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Politicizing Women's Bodies: Examining the Impact on Inequalities in Maternal Mortality and Assisted Reproductive Technologies in the United States

Ava Rastegar-Panah
ava.panah@icloud.com

ABSTRACT

In an increasingly political climate in the United States, reproductive health has been at the forefront of political contention, enabling policy to determine whose reproductive choices are valued and who has the privilege to reproduce safely. Existing research has thus far explored the issues of declining fertility rates, discrepancies in maternal mortality, and unequal access to assisted reproductive technologies (ART) in isolated contexts, though it falls short in examining them as a whole and establishing a political throughline. This paper synthesizes scholarship on fertility trends, maternal mortality, and ART to place them in the context of the contemporary reproductive landscape, and examines how politicizing women's bodies has exacerbated inequalities within reproductive healthcare in the United States. The review points to several major findings: declining fertility rates and consequent population concerns have allowed reproduction to be framed as a matter of national interest; maternal mortality disproportionately affects Black and American Indian/Alaska Native women, as well as women living in rural communities; and the tendency of ART to predominantly serve affluent, educated communities demonstrates a pattern of stratified reproduction. These inequalities in reproductive healthcare suggest that select groups of people have the ability to maximize their reproductive capabilities while protecting themselves from negative reproductive outcomes, a privilege that is reserved for some and withheld from others. Ultimately, the politicization of reproductive healthcare dangerously leaves the well-being of women contingent on political shifts and agendas.

INTRODUCTION

In June 2022, the Supreme Court decision *Dobbs v. Jackson Women's Health Organization* overturned the *Roe v. Wade* decision, eliminating Constitutional protection of a woman's right to an abortion and leaving it up to each state to independently determine the legality of abortion (Berg and Woods). This decision revoked the reproductive autonomy that women had obtained under *Roe v. Wade* and the broader movement for women's and reproductive rights in the U.S. in the latter half of the 20th century. The *Roe v. Wade* decision in January 1973 had established the constitutionality of abortion, protected by the right to personal privacy under the Fourteenth Amendment (Hull and Hoffer). With its overturning, state lines now influence a woman's access to reproductive healthcare and can consequently impact reproductive health outcomes, demonstrating how the politicization of reproduction has a significant impact on the

well-being of women and the course of their lives. This is not an isolated case, but rather a representation of a larger issue that has a tangible impact on many women.

In today's modern age, one marked by deep political polarization, politics has managed to infiltrate numerous aspects of our lives and has implications for social inequalities. From governing our routines and relationships to influencing if and how we can reproduce, politics has become inextricable from the way societies are organized. Reproductive politics are not the exception, and this has been the case for millennia. At the expense of women, girls, and families, sexual and reproductive rights have been manipulated by governments to align with shifting politics and national interests (Pugh; Forati and Bartz). From obtaining an abortion to contraception to fertility treatments and more, there are debates over whether these reproductive rights are human rights or ones determined by people in power.

Despite the reproductive rights movement gaining influence and credibility in the past few decades, the current state of reproductive health has seen steps taken in the opposite direction (Rebouché; Berg and Woods). As with many aspects of healthcare in the United States, the politicization of reproductive health has magnified existing inequalities in reproductive healthcare access, raising the question of whose reproductive rights are supported and whose are not. The term *reproductive justice* describes the right to have a child, the right not to have a child, and the right to parent children in safe and healthy environments (Ross and Solinger). In reality, one's ability to reproduce is heavily influenced by factors such as race, income, geography, and education, to name only a few. Reproduction is not just a matter of personal health, but rather something that is heavily shaped by politics and resulting inequalities, making it a topic of disagreement and division.

To understand current issues about reproductive healthcare access, it's important to understand not only how policies affect an individual's access to reproductive healthcare, but also how these decisions affect and are affected by social inequalities. Furthermore, in an age of technological advancement, new innovations in reproduction have provided certain populations with reproductive choice while leaving other populations out. This paper will discuss how issues such as declining fertility rates, maternal mortality, and the rise of assisted reproductive technologies (ART) in the United States are informed by the contemporary political landscape and the way they exacerbate structural inequalities, thereby answering the question of who can reproduce and who can do so safely.

METHODS

I found my sources by performing a wide search on Google Scholar, using keywords such as *reproductive health inequalities*, *pronatalism*, *maternal mortality*, *IVF*, and *surrogacy*. I read through the top journal articles that were generated from this search, prioritizing those published within the last decade and ones with U.S.-specific findings. While I began my search focused on major themes related to reproductive health, sources became more specific to individual issues as the process progressed. Examples include *maternity care deserts* and *biomedicalization of infertility*. I began reviewing sources with an eye for how

politics shape reproductive health, and found a diverse collection of over thirty peer reviewed articles, books, and government sites to draw upon. Using information from these sources, I included in-text citations to point readers to specific authors and created a corresponding references page.

TRENDS IN FERTILITY RATES

With recent declining fertility rates worldwide, reproductive health has become part of mainstream discourse in the United States and reproduction has been cast in an increasingly political light, calling into question which populations are encouraged to reproduce and which populations are discouraged. Pronatalist policies, which are those that encourage people to have more children, have existed dating back to ancient civilizations, whether it be for economic, nationalist, or population growth purposes. In the United States, pronatalism has become a stance adopted by politicians and voters due to increased religious traditionalism and nationalist sentiment (Forati and Bartz; Perry et al.). On the other hand, antinatalist policies have been enacted throughout the centuries to prevent people from having children, reflecting the anti-procreationist aspect of antinatalist thought (Morioka). Examples include China's one-child policy and India's forced sterilization to suppress excessive population growth and its burdens. These reproductive policies, whether ethical or not, reflect how governments frame reproduction as a matter of national interest or benefit.

