agenda-setting theory and therefore contribute to a more nuanced framework and engagement with data.

4.1 Agenda-setting theory

One of the main theoretical frameworks used in this thesis to uncover the structural processes behind experts framings of infertility is political scientist John W. Kingdon’s (2014) theory on agenda-setting. It situates itself at the beginning of the policy making process and aims to illuminate otherwise murky processes in which issues, policies and solutions come to be defined

for decision makers among a plethora of other issues vying for attention (Cobb et al., 1976). In short, it investigates the strategies and patterns used by various groups to achieve this attention (Cobb et al., 1976). Agendas can be specific to a certain field, like health, or even more specialised within that (Cobb et al., 1976), such as the SRHR agenda. Kingdon conceives of agenda quite broadly as

> *"the list of subjects or problems to which governmental officials, and people outside of government closely associated with those officials, are paying some serious attention at any given time"* (pg. 3, Kingdon, 2014).

Alongside proposed issues for an agenda are also a set of alternative proposed actions and solutions, out of which officials will hold some in higher regard than others (Kingdon, 2014). This process of narrowing down options to increase the likelihood of particular ones being selected is called 'alternative specification'. Agenda items and alternatives specifications can gain visibility through three streams: problem recognition, generation of policy proposals and political events (Kingdon, 2014). The problem stream focuses on how actors define conditions as problems to create a sense of importance and urgency for the need to solve this. Secondly, the policy stream includes the accumulation of evidence, arguments, ideas and networks among specialists and academics to shape certain policy proposals to be more favourable to officials (Kingdon, 2014; Greer, 2016). Here, the proposal's cultural fit with their audience, technical feasibility and political favourability are of importance. Lastly, the political stream relates to the effect of wider political factors such as elections, public opinion, interest groups and pressure campaigns on the alternatives considered. In sum, Kingdon posits that "*agendas are set by politics and problems, and alternatives are generated in the policy stream*" (2014, pg. 20).

Another vital part of these processes is how issues find their 'venue', meaning how institutions determine whose jurisdiction the issue falls under, such as the government or the private sector (Kingdon, 2014). Thus, the issue is defined and presented in certain ways to fit into and be adopted by a certain venue, also called venue-shopping (Kingdon, 2014). In short, issues arise by various groups interested in creating awareness of this issue (Cobb et al., 1976), cementing a

dominant understanding of it, and encouraging a specific set of solutions all for the adoption onto the desired agenda.

4.2 Relations of power in SRHR

Another vital concept that will inform this thesis is relations of power within SRHR research. This is an essential concept as it forces reflection into the SRHR agenda as a site of contesting power, beliefs and values that is politically negotiated (Schaaf et al., 2021, pg. 2). Relatedly, examining power as strongly shaping determinants and barriers in reproductive health outcomes is key in the study of infertility as it connects to gendered and patriarchal norms and stigmas around fertility, the common lack of funding and financing by donors or national governments as well as how power might be enacted in service delivery and treatment; in short who gets treated and who doesn't. This goes hand in hand with agenda-setting, making it possible to examine what power dynamics and political aims are behind various conceptualisations of infertility by a highly influential expert academic and research elite. Additionally, examining relations of power also requires me as the researcher to understand how the institutions they are in, and how their research, fits into these power structures, which will be discussed in relation to positionality in the following chapter.

4.3 Reproductive Imaginaries

The concept of reproductive imaginaries will also inform the analysis. The concept stems from an earlier concept of the 'heterosexual imaginary' by Ingraham (1994), referring to the unquestioned and unexplored way heterosexuality is normalised and implicitly assumed in feminist sociology (Nordqvist, 2008). Building off of this term, Nordqvist (2008) explores the heterosexual imaginary of procreation, in other words the concealed ways of thinking in which conception and reproduction is normatively understood as between a man and a woman, even though ARTs allows for same sex couples to conceive as well. The concept of reproductive imaginaries is built on similar critiques, referring to the implicit sociocultural desires and beliefs on what groups can and should reproduce (Barnes & Fledderjohann, 2020), shaped by class, gender and race (Fernández-Jimeno, 2025). In short, they are

> "*collective visions of motherhood, infertility and kinship ties that are collectively maintained and carried out*" in different ways (Fernández-Jimeno, 2025, p. 53).

Inhorn et al. (2009) critically argue that this is a highly gendered imaginary, in which visions of men's roles as partners, fathers and decision makers are missing. Reproductive imaginaries is thus a key analytical lens through which to interpret the data, as it reveals expert's implicit understandings and conceptualisations of reproduction, and who is, and who ought to be prioritised, especially when it comes to infertility and access to care.

4.4 Stratified Reproduction

This concept leans closely on reproductive imaginaries in that it also stems from deep-rooted societal and cultural ideas of who can and should reproduce. However stratified reproduction is also about the social structure and hierarchy which impedes or facilitates reproduction of certain groups. Stratified reproduction investigates the reproductive hierarchies created by politics and practices and shaped by globalised inequalities (Hough, 2010). This is clear through the unequal distribution of infertility prevalence and access to services, a structural system in which fulfillment of reproductive needs and desires varies depending on race, class, gender, sexual orientation and more (Barnes & Fledderjohann, 2020; Díaz & Watkins, 2025).

4.5 Operationalisation in data analysis

These concepts all focus on power, politicisation, and how issues are socially constructed. They are therefore well suited for use together in the analysis, as they all create a framework that views reproductive bodies as politically contested sites. Agenda-setting theory reveals experts' framing of infertility as inherently political and strategic, and situates these in the context of a larger political process. The concept of relations of power explains how power and inequities shape the SRHR agenda and shows the influence of the actors involved, and lastly the concepts of reproductive imaginary and stratified reproduction add a critical and gendered nuance to the theoretical framework by focusing on the ideological and normative underpinnings of infertility and making visible reproductive hierarchies.

Interview data and the generation of frames will be informed in an iterative process by the theoretical framework. In addition, the framework will focus on points of contradiction, tension and compromise in the data. This framework is well-suited to assess the viewpoints of experts in particular, as it has a strong focus on relations of power and dominant narratives, meaning it will be able to critically engage with a group with high influence, strong agendas and deep knowledge. It does not function as a rigid structure imposed on the data, but rather as a guiding tool that enables a systematic and critical interpretation of how infertility is understood and negotiated within positions of power. Not all parts of the framework will be relevant and applied in the same places, where some data points are more relevant for some concepts. The coding process will be attentive to how interviewees frame infertility as a problem, including what is recognised as desirable solutions and convincing arguments. It will also focus on how agenda-setting infertility is embedded within systems of power and inequality.

5. Methodology

The below chapter outlines all aspects of this study's methodology, including the constructivist ontological and interpretivist epistemological groundings, a reflection on my positionality as a researcher, the qualitative and iterative frame analysis research design, and the data collection through expert interviews. The methodological limitations are also discussed.

5.1 Research Paradigm

Prior to detailing the methodological approach, it is necessary to clarify this paper's 'position' on how it studies knowledge and reality (Bhattacherjee, 2012c; Scotland, 2012). This study employed a constructivist ontological position which views reality as subjective and varying depending on the person who is experiencing it, and is therefore constructed through language shaping our understanding of the world around us (Scotland, 2012). This paper's interpretive epistemology posits that by virtue of interacting in the world, we are participating in molding meanings and understandings of the phenomena being studied, which cannot be separated from an independent reality (Scotland, 2012). As such, the same phenomenon may be constructed differently depending on the researcher and their approach (Scotland, 2012). Knowledge is not

value-free, it is culturally and historically situated, and this is accepted and explicitly taken into account in the interpretive research paradigm (Scotland, 2012). New understanding and insights are generated from the co-production of truth between researchers and participants (Scotland, 2012), making them vital in this research paradigm and this investigation.

