Inequity and injustice: recognizing infertility as a reproductive justice issue

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In recent years, as knowledge of the tenets of reproductive justice has increased, the framework has garnered increasing attention in media, public health, and public policy spaces. Nevertheless, one domain of the reproductive justice framework is frequently overlooked—the right to have a child; specifically, we refer to the right and ability to access infertility treatment and services. Black, Indigenous, and other people of color, those living on low incomes, and other historically marginalized communities often experience disparate access to infertility evaluation, treatment, and care. This commentary aims to explore the inequities that exist for those seeking fertility services and advocate for examining and addressing these inequities using a reproductive justice lens. (Fertil Steril 2022;—.) © 2021 by American Society for Reproductive Medicine.)

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Reproductive Justice is a term that has more recently garnered attention. Created by Black women in 1994, this framework holds that decision-making about sexual and reproductive health is shaped by both the conditions of one’s community and the context of their life. It rests on four core tenets: every person is endowed with the human right to reproductive health and rights were dominated by the language of “choice,” and focused primarily on the right to access contraception and abortion care. However, in recent years, as familiarity with the tenets of reproductive justice has increased, there has also been an increasing demand to interrogate the primacy of abortion and contraception in our advocacy. Those looking to impart change have begun to integrate the reproductive justice framework into the reproductive health care delivery system as a way to rectify health inequities. Reproductive justice has been often used as a way to advance birth justice, reduce maternal mortality rates, and assess the impact of economic, environmental, and racial injustice on pregnant and parenting people.

Nevertheless, one domain of the reproductive justice framework is frequently overlooked—the right to have a child; specifically, we refer to the right and ability to access infertility treatment and services. There have been several attempts to underscore the importance of creating equitable access to infertility services and treatment, including The World Health Organization’s recognition of infertility as a disease and the US Centers for Disease Control’s (CDC) declaration of the diagnosis and treatment of infertility as a national public health priority. Unfortunately, little has changed for impacted communities, and more work still needs to be done on the part of health care professionals and policymakers. In the same way that health care providers and policy advocates must work to ensure that people have access to safe abortion and pregnancy care, we must also work to ensure that people have equitable access to infertility evaluation, treatment, and care.

Although infertility affects about 12% of women (we recognize that many individuals experience gender beyond the male-female binary, and in this instance, gender-specific terms are used to reflect data collection during cited research), there are significant differences along racial and socioeconomic lines. For instance, the current data holds that Black women are twice as likely to report experiencing infertility as White women. This disparity holds true even after adjusting for socioeconomic status, pregnancy intent, and known risk factors for infertility such as age, smoking, fibroid presence, and ovarian volume.

Moreover, Black, Indigenous, and other people of color (BIPOC) have a lower rate of achieving pregnancy and live birth after the use of assisted
reproductive technology, such as in vitro fertilization (IVF) for reasons that have not been identified. Despite this disparate impact, Black women are only half as likely to be evaluated and treated for infertility as White women. Moreover, persons of middle to lower socioeconomic status are also significantly underrepresented in those seeking infertility services (3).

The cause of these inequities in seeking and receiving infertility are poorly understood and likely multifactorial, including historical and present-day structural racism, economic inequity, and inequitable access to resources.

**Stratified Reproduction, the Myth of Hyper-Fertility, and Other Familiar Tropes**

The differential in the value placed on the fertility of BIPOC people, those living on low incomes, and other historically marginalized communities has resulted in unjust treatment and abuse at the hands of medical providers. Many of these practices are grounded in stereotypes and myths about Black women, specifically, and BIPOC communities, more broadly, including the belief that Black women are both hyper-sexual and hyper-fertile (4). This stereotype, rooted in slavery and colonization, has had many far-reaching and horrific effects, including its use to justify sexual exploitation of enslaved African and Indigenous people, coercive and forced sterilization practices, and contraception experimentation and abuse. Although race-specific hyper-sexuality and/or hyper-fertility is not supported by medical evidence, these stereotypes can consciously or unconsciously affect a person’s judgment of themselves and others. There is evidence that bias in health care professionals leads to discriminatory care and inequities in health outcomes for patients (5). For patients, stereotype belief can result in internalized stigma and shame. As a result, when BIPOC patients experience infertility or pregnancy loss, this can result in delays in seeking care for patients and delays in evaluation, treatment, and intervention for infertility by their provider.

**Separate and Unequal Care: Cost, Insurance Coverage, and Logistical Burdens**

Moreover, once a diagnosis is made, there are often additional barriers to receiving timely evaluation and treatment. The most significant barriers cited in a CDC report were cost and inadequate insurance coverage (6). Infertility evaluation and treatment can include a wide range of procedures, from menstrual cycle charting and ovarian stimulation to intrauterine insemination and IVF. In vitro fertilization, the most common form of assisted reproductive technology, is frequently a privately funded service with per-cycle costs ranging from $8,000 to $15,000 (7). Insurance coverage for this service varies based on employer, insurer policy, and state law. Currently, only six states (Connecticut, Illinois, Maryland, Massachusetts, New Jersey, and Rhode Island) have mandates for private insurers to provide comprehensive or near-comprehensive coverage for infertility treatment, including IVF. However, even in cases where state law mandates coverage of infertility evaluation and treatment, federal law precludes mandates for coverage of this care for those receiving Medicaid. It prohibits regulating or applying these mandates to self-insured plans, such as the plans of many large employers. Because BIPOC people and those living on low incomes are more likely to use governmental insurance as their source of insurance coverage funding and be uninsured (8), this burden falls most heavily on those communities. This inequity in access is compounded by the requirement of multiple office visits for evaluation and treatment and the need for paid leave from work to attend appointments and travel for care that is often distant and not located in communities experiencing inequitable access. As a result, infertility evaluation and treatment access are largely out of reach for many who may desire it.

**Aligning Our Vision and Values**

Embracing a reproductive justice framework demands that we broaden the lens with which we view reproductive health care. Although the term “reproductive justice” has found its way into the public health and public policy lexicon, many clinical providers are still grappling with the ways to practically incorporate this framework into the care they provide. When we examine access to infertility care through a reproductive justice lens, it becomes clear that to support the right to have a child, we must analyze and interrogate those systems and structures that do not make this right a reality. This includes:

- Grappling with the complicated, coercive, and harmful history perpetrated by reproductive health care providers in communities that have been historically marginalized, targeted, and abused.
- Advocating against legislative and institutional policies that reinforce segregation of risk and resources, including disparate insurance coverage, pay inequities that run along racial and gender lines, and lack of support for paid family leave.
- Lead, fund, and prioritize research that does not simply identify disparity but works to identify the causes and the remedies for these inequitable outcomes.

A vision for reproductive health and wellbeing that truly supports reproductive justice must include access to infertility care regardless of race, income, geography, or insurance status. Centering and focusing our advocacy on those who experience the greatest inequities and outcomes, as well as disparate access to care, must be a priority if we hope to achieve reproductive justice for all people.

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