5.2 Positionality and Reflexivity

My positionality as a researcher is shaped by factors such as my gender, race, personal experiences and values, which must be addressed within a study to give it clarity and credibility in how findings were assessed and interpreted (Goundar, 2025). As a woman I have been aware of and thought about infertility before deciding on this topic. My initial perception of infertility was thus through a gendered lens, which was later nuanced by the literature and the data collection. In addition, my academic background in International Relations gave me a research lens informed by political science, with a predisposition to politically unfavourable, difficult or overlooked topics. My foundational experience in SRHR was an internship at UNFPA where I worked on a small segment of their mandate. Thus, these experiences initially drew me to infertility in SRHR as I noticed it was a rising political issue but not present in much of the global policy documents or key literature on SRHR.

As a researcher that is half Danish and half Argentine, I have a two-sided position in this research. On one hand, my Danish background and academic study within a Northern European academic institution aligns me in many ways with the predominantly Western experts I studied, possibly providing a degree of cultural and institutional familiarity that likely facilitated access and rapport with experts. At the same time, this proximity carries a risk of uncritically reproducing the assumptions and blind spots of the expert community under study, so I have remained attentive to this throughout the analytical process. In addition, my Argentine background familiarised me with the varying politicisation of reproductive politics in non-Western contexts where rights-based framings and advocacy can have its own challenges and risks. This nuance was important in retaining the ‘global’ view and aspect of my findings.

Reflexivity required me to assess my position as the researcher in knowledge production and continually reflect on how my assumptions and perspectives might be impacting and evolving in

this process (Trainor & Bundon, 2021; Polat, 2025). I approached the research with strong existing values and commitments to rights-based, equitable and intersectional approaches to reproductive health which makes me more attune to certain language choices and framings. I remained transparent about the different interpretative choices made throughout the study, grounding these interpretations closely in experts' own words and reasoning through the use of quotes.

5.3 Research Approach and design

5.3.1 Qualitative and iterative frame analysis design

This research was qualitative in approach, design and analysis, in line with the chosen interpretive research paradigm. Qualitative research is in depth and holistic, contributing nuanced and comprehensive insights on a phenomenon by studying groups or individuals' experiences, perceptions and their attached meanings (Moser & Korstjens, 2017; Polat, 2025). To address the research aim, the study employed a frame analysis as the research design. The research design is iterative, meaning it constantly shifted between inductive reasoning, which moves from the data to reveal patterns and themes, and deductive reasoning, which moves from theory to illuminate the data (Polat, 2025). In creating the study and collecting data, the approach was more inductive, as a theoretical framework had not been chosen yet and was identified by the patterns, themes and interesting particularities in the data. When beginning the analysis of findings, this was done slightly more deductively, to reveal what the theory could illuminate about experts' framing choices. From there, the amendments to the analysis were made iteratively moving between theory and observations (Bhattacherjee, 2012a; Bhattacherjee, 2012b).

5.3.2 Unit and level of analysis

The unit of analysis in this study was the global academic, research and health policy experts framings of infertility. This study unit was the most fitting for the study aim and research question, since it concerns framings of infertility and how this will influence future policy-making, advocacy and programming, all processes that take place within a smaller

agenda-setting group of global experts. Accordingly, the level of analysis, or the scale at which the study unit is analysed, is both at the meso-level of group advocacy embedded within larger institutions, but also at the macro-level, as the second sub-research question invokes structural frames that situate expert framings within larger political, economic and ideological conditions.

5.3.3 Purposive sampling strategy

The interviewees were selected through purposive sampling, meaning the sample was consciously chosen to cover particular segments of the population with relevant experience for the research question (Skovdal & Cornish, 2015). Experts were chosen through the relevance of their research, their involvement and credit in WHO or other seminal publications on infertility, and the length of their experience in the field of infertility, usually around 10 years. Therefore the sample is not aiming to be random or perfectly representative, with the selection process making use of convenience sampling and snowball sampling (Skovdal & Cornish, 2015), where interviewees were asked over email correspondence to recommend other colleagues who they thought would be relevant and interested.

5.4 Data collection

5.4.1 Exploratory, semi-structured interviews

The interviews were semi-structured, in depth, discussion based and exploratory in answering the ‘how’ of the research question, meaning they were open-ended and seeking to uncover new information and angles (Kvale, 2007a). An interview guide was created with guiding questions and certain topics for discussion (see appendix 2), which was helpful in dividing into parts a complex phenomenon such as infertility (Polat, 2025). However the guide was not strictly adhered to during the interview, as following the natural flow of conversation and following up on various insights was prioritised, allowing for the exploration of unforeseen aspects or possible themes. It also did not determine the structure of the analysis or the frames generated (Polat, 2025).

With an interview study, the quality is in large part dependent on the advance preparation and competence of the interviewer (Kvale, 2007b), ensured through the completion of all background and literature review readings and creating and revising an interview guide in advance. Interviewees were also briefed on the research in the form of a two-page FAQ alongside the invitation for interview, and oftentimes after the interview was complete.

5.5 Ethical considerations

5.5.1 Participant consent

Consent for interviews was granted from experts in written form by email in response to the invitation, where information was attached on data handling, confidentiality and anonymity in the research, as well as the audio recording of interviews (see appendix 1). Consent for audio recording was prompted again at the beginning of each interview, and all interviewees granted their consent. If experts shared personal and private details as part of their response to a question, they clarified whether those details should be included in the transcript and analysis. In the instances where details were shared that they did not wish to be included, those sections were deleted out of the transcript and did not form part of the data set. It was made clear during the interview that experts could withdraw their consent for participation and the inclusion of certain details after the interview by contacting me, but no experts have done this.

5.5.2 Anonymity

In all parts of this thesis, the experts have been anonymised. None of the data which may include identifying details was included as part of the analysed data. Nonetheless, their positions and research focus is also important to supplement their quotes in the analysis, so this is included to introduce each speaker. However, it is not specific enough to risk their anonymity.

5.5.3 Data storage

Audio recordings of the interviews were made using my computer's local audio recording app, and transcripts were stored on my local Word account on my personal computer. The

transcription process was aided using an encrypted and GDPR compliant AI service OtterAI, where I disabled the use of my conversations and data for training the model. The transcripts were also uploaded to the coding software Nvivo, where the project was also downloaded locally only on my laptop.

5.6 Data analysis method

The data from the expert interviews was analysed using the method of frame analysis. Given the chosen theoretical framework, frame analysis is well-suited for extracting meaning to enable a theoretical understanding and discussion of its agenda-setting aims (Joachim, 2003). As the name suggests, frame analysis is the development of 'frames' from an iterative process of reviewing and analysing data. By 'frame-setting', actors aim to create a coherent understanding of a certain issue for political ends, such as influencing the opinions and attitudes of a certain group towards this issue (McCombs & Ghanem, 2001; Moy et al., 2016). Fraims aim to communicate the nature, causes and consequences of problems and those responsible for solving them (Moy et al., 2016). Concretely, framing is

> *"selecting some aspects of a perceived reality and make(ing) them more salient in a communicating text, in such a way as to promote a particular problem definition, causal interpretation, moral evaluation, and/or treatment recommendation"* (Entman, 1993, p. 52).

Frames are thus the end product of a frame analysis, they are analytical structures defined by the related concepts and data they contain (Hertog & McLeod, 2001). Frames are therefore not something that can be made up of a single element, and cannot be identified before beginning the analysis, they emerge from the process itself (Matthes & Kohring, 2008). The elements determine the meaning assigned to the frame, and the frame then serves a certain purpose in communicating a goal or a value, where multiple frames "*provide the ground rules necessary for an issue to form*" (Hertog & McLeod, 2001, pg. 146). In addition, there are also 'master' frames, or as referred to in this thesis, structural frames, that extend frames and analysis of them from micro-level to the macro-level, allowing for an understanding of "*how frames function in a larger context*" (Snow & Bedford, 1992, p.134).

5.6.1 Strengths and limitations of frame analysis

This method is well-suited to the research aim of uncovering how experts position infertility to be included in the SRHR agenda, as it both allows for insight into experts own ways of framing the issue and also an understanding of larger structural frames that impact their ability to do so. Frames uncover the arguments, negotiations and compromises made by experts and illuminate the mechanics behind their agenda-setting efforts.

Frame analysis does not have one accompanying theoretical framework (Hertog & McLeod, 2001), and studies have diverse research designs, approaches to coding and arrangement of content and analysis (David et al., 2011), and has been critiqued as being a vague analytical method (van Dijk, 2023). This necessitates the researcher to articulate methodological decisions, assumptions and other parameters structuring the analysis (Trainor & Bundon, 2021; Polat, 2025), which has been done in the preceding sections that justified the paradigmatic and iterative approach. This also requires reflexivity on interpretive decisions to ensure transparency and rigor, as the reliability and validity of the study depends on transparency in the research process (Hertog & McLeod, 2001; Matthes & Kohring, 2008), which has also been addressed in the preceding sections.

The abstract and highly interpretative nature of frames can make them difficult to identify consistently and uniformly across several texts and researchers. Thus the impact of the researcher in creating certain frames is difficult to neutralise, which means it is a method with limited exact replicability (Matthes & Kohring, 2008). In addition, researching highly complex issues may be further complicated by this method, as it will lead to the creation of a large number of frames which could be difficult to differentiate (David et al., 2011). Lastly, critics posit that the application of a frame analysis as a method may not uncover anything unique from the use of notions in other disciplines such as themes, narratives, ideologies etc. (van Dijk, 2023). However, it is useful for the research aim in that it invokes the notion of a conscious and strategic positioning, which complements the theoretical framework of agenda-setting, power and normative ideologies on reproduction.

5.7 Analysis process

In this section, each step of the process of the data analysis will be described and justified.

5.7.1 Transcription and data familiarisation

Transcription of the interviews was also a process of data familiarisation. A methodological decision was made to transcribe in the formal style of written text. They are therefore not verbatim, as the filler words and sounds that naturally form part of speech were not included. This was done for clarity of reading comprehension and flow, as excerpts are used in the analysis section to evidence choice of frames and interpretations. In doing so, certain details of the atmosphere of the conversation are lost, such as hesitancies, emphasis, and breathing (Kvale, 2007c), but this was not deemed essential, as the ideas, concepts and perspectives of experts is the data of interest for this research. These methodological choices reveal that transcription itself is also an act of analysis (Ahmed et al., 2025).

5.7.2 Initial coding

Coding of the interview transcripts was done in the software NVivo, which eased organisation and accuracy in keeping track of many different elements in the texts. I manually created codes for different parts of text such as whole phrases or multiple sentences according to its meaning, subject matter or opinion. No codes were applied at the micro-level of a single word or grammatical element. Parts of the text, although interesting, were not coded as it was not related to the research question or where the chosen theory was not applicable or relevant. The same code was applied in instances where the same ideas or content was present, meaning some codes were more commonly occurring than others.

5.7.3 Creating frames

These codes were then narrowed down and grouped together by what is similar in terms of content and theme, which were categorised together manually in a table (see appendix 3), where each column represented a cluster of codes making up a frame and each cell was made up of

codes. There was no use of any automated coding functions for the frame identification and creation. Here it is important to name the criteria for the identification of frames (Matthes & Kohring, 2008). Within each group of codes that was created, their main argument was identified. This came to be a frame, with a coherent logic and argument for each of the codes within it. Frames that did not generate new analytical insights, lacked conceptual depth, or did not meaningfully engage with the core research question, were scrapped as not being central and foundational enough. Sometimes the codes from the scrapped frame could be incorporated into another one to bolster the argument and evidence base. The frame creation was a reflexive process, where I kept a log of my reflections. When frames were identified, I tested their robustness by examining which theoretical elements could be applied to enhance the analysis.

6. Data Analysis

Experts' framing of infertility, and how they navigate structural factors in shaping these frames provides insight into the ongoing agenda-setting process. This chapter presents findings from the interview data, applying the theoretical framework to different framings. The analysis is structured around the sub-research questions; first, it demonstrates how experts frame infertility, second, it examines how structural frames influence these framings.

6.1 Framings of infertility

This section shows how experts frame infertility in four ways; along a clinical-social continuum, as a gendered fertility/infertility nexus, emphasising health systems over rights, and as de-medicalised prevention.

6.1.1 A clinical-social continuum

This framing describes how experts navigate the nuance of infertility. It was clear from multiple interviews that experts strongly advocated for infertility to be understood not as a condition, but as a disease. A social and behavioural scientist researching reproductive health in Sub-Saharan Africa explained that this was in order to add "*seriousness*" and show "*the weight of the*

experience" (P2), and crucially to "*help with advocacy and funding*" (P2). These considerations were echoed by a professor in maternal and child health (P3), who underscored how they used the word 'disease' to educate communities and destigmatise infertility, in order for it to be understood as a bodily disease that can be prevented and treated. In addition, a professor in health psychology explained that the clinical focus on infertility as a bodily disease positions it as a legitimate medical and public health problem, away from simply being *"bad luck*" (P5). This can be clearly identified within agenda-setting theory's problem stream, where a clinical framing of infertility serves to define this as a problem that both can and should be solved, rather than a condition that people should learn to live with. Infertility is therefore defined in this way by experts in order to maximise chances that this will be understood urgently and seriously enough for it to register on the SRHR agenda as something to be solved. This seems to be a popular framing as it is also used by the WHO in their newest guidelines, defining it as a disease with clinical interventions (WHO, 2025).

At the same time, this is only one end of the continuum, as many experts also thought it was vital to recognise the social elements of infertility that often go unrecognised within a clinical focus. Experts argue that greater efforts should be undertaken to address the social consequences of infertility. As an SRHR specialist in development explains: "*infertility is not just a body that cannot conceive, it is the stigma associated with that, it's the access to services, it's the availability of services, it's the cost of services"* (P1). Here the focus is on fertility as a social condition that impacts a person way beyond their reproductive capacity and requires social interventions such as counselling, destigmatisation and cultural context and equity considerations in service delivery. Experts are also attempting to nuance infertility and frame it within discussions of structures of care, access, power and inequality, which are often absent in clinical framings.

This major caveat to the clinical framing thus places infertility on a continuum between two understandings, where experts often navigate in the middle, avoiding being pigeon-holed to one side and risk an unnuanced and fragmented framing of this issue, which is something that a researcher in social justice and inequality argues "*we frequently get wrong*" (P6). This definition of infertility is an essential part of the problem stream (Kingdon, 2014), where experts are

ensuring infertility is understood as a nuanced but urgent problem. This continuum positions experts to be able to negotiate infertility onto the agenda in very flexible ways depending on the audience and the political factors, where the clinical and/or social side can be highlighted when needed. As a population health scientist reveals, *"we need both [understandings]. They'll be used for different purposes, but both are relevant from a public health perspective"* (P8).

6.1.2 A gendered fertility/infertility nexus

By connecting infertility to some of the most visible issues on the agenda such as gender inequality in health and preventing unintended pregnancy (Starrs et al., 2018), this framing cleverly positions infertility on the SRHR agenda already. Experts harness the field's focus on fertility management and argue that prevention and treatment of infertility are complementary to those goals. A population health scientist argues that many communities' persistent lack of contraception uptake due to myths that it causes infertility can be alleviated by coupling infertility awareness to fertility management efforts, "*so you can be addressing these things at the same time, they're interrelated"* (P8). This positions fertility and infertility as two sides of the same coin, where addressing one can help the other.

In addition, experts problematisation of the gendered understandings of infertility also fits neatly in the SRHR agenda focus on gendered determinants of health, gendered stigma and gendered care services. The gendered burden of infertility was discussed by many experts, problematizing how it was often associated as "*a woman problem*" where women's behaviour and sexual past like early sexual debut, prior abortions and STIs is often used to blame them for their infertility. They also draw attention to infertility treatment itself being gendered, with social and behavioural scientist researching reproductive health in Sub-Saharan Africa explaining "*women are responsible ... for the emotional management, the information management that goes alongside it as well*" (P2). Experts also emphasised how the gendered medical gaze has meant that most treatments and interventions "*linked to infertility occur on women's bodies disproportionately"* (P6), even in cases of male infertility (P4, P8). Male responsibility and accountability is thus systematically obscured even though one third of infertility is due to male

factors, revealing how gendered power relations are implicitly reproduced and legitimised in reproductive healthcare.

Experts have drawn clear links between preventing unintended pregnancy, reducing STIs and gender inequality as central to infertility prevention. This frame aims to heighten infertility's importance on the SRHR agenda among other high-status issues. This serves experts in what agenda-setting theory calls 'venue shopping' (Kingdon, 2014), in other words positioning the issue towards specific institutions and jurisdictions that actors think this issue belongs to. Such 'venues' or institutions could be influential organisations directly dealing with the SRHR agenda but also advocacy organisations that are shown to have been instrumental with putting other SRHR issues on the agenda (Joachim, 2003).

6.1.3 Health systems over rights

Experts mainly frame infertility as a structural issue within healthcare systems. Although they see infertility as an issue of rights, equity, access, and care beyond the healthcare system, they attempt to address these perspectives through a health system framing to be more politically palatable. All experts emphasised subscribing to and having a human rights based approach, but have not used this as the overarching framing of infertility with different actors. A demographer researching fertility and related behaviours explained that this framing "*is not always super compelling in some of the settings I've worked in"* (P9) and pointed out that for other politicised issues, such as abortion, arguments have been more effective when framed in public health terms, focusing on maternal morbidity, mortality, and equity in access to care. Therefore experts are inclined to follow the same rulebook, as the demographer *"find[s] it hard to believe that the human rights framing, if it didn't work for that, that it would work for infertility"* (P9). The next section on structural factors will also discuss the larger conservative political climate that disadvantages such framings. Two different framings of reproductive rights and health systems are competing internally, where the health system one eventually wins out as experts favour a more politically safe and effective framing. Thus, rights and equity are not absent from their conceptualisations, but they are channeled through a health systems framing. This does however

have implications, as dropping rights language may implicitly invisibilise already marginalised groups' reproduction and thus leave a dominant reproductive imaginary unchallenged.

Universal healthcare coverage (UHC) and a focus on strong PHC was central to discussions surrounding fertility care. Experts focus on the economic burden on patients, the lack of medical coverage and treatment facilities framed infertility within a larger structure of lacking health systems. More specifically, inequity in fertility care was discussed by experts mainly in terms of socioeconomic differences in accessing care and treatment, and geographical inequities in the availability of services close to affected populations, both on a global and national scale. Thus a professor in maternal and child health advocates for infertility treatment "*starting from Primary Health Care Center and referral"* (P3) where services are more centralised between obstetrician-gynecologists and other physicians with protections against abuse and a focus on culturally appropriate care. The challenges of fertility care are similar to those faced in UHC and PHC systems, as a researcher on social justice and inequality notes "*all of these things map on to problems that we have with healthcare systems around the world more broadly"* (P6). By emphasizing these shared challenges, experts attempt to align infertility with health systems and frame it as an issue that can be addressed through this.

Although the health systems framing is favoured among most experts to be more politically palatable, concepts such as UHC can still be quite political (Gruending et al., 2020). The emphasis on service availability and financial coverage to achieve equitable fertility care and improve reproductive health also signals a desired venue change among experts from the private sector, which currently dominates a lot of fertility services globally (Ombelet & Lopes, 2024), to the public health sector. The systems-oriented framing places greater responsibility and impetus for action towards the desired venue of governments and legislators, as experts highlight the wider structural conditions that determine whether care is available and accessible.

6.1.4 De-medicalised prevention

The framing of infertility as a matter of prevention and education highlights the benefits of this approach, which is more accessible than ARTs, easily integratable into existing structures and

programmes, addresses risk factors and poor reproductive health literacy through education, and helps to destigmatise infertility. This is a conscious reframing by experts away from infertility as associated with siloed, expensive and technological treatment, as a scientist in contraception and fertility care states that *"the immediate thinking amongst policy makers and health systems managers is that if you include infertility, that means you have to provide IVF"* (P4). Due to this, a population health scientist explains "*people also dismiss that too. It's like, "well, that's just too expensive. We can't do that*"" (P8). Therefore, to make infertility more likely to be taken seriously and included in policy, the social and behavioural scientist explains that *"the focus should be on prevention and early diagnostic testing ... that will have more bang for its buck"* (P2). This reflects a deliberate strategy to convince governments and donors to begin addressing infertility with interventions that are easily integratable into existing PHC systems, such as adding infertility information and basic testing to family planning services. The professor in maternal and child health employed this strategy:

> *"The government kind of doesn't like surprises. So we pass things in small doses…We have [infertility] screening services and preliminary medication and intervention. So with this, it [including infertility in the national strategy for reproductive and sexual health] passed, and the government said, "as long as it's not going to cost us extra money to implement"* (P3).

Experts also emphasise prevention and education as solutions to what they describe as "situational" or "artificial" infertility, which are cases where people are not biologically infertile but lack knowledge about fertility, such as how the menstrual cycle or ovulation works. This kind of infertility is quite prevalent in some LIC contexts and as the social and behavioural scientist points out "*if you don't understand your ovulation or menstrual cycles as a sign of fertility health, you wouldn't know to seek help"* (P2). These approaches are also viewed as more equitable, since, as a demographer researching fertility and related behaviours notes, "*preventative measures can be more equitable in terms of who might be exposed to them or understand"* (P9). This focus on prevention is not a new strategy in global health, as it can reduce health inequalities and the cost of public services, with the politically palatable argument that "*prevention is better than cure*" (Cairney et al., 2025, p.1).

A scientist in contraception and fertility care underpins this view of prevention and education as a policy strategy, as "*the people who make policies come from communities. If those communities don't have awareness about infertility, they won't necessarily prioritise it"* (P4). Agenda-setting theory would identify this process as alternative specification (Kingdon, 2014), where experts are actively framing the main policy solution to infertility as raising awareness, education and prevention efforts and thereby increasing the likelihood that this solution will be chosen. This frame is working within the policy stream as experts develop policy proposals that fit to the officials and key actors in mind, thereby framing it away from treatment and ARTs towards the more politically favourable frame of prevention.

6.2 Structural frames influencing expert framings

Building on how experts frame infertility as a policy issue, they also identify larger structural 'frames' which impact experts' ability to frame infertility in distinct ways. Three key framings are presented, namely the medicalisation of infertility, the politicisation of reproduction, and the evidence and standardisation gap.

6.2.1 The medicalisation of infertility

Commercial interests in infertility are seen by experts as having 'medicalised' infertility to sell their services but also to educate and reduce stigma. Experts framed this as a double-edged sword, resulting in both significant advancements but also detrimental inequalities. Many experts view commercial interests as foundational in generating awareness of and an interest in solving infertility among governments. Experts argue that these interests have pushed the norms for acceptance in a way that actors with less financial and political power are unable to. As a professor of health psychology argues:

> *"They have to find markets, they have to find new groups, they have to push the norms to meet their commercial interests… If it wasn't for commercial determinants, probably gay people still wouldn't be having kids. So somebody had to move into that space and enable that"* (P5).

Not only have commercial interests enabled norm change in who should be allowed to access reproduction, they also lobby governments and pressure for the creation of a legislative favourable environment for their infertility services. Experts explained this is especially true for low and middle income countries, where the private sector was first movers on infertility and is one of few actors highlighting this issue. Experts do not claim this is due to the altruism or rights-based approach of the sector, with the professor in health psychology acknowledging that:

> *"It's a great thing for lifting the profile of infertility in low and middle income countries, but… they do benefit from the public facing things. It's just the nature of business, isn't it?"* (P5).

However, experts are acutely aware of the other side of this coin, where commercial determinants, in their pursuit of profit and growth, have cemented a lot of inequity in access, exploitation of patients and preventing the establishment of lower cost interventions. Experts highlight the exorbitant costs of care patients face, the multiple rounds of treatment they are convinced to undergo even though it might not be needed, and the unwillingness to integrate into national health structures and public insurance schemes. This approach quickly becomes political as these high barriers to treatment also gatekeep who is worthy of treatment (Lemoine & Ravitsky, 2013) from low-income or other marginalised populations, stratifying reproduction to a certain desired population. A medical anthropologist researching infertility and reproductive technology also points out that because of these commercial interests "*I'm afraid that those low cost options will not get the attention that they would need to be able to grow"* (P10).

Experts are thus trying to navigate the power behind commercial interests and determinants. They clearly see this '*medicalisation of infertility*' (Bell, 2010) as within the political stream of agenda-setting (Kingdon, 2014), where lobbying and pressure campaigns of private sector actors is not something experts can do without or ignore. They are attuned to the powerful players in the field of infertility, and to the larger frames created by actors like the private sector interests, which early on have framed infertility as technological medical interventions and complex treatments. Experts' agenda-setting power lies mainly in the problem and policy stream and less

in the political stream, and therefore in this stream they must navigate and influence other actors with capital and ability to play the political game of agenda-setting.

6.2.2 Politicised reproduction

Another structural frame impacting experts framing of infertility is that of a pronatalist, conservative and anti-gender political climate, which has to some extent politicised and co-opted infertility particularly in the Global North, affecting how it can be positioned on the SRHR agenda. This was a central point of discussion and worry, as a researcher in public health shared that they've discussed with their colleagues:

> *"How do we make sure that we are constantly situating infertility research as choice, reproductive justice, gender equality, access to services, rather than as some kind of enforced population level thing that tells people to have more children?"* (P7).

In their view, the political climate in the Global North brings up difficult debates around resource allocation, who should parent and reproduce, whose reproduction is valued and whose is discouraged, all infused with nationalistic and racialised visions of a desired future population. Experts see political aims to only encourage reproduction for wealthy white nuclear families as a grave challenge to their human rights based, intersectional and holistic vision of infertility that they want to promote. The social and behavioural scientist researching reproductive health in Sub-Saharan Africa recognises that "*there's just not a lot of impetus to fund research and programmes to reduce infertility in low socioeconomic settings because people just don't care about poor women having children".* (P2) A researcher on social justice and inequality has faced similar challenges in funding her work in this political climate, where "*getting funding to study infertility in global majority countries is quite challenging…[there's] a sort of soft eugenic mindset that underpins a lot of funding and a lot of reviewers".* (P6)

This politicisation of infertility produces a fundamental tension for experts between gaining access to the policy agenda and maintaining the normative integrity of rights-based and equity-oriented framings of infertility. Nonetheless, experts are willing to maneuver this climate

in order to ensure infertility gains the visibility it needs on the agenda, and some have indicated they are willing to play by the rules of politics to achieve this. The social and behavioural scientist pragmatically approaches this dilemma and is open to meeting in the middle with many Global North countries' pronatalist agenda, as both are

> *"in alignment with helping people reach their reproductive goals and… ensure that people have access to services to protect their fertility. So if we have to change the narrative in a grant application to get funding … to help people have the best chance for that, I would do that"* (P2).

The reproductive imaginaries of gatekeepers such as funders and reviewers as well as conservative political actors and institutions seeking to stratify reproduction to certain population groups, form a central part of the political stream. These political conditions constrain expert's work in both the problem and policy streams (Kingdon, 2014), as dominant political ideas increasingly co-opt or reshape how infertility can be defined, researched, and translated into policy proposals. As a result, agenda-setting in this context is more about negotiating ideological boundaries in advocating for infertility. Experts are aware that this process is structured by unequal power over whose reproduction is valued and prioritised, which they try to pragmatically navigate in order for infertility to gain visibility, to conduct research and to make services available rather than not engaging out of principle.

6.2.3 The evidence and standardisation gap

The lacking evidence base of infertility prevalence, as well as the lack of standardisation and definitions across infertility services and care was another structural factor in the expert's agenda-setting process. Discussions with experts around advocacy and awareness raising began with the lack of research and evidence on infertility prevalence in most communities globally. Indeed, without a comprehensive scope of the problem and data to back this up, it is hard to convince officials of the severity and need for action. A demographer researching fertility and related behaviours aptly states that

> *"There are very few things that we don't track that we also are really concerned about… so without that, I think it's hard to be bringing this issue to stakeholders, to impress upon them"* (P9).

In the experts' view, collecting data needs to be prioritised and systematised by governments in the form of health and epidemiological surveys. However data collection is further hampered by diverse definitions of infertility and the slow adoption of the WHO definition. As a researcher in public health argues, "*we do need to be talking about the same thing. We need to be … using the same definition, and standardising across countries and across studies"*. (P7) Experts see various benefits to standardisation, where for example the clarification of the WHO definition and its specific temporal aspect of 12 months helps with medical coverage and can remove other regulatory barriers for some groups, however this requires continued focus on equity and inclusion. Additionally, a social and behavioural scientist emphasises that the timeframe *"helps people understand how long is really too long to then go and seek help*." (P2).

Other experts highlighted how standardisation is essential to regulate the current "*cowboy land*" (P5) of infertility services that are managed differently across jurisdictions. Experts emphasised that standardising disease knowledge, staff training and certification is essential to building responsible and equitable services within healthcare systems.

The WHO Guideline for the Prevention, Diagnosis and Treatment of Infertility were seen by experts as a very favourable development of these efforts at standardisation, especially in lower income settings, as a demographer explains it is providing "*clear guidance on what to do in the absence of some of these kind of gold standard options for testing and treatment, which is great"* (P9). The guidelines function as a tool in agenda-setting and as an output of the policy stream, offering greater clarity and more consistent interventions for officials. This process is highly shaped by power, with normatively authoritative organisations like the WHO influencing agenda-setting through research and publications and pushing for standardisation in the field. Thus, the standardisation and evidence gap is a political and structural factor that is forcing experts to consolidate dominant and favoured frames of infertility in order to increase the likelihood of putting infertility on the agenda.

7. Discussion

This final chapter of the study discusses the findings from the analysis and interprets experts frames and structural frames together to derive broader analytical insights. The findings are also compared to the previous literature, highlighting the similarities but also the novelty of this study's contributions. Several implications for infertility policy and the wider field of development are discussed, the study's strengths and limitations are assessed, and lastly ideas for future research on infertility are outlined.

7.1 Interpretation of Findings

The analysis showed that experts frame infertility in flexible and politically advantageous ways to increase the likelihood that it is adopted onto the global SRHR agenda. It also revealed that the structural frames around agenda-setting infertility shaped expert framings with pragmatism.

Experts framings of infertility were seen through the theoretical framework as part of the problem and policy stream, where the internal processes of defining infertility as clinical vs. social, the competing rights based and health-systems oriented approaches and policy solutions, and the attempts at venue-shopping towards SRHR were shown. Despite experts' strong beliefs in and values of RJ and rights, a health systems-oriented preventative frame prevailed. This is in large part due to experts' strategic positioning towards structural frames in the agenda-setting process. The structural frames shaping infertility framing were identified as the political stream, where larger and more powerful frames of the medicalisation of infertility, politicisation of reproduction and the evidence and standardisation gap set boundaries in which experts could adjust their own framings.

Power in SRHR, particularly normative, monetary and political power restricted experts' visions for framing infertility through RJ, and therefore influenced more calculated and pragmatic framings. This is clear when findings from both sections of the analysis are compared. The framing of infertility as de-medicalised intervention focusing on low cost prevention and education can be traced to the larger structural framing of the medicalisation of infertility, and the ways in which commercial interests and private actors have associated infertility with

high-tech costly treatment. Experts are attempting to reshift this larger frame through the alternative specification (Kingdon, 2014) of prevention and education, as their experience has shown these are more politically successful arguments and are more accessible and available for marginalised populations. In addition, the framing of infertility as a problem of health systems over RJ and rights can be seen as a response to the structural factor of the politicisation of reproduction (Boydell et al., 2019). Lastly, the structural push for standardisation and evidence has impacted expert framings of infertility to make sure the problem definition is both as a bodily disease but also beyond the body, where the clinical-social continuum seeks to maintain some nuance that evidence and standardisation efforts often overlook.

7.2 Comparing Findings to the Literature

Although many of the findings are supported by the existing literature, this study contributes novel findings to the body of social science research on infertility by examining the process of infertility advocacy itself, particularly through its use of expert interviews and its explicitly political theoretical approach. This study revealed *how* and *why* experts frame infertility in order to position it on the SRHR agenda, whereas the literature can only reveal *what* the content, knowledge and research these frames are built upon. Thus, interviews with experts in the field were the key component of the study, as they allowed for insight into the behind the scenes of infertility advocacy, and illuminated the different considerations, trade offs and strategic choices experts make in order to position infertility politically favourably.

Many elements of the different frames are echoed in the previous literature outlined. Both the frames and the literature show infertility to be neglected, inequitable, socially embedded, and politically shaped. The strongest links between the literature and the frames are their understanding of infertility as existing at the intersection of the clinical and social (Thoma et al., 2021b; Díaz & Watkins 2025; Howe et al., 2020; Bell et al., 2025; Ombelet et al., 2008), their strong linking to gender, local and global inequalities (Barnes & Fledderjohann, 2018; Nnagbo et al., 2024), and focus on prevention and broader approaches beyond technological treatment (Gerrits et al., 2023, Mburu et al., 2023).

The literature on agenda-setting other SRHR issues also mentions the strong influence of political and structural factors (Edouard, 2023; Joachim, 2003) but only McDougall (2016) traced how these influence advocacy, showing that advocates adjusted framings for political attention but did not sacrifice their core beliefs. This study finds a similar tendency, where strong structural pressures in agenda-setting prompts a more pragmatic approach where rights are more embedded than explicit. The framing of infertility with other SRHR issues to position it onto the agenda is also a strategy that has been used across issues such as maternal mortality (Smith & Rodriguez, 2016). Much of the agenda-setting literature brings up the need for evidence (Danquah & Koray, 2025; Edouard, 2023), which is aligned with the findings of this study and indicates this is a broader structural factor for advocacy in general. Additionally, the WHO (2025) guidelines on the prevention, diagnosis, and treatment of infertility represent a concrete output of precisely the evidence-building and standardisation efforts that experts identified as critical to advancing infertility on the agenda, supporting the finding that consolidating the knowledge base is a necessary condition for agenda-setting infertility. While the WHO guidelines may strengthen the problem and policy streams, whether governments translate this into funded and equitable services depends on the wider political stream outside of the purview of the guidelines. This points to a gap in the existing SRHR agenda-setting literature, where the relationship between evidence production and political will remains obscure.

The literature is also very engaged with theoretical perspectives of RJ and dominant narratives of development and reproduction (Ombelet, 2011; Inhorn & Patrizio, 2015; Letherby, 2002; Barnes & Fledderjohann, 2020), and this is also reflected in recent global policy documents such as UNFPA's SWOP (2025), which explicitly centers bodily autonomy, reproductive rights and equity as foundational principles for reproductive health policy. However, expert frames reveal a pragmatic and strategic understanding and engagement with these narratives in practice. The analysis shows experts prioritisations and compromises away from explicit RJ frames due to the realities of the political climate and the interests of government actors. RJ's focus on rights, equity, access and larger structural change (Ross & Solinger, 2017) was translated implicitly by experts and incorporated into a larger frame that favored an explicit health-systems approach. This calls into question the utility and adaptability of the RJ perspective in real-life advocacy work, where similar constraints may not allow for the language and full vision of RJ to be carried

out as boldly as in the literature. Thus, global policy documents like UNFPAs SWOP might be serving more to uphold an institutional ideal but may not be very in tune with advocates constrained environments and difficult choices.

Several identified frames depart from the literature, where the role of commercial interests and experts' professional insights and experiences with the private sector was much more pronounced in the interviews and therefore made up its own frame. While some literature focused specifically on access to ARTs (Whittaker et al., 2024; Ombelet, 2011), the political economy of private sector healthcare, financial and political power was more present in the findings of this study. In addition, the literature is often context-specific and makes clear a Global South or Global North focus, however in this study these geographical and political categorisations were not particularly relevant, as experts drew from experiences in both settings as inequality and lack of access and awareness as it relates to infertility could be found in various ways in all settings.

Thus, the existing literature diagnoses the problem of infertility and its various nuances, but this study provides unique insight in mapping the findings as mechanisms within a larger political process of agenda setting. The literature highlights equity principles, while the framings show that experts emphasise these principles varyingly in practice for pragmatic and strategic reasons. Therefore, this research steps behind the curtains to understand the arguments and political factors experts are weighing and navigating as infertility is gaining more visibility.

7.3 Implications for Policy and the Field of Development

The findings of this study have several implications for the growing agenda-setting of infertility and future policy-making around infertility care. Experts framings of infertility and the impact of structural frames reveal a central tension between pragmatic and transformative infertility advocacy, what is considered politically possible, and what trade-offs can and should be made for awareness and visibility. The analysis suggests that experts will continue to advocate for policies that demand less resources and political will, such as prevention and education, and policies that are low-cost and viable, such as integration through PHC. Experts' alternative specification of de-medicalised prevention of infertility has wide policy implications as it

highlights many lower-level community-based interventions and awareness programmes but also risks reinforcing the notion that infertility is a problem of knowledge and behaviour, thus decentering RJ and its highlighting of structural neglect. These policies will likely focus on access and availability of services for everyone, without distinguishing or highlighting particular groups into focus, in order to avoid morally charged debates around desired reproduction and populations, although this may likely follow regardless. Side-stepping these questions risks policies that maintain the reproductive status quo.

In addition, all expert framings and consequent possible policies implicate a wide range of actors and fields such as educational institutions for awareness and reproductive health literacy, healthcare structures and professionals for service delivery and training, insurance and financial systems for coverage and affordability, regulatory and legal bodies for governing standards and eligibility, civil society and community organisations for destigmatisation, research institutions and funding bodies for evidence generation, and the private fertility sector whose commercial interests actively shape the landscape of available care. Infertility policy will span several sectors, and cannot be advanced through any single institution. There is therefore a risk of siloed infertility policy. It also implicates the political economy of global health and possibly a much closer collaboration with the private sector, raising the question of whether advocacy efforts should be targeted not only at governments but increasingly at the private sector. This orientation towards the private sector would be in line with development policy's increasing focus on public-private partnerships (Kang et al., 2019).

A stronger focus on infertility would have several implications for the field of development. Reproduction is foundational to society and development, and infertility challenges the field's tendency to view reproduction primarily through the lens of fertility reduction (Gipson et al., 2020). It also challenges core narratives in development, particularly the logic of the demographic dividend, the widely held idea that economic growth and development are best served by fertility reduction (Foley, 2022). Infertility advocacy disrupts these narratives by presenting infertility as a development problem as well. Therefore, a focus on infertility requires the development field's reckoning with the full spectrum of reproductive experiences and a reorienting of the goal of development-focused reproductive health policy.

7.4 Study Strengths and Limitations

This section critically evaluates the theoretical framework and the study design and scope, examining both their utility in the analysis and their strengths and limitations that shaped what could and could not be illuminated by this study.

7.4.1 Evaluating the Theoretical Framework

Overall, the theoretical framework provided an essential analytical layer to the findings. Agenda-setting theory was the strongest and most applied element, as it contextualised experts' frames as pragmatic choices in problem formulation, policy generation and political navigation. It provided insight into the role of experts in the problem and policy stream, identified crucial frames within the political stream (Kingdon, 2014), and compared experts' framings across streams by tracing how the political stream affects problem formulation and proposed policy solutions. The theory has a balance between the emphasis on agency and on structure (Zahariadis, 2025), which allowed for experts to be understood as actors with agency and authority to frame infertility but who were also significantly constrained by structural frames. However, the study did not make use of the aspect of the theory related to policy change in itself and did not explore what factors could contribute to a 'policy window' (Kingdon, 2014) occurring that allows infertility to be put on the agenda.

Agenda-setting theory also does not place a lot of emphasis on interrogating the positionality of the experts themselves in the agenda-setting process, but this limitation was partly remedied through the use of the theoretical framework's concept of relations of power in SRHR. A distinct focus on power supplemented the agenda-setting theory by showing when experts had authority in the process, when they were limited by others authority, and how this affected framings of infertility. It also reveals the WHO's authority to define and classify infertility not merely as a technical exercise but as a form of normative power that experts adhere to. However, this was not further developed due to time and space constraints. It also did not specify between the various distinct conceptions of power (by theorists such as Foucault or Bourdieu) and thus the mechanisms behind this power remained unexplored.

Lastly, the critical concepts of reproductive imaginary and stratified reproduction ensured an understanding of the structural and ideological underpinnings of certain actors and arguments, particularly in the politicised reproduction frame, the medicalisation of infertility frame and the health over rights frame. It supplemented the theoretical framework by providing a specific understanding of reproduction and by extension infertility as deeply political. Alongside the main theoretical focus on the study on agenda-setting, these concepts provided a more analytical understanding of infertility as an issue.

Together these theoretical elements supplemented the analysis by moving between the procedural (how does agenda-setting work), the structural (what power conditions shape it) and the normative (whose reproduction is valued). However, the main limitation is integration, as the three elements sometimes operate in parallel rather than in dialogue with each other, and their interconnections are not always highlighted.

7.4.2 Evaluating the Research Design and Scope

The research design was well-suited to my study, as it addressed an unexplored side of infertility advocacy in SRHR by interviewing experts and applying a frame analysis, a group of informants and a method that has not been examined in the literature. Ten interviews generated a satisfactory amount of data and enough unique aspects. However, almost all of the informants were Western researchers and professors based in Western institutions, meaning only a narrow set of perspectives and experiences were explored. This was somewhat intentional, as these experts were chosen due to their professional and academic expertise with infertility and their power and connections to research groups, governmental institutions and UN agencies.

A further limitation is the study's exclusive reliance on data generated from interviews, and while it provides experiential and strategic insight, it is only a single source of data. Further triangulating these findings with an analysis of global policy documents would have allowed for a comparison between how experts frame infertility and how these framings are translated, adopted or contested in policy documents, but this study focused on depth rather than breadth. Additionally, the study does not focus on a single country case or policy context, instead it draws

on the perspectives of experts working across a range of national and institutional settings. While this was a deliberate choice to capture a broader, global-level picture of infertility advocacy, it means that the findings remain at a somewhat abstract level and may do fully account for how these framings are formulated or operate when applied to specific Global North or Global South political, cultural or health system contexts. Infertility and its effects can vary socio-culturally and thus it can be risky to universalise this disease, however this study has not attempted this, instead it has interrogated the views of a specific group.

7.5 Directions for Future Research

Based on the limitations and narrow scope of this study, there are multiple possible directions for future research on infertility agenda-setting. An unexplored aspect of this study that would provide additional insights would be to examine the institutions (donors, governments, UN officials, reviewers, private sector) at play more widely in SRHR agenda-setting and map how the institutional environment affects infertility advocacy. This could be done through the lens of New Institutional Economics. A single LMIC country case study that applies frame analysis to a specific infertility policy would also illuminate the mechanisms behind agenda-setting further. More critical research examining the role of the private fertility sector as a political actor in LMIC contexts specifically is needed to better understand this actor and this political context. Lastly, research on agenda-setting infertility using a RJ lens is crucial to reveal the utility of this concept and to map out the long-term consequences of strategic framing compromises.

8. Conclusion

This study has addressed a crucial gap in the infertility and SRHR literature on the ongoing political process of advocating for and negotiating infertility onto the SRHR agenda. It has therefore examined the agenda-setting process behind infertility advocacy, specifically how this issue is framed for adoption onto the SRHR agenda. A frame analysis supplemented with a theoretical framework of agenda-setting, power and normative ideas of reproduction examined ten expert interviews to reveal the mechanisms behind how and why infertility is framed in certain ways.

The main findings of this study are that infertility is framed in politically advantageous ways where larger structural frames result in a pragmatic approach to experts' framings of infertility. Therefore, experts are shown to negotiate between explicit rights-based language and a more agreeable focus on low-cost prevention, education, access and availability of services and care. Experts framings focused on problem definition and policy solutions that side-stepped many foundational questions as to whose reproduction should be valued, prioritised and advocated for. In addition, larger political, economic and technical structural frames were also found to restrict rights-based framings of experts, as the actors behind these structural frames wield significant political power in agenda-setting.

These findings are significant and have several implications for infertility advocacy. They highlight fundamental tensions in advocacy between political pragmatism and normative integrity, and although it is not unique to infertility it manifests in unique ways, due to the foundational significance of reproduction and fertility management to societies and nations. Structural features of SRHR agenda-setting are also revealed that could likely shape advocacy for other neglected or contested reproductive health issues as well.

The strategic framing choices, compromises and structural constraints described here ultimately determine whether and for whom infertility is recognised, resourced and addressed as a legitimate public health concern. Given that the burden of infertility tends to fall on those with the least political and economic power, experts framings and advocacy have implications beyond the policy process itself. This study is a contribution to a more grounded and critical understanding of the ongoing agenda-setting process of infertility.

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Appendices

Appendix 1: Information for research participants

What is the project and why am I being asked to participate?

You are invited to take part in a master's thesis research project on Infertility Discourse in SRHR and Development conducted as part of the MA in International Development and Management at Lund University. The project explores how infertility is conceptualised within emerging sexual and reproductive health and rights (SRHR) and development discourses, and how these conceptualisations may influence policymaking, programme design, funding priorities, and access to care. You are being asked to participate because of your professional knowledge, experience, or engagement with SRHR, development policy, advocacy, or related fields. Your insights are valuable for understanding how infertility is framed, neglected, or prioritised within policy and practice, and for identifying potential risks and opportunities linked to emerging infertility discourses.

Below is a brief background:

Infertility has long been a neglected issue on the sexual and reproductive health and rights (SRHR) and development agenda, but in 2023 the WHO published new estimates which shed light on its importance and relevance worldwide, revealing that one in six people experience infertility globally. Infertility intersects with the core areas of SRHR, such as HIV/AIDS, gender based violence, maternal health and abortion. However, there are currently very few SRHR programmes directly addressing infertility in development contexts. The newfound resurgence and emerging interest in infertility both in national anxieties of population dynamics and also within the field of SRHR means there may soon come an increased effort at funding programmes to address infertility. Therefore, the way in which infertility is defined and delineated by institutions will have a profound impact on how programmes will be designed and carried out, what counts as infertility care and who can receive access to care and support.

This thesis aims to respond to the limited attention to infertility within SRHR and development policy by drawing on semi-structured expert interviews to explore both risks of political co-optation as well as the consequences of infertility definitions for SRHR programming, funding, and access.

How will the interviews be conducted?

The study is based on qualitative research methods consisting in part of semi-structured interviews with experts, practitioners, policymakers, and advocates working within SRHR and

development. The interview will take the form of a guided, in-depth conversation that draws on your professional knowledge and experience, and will focus on themes such as:

- Understandings and definitions of infertility within SRHR and development
- Perceived reasons for the historical neglect of infertility in policy and programming
- Emerging policy trends and institutional framings of infertility
- Potential implications for inclusion, access to care, funding, and reproductive justice

The interview is expected to last approximately 60–90 minutes and as I am based in Copenhagen, Denmark, the interviews will be conducted online on the video platform most convenient for you. With your consent, the interview will be audio-recorded to ensure accuracy. You may choose not to answer specific questions, request a break, or ask to stop the recording at any time.

Possible consequences and risks of participating in the project

Participation in this study involves minimal risk. The main potential discomfort may relate to discussing professional experiences, institutional dynamics, or sensitive policy issues. You are free to refrain from answering any questions that you find uncomfortable.

All data will be handled confidentially, and your identity will be protected through anonymisation or pseudonymisation. No identifying information will be shared in publications or presentations.

What happens to my data?

The project involves the collection and processing of personal data, such as interview recordings and transcripts. All data will be handled in accordance with the EU General Data Protection Regulation (GDPR).

Audio recordings will be transcribed, and any names, institutions, or other identifying details will be removed or altered. The data will be stored securely on password-protected devices accessible only to the researcher. The material will be used solely for academic purposes, including the master's thesis and possible future academic publications or presentations.

You have the right to access your data, request corrections, or withdraw your data at any point prior to the completion of the thesis.

How will I receive information about the results of the project?

If you wish to receive information about the findings of the thesis or access a copy of the completed thesis, you are welcome to contact the researcher. The results may also be presented in academic contexts such as seminars or conferences.

Insurance and compensation

No financial compensation is provided for participation in this study. No special insurance is required to participate.

Participation is voluntary

Your participation in this project is entirely voluntary. You may decline to participate or withdraw from the study at any time without providing a reason and without any negative consequences.

Persons responsible for the project

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Appendix 2: Interview guide

Interview Guide

Interviewee: Date and time:

Section 1: How infertility appears in SRHR discourse

- In the contexts you work in, how is SRHR generally framed, and what tends to be prioritised?

- Where does infertility sit within these SRHR discussions, if at all?

- What shapes the way infertility is taken up—or not taken up—in policy?

Section 2: Definitions and meanings of infertility

- How is infertility usually understood or defined in the policy or institutional spaces you engage with?

- What do you think is gained or lost through the ways infertility is currently defined and discussed?

- Are there differences in how infertility is understood across different spaces (for example clinical, policy, or community settings)? In your view, what are the effects of these different understandings?

- Are there other ways of conceptualising infertility that you think are useful in your context?

Section 3: Inclusion & equity

- When institutions talk about “fertility care,” what does that usually include and not include?

- Who tends to be the main focus of infertility-related policies or services, and why? Are there groups whose experiences or needs receive less attention in infertility policy or service provision?

- What considerations do you think are important for ensuring equity in how infertility is addressed within SRHR in the Global South?

Section 4: Politics and risks

- Are there political or demographic factors that influence how infertility is discussed in your context?

- How do these broader debates influence the way infertility is framed, and the kinds of interventions that are supported?

Wrap-up

- What changes would you most want to see in how infertility is understood within SRHR?

- Are there any resources, people, or documents you’d recommend I look at?

- Is there anything important we haven’t covered that you think I should be asking about?

Appendix 3: Table of frames and codes for RQs

RQ 1: How do experts frame infertility?

A clinical-social continuum	A gendered fertility/infertility nexus	De-medicalized prevention	Health systems over rights
Infertility as a disease - Something more serious and politically interesting than a 'condition'. - Helps with advocacy and funding - Awareness that it is a medical issue not just bad luck	Strong ties to contraception and related to fertility management - Argument that fertility and infertility can be addressed in tandem due to myths of infertility due to contraception - Place it at the intersection of other key SRHR issues for visibility - Added beneficial health outcomes of focusing on infertility namely contraception uptake	Prevention and education are cost-effective and moving away from IVF framing - More politically powerful because it can't be dismissed as easily due to budget and financial constraints - Treatment isn't cost effective, prevention can be more realistic - Moving away from strong associations between IVF/treatment/medicalization of infertility	Avoid rights-based framing even though their actual work will have this approach - Would rather change away from a rights-based framing to receive funding and actually conduct research and provide services - Rights-framing brings many tensions and fundamental bioethical and philosophical questions of prioritization and resource allocation - Intersectional view on rights that still highlights structural global health systems factors
Both aspects of clinical and social are needed - to ensure comprehensive advocacy and policy and to maintain nuance - To still maintain element of psychosocial support and consideration of other elements beyond the body - Having both includes a much broader category of people as not all who identify as infertile are biologically infertile	Focusing on the risk factors with a lot of funding and attention - By relating infertility to other more visible issues it can help get funding to address infertility - Opens up different funding mechanisms and possibilities	Education and awareness to create sustained policy interest and focus - If communities are aware about infertility and care and services they will support policy	Health systems framing more palatable and implicitly addresses rights - Still focuses on infertility as a structural issue - Speaks to financial and geographical inequities - Has had more success with other politicized issues such as abortion - Broader question of making healthcare systems more equitable
An undeniable and very serious social element that cannot be forgotten - Much more beyond a body that cannot conceive, has far wider consequences - Social elements point to wider structural things such as stigma, access, services, cost etc.	Strong ties to gender and gendering of infertility - Moving away from the gendered medical gaze - Undoing the gendered burden of care and of mental and emotional management of treatment processes - Blame is often automatically placed on women and their sexual and reproductive past (early sexual debut, abortions etc.)	Easily integratable into existing structures - Family planning clinics can provide education and basic testing - Doesn't require highly specialized staff that might not be attainable - Scalable and implementable in most contexts	Fertility care as part and parcel of UHC and PHC - Fundamentally a question of access to and availability of services - Should be integrated into these structures to reduce costs of insurance coverage
Focus on social ensures equity considerations - Key aspect of health seeking behavior - cultural context and nuance vital in providing services		Addresses and avoids artificial, social and situation infertility & risk factors - A lot of situational and artificial infertility that is due to a lack of knowledge of menstrual cycle and ovulation and reproductive health literacy - Can be implemented into existing sex education programmes and target adolescents also to reduce stigma - Can change norms around preventive and health seeking behaviors, so people seek help in time - These efforts are more accessible and thus equitable as there are less barriers to being exposed to this information and understanding it	

RQ 2: How do structural frames influence expert framings of infertility?

The medicalisation of infertility	**Politicised reproduction**	**The evidence and standardization gap**
Commercial interests are powerful actors that enact a lot of pressure and change - Commercial activity raised the profile of infertility and pressured governments to create policy - They have lobbying power and a lot of financial power as it is a viable industry that is attractive for national governments	Difficult but maneuverable political climate - Pronatalist agenda provides a visibility that can be harnessed but also only envisions certain kinds of reproduction - This political climate is missing human rights and reproductive justice lens but can meet in the middle to provide services and help people reach reproductive goals - Infertility is politicised due to demographic anxieties and there is a risk of co-optation by these alternate political agendas	Importance of definitions for advocacy and policy - It can clarify medical coverage and eligibility - Directly affects regulatory language - Differing definitions due to different disciplines and societal and cultural understandings - Standardizing the definition has only recently begun on a global scale
Commercial determinants pushes norms and access - In their search for profit and clients they can be much more open minded that society on who should have access as long as theyre paying - This is especially true in low and middle income countries where they tend to be the first large actor advocating for infertility - These changes are not altruistic as they come for a profit lens	Negotiating normative groundings of infertility - Aversion among politicians, funders and reviewers to understand infertility as a problem among poorer communities - Implicit but strong desires around only a particular group reproducing that does not include marginalized communities - Eugenic mindsets and strong fertility norms in the field that has historically focused on suppressing fertility for non-white populations and putting the burden of overpopulation on poor people from LMICs	Lacking evidence base - Essential for advocacy and proving the extent and urgency of the problem - Only beginning to standardize global efforts at data collection of infertility, the prevalence, affected groups, type of infertility, length of disease etc. - Data collection needs to be more prioritized in national health systems, historically not part of many demography surveys

Leads to inequity, exploitation and exclusion - Private and high cost fertility services have also worsened inequity in excluding almost everyone who cannot afford it - It can lead to exploitation of customers and suggest unnecessary treatments or push for multiple rounds - Hindered integration into national public health systems and more equitable insurance coverage - Excludes investment and research in low cost treatments		Benefits of standardisation - Allows contexts with little experience and knowledge to have standardised practices and guidelines - Easier to pressure governments to put infertility in reproductive policies and action plans because there are clear interventions - Management of infertility, treatment and approach standardized to best practices