Previously, antinatalist policies were enacted with the intention of curbing population growth; there were concerns that overpopulation would lead to overcrowding, disease, famine, poor sanitation, and a wide range of other alarming issues that would put humankind at risk (Fauser et al.). However, due to increased educational and career opportunities for women, paired with effective and accepted contraceptive approaches, women have delayed childbearing and fertility rates have consequently declined. In fact, fertility rates have dropped below the population replacement threshold of 2.1 births per woman in the United States (Kushnir et al.). Another cause of declining fertility rates is the surge of infertility in reproductive-age women in the past half-century, which is defined as the failure to conceive after 12 or more months of regular, unprotected sexual intercourse (Vander Borght and Wyns). ART developed within the last three decades has improved family-building opportunities for those affected by infertility, yet it remains unaffordable for most. This demonstrates how declining fertility rates have contributed to a stratified reproductive landscape.

Understanding these reproductive trends, such as declining fertility rates, gives us context for government involvement in reproductive health in the United States and the resulting policies that perpetuate inequalities. Analyzing the ways in which demographic changes turn population issues into political ones reveals how interconnected reproductive trends and politics really are. When policies, whether they be pronatalist or antinatalist, begin to shape reproductive choices and family planning, they naturally produce inequities that call into question the notion that all women have an equal right to reproduction.

REPRODUCTIVE HEALTH AND MATERNAL MORTALITY

Reproductive health policy has effects that extend far beyond legislation itself as it can significantly impact reproductive health outcomes across the United States. Reproductive health outcomes can be subject to a variety of inequalities deeply ingrained in the American healthcare system and broader society. Disparities exist across many areas of reproductive health, including contraceptive access and use, STI and HIV care, maternal mortality, prenatal care, reproductive cancer screenings, unintended pregnancies, preterm births, and more (Sutton et al.; Lewis et al.). This section will focus on maternal mortality: what it is, what causes it, the ways it disproportionately affects vulnerable populations, and how certain policies have worsened it.

Maternal mortality is defined as the death of a woman during pregnancy or shortly after childbirth due to pregnancy-related causes (Fleszar et al.). Specifically, the World Health Organization (WHO) states that maternal deaths include deaths within 42 days of termination of pregnancy but do not include pregnancy-associated deaths, which are deaths during or after pregnancy but not directly caused by the pregnancy (Hoyert). Maternal mortality rate (MMR), in particular, measures the number of maternal deaths per 100,000 live births, and is a statistic that has been tracked for decades. Over the past twenty years, there has been a rising trend in maternal deaths in the United States compared to declining maternal deaths in other high-income countries, indicating how the United States has been lagging behind the rest of the developed world when it comes to reducing preventable pregnancy-related deaths (Fleszar et al.). In fact, the MMR has tripled in the United States between the years 1990 and 2019, and the COVID-19 pandemic exacerbated this trend even further. Causes of maternal mortality include cardiovascular conditions, hemorrhage, infection, hypertensive disorders, amniotic fluid and pulmonary embolisms, anesthesia complications, and much more (Wang et al.; Njie et al.).

MMRs are noticeably influenced by a range of social determinants, highlighting how susceptible maternal health outcomes are to systemic inequalities. MMRs vary by race, income, education level, access to healthcare, housing conditions, social supports, culture, and beyond (Joseph et al.). A study conducted to determine how inequality affects maternal and infant mortality rates compared two measures: Human Development Index (HDI) and Inequality-Adjusted Human Development Index (IHDI). While both maternal and infant mortality were associated with lower development in a given area, IHDI predicted mortality rates more accurately than HDI, showing that unequal distribution of resources has a greater effect on MMRs than national development alone (Ruiz et al.).

One of the largest inequalities in maternal mortality is on the basis of race and ethnicity. Non-Hispanic Black women experience 3-4 times higher MMRs than non-Hispanic White women. American Indian/Alaska Native women are also disproportionately affected by maternal mortality. In fact, each year between 1989 and 2019, Black women experienced the highest median state MMR, and the median state MMR increased the most for American Indian/Alaska Native women (Fleszar et al.; Collier and Molina). This trend is due in part to Black women experiencing obstetric racism, a phenomenon in which the reproductive care of Black women follows the track of anti-Black racism in the United States. Obstetric

racism can lead to diagnostic lapses, neglect or dismissiveness, and coercion, which contribute to the higher MMR seen in Black women (Davis). These disparities are closely tied to implicit biases, which are unconscious attitudes and stereotypes that influence healthcare providers' decisions and behaviors toward their patients. Implicit biases lead to misdiagnosis, delayed treatment, and underestimation of patients' symptoms, which ultimately contribute to higher maternal mortality and morbidity (Majebi et al.). Negative reproductive health outcomes for women of color can also be attributed to fewer neighborhood health services, redlining, less insurance coverage, unequal access to education and employment, distrust of physicians and the healthcare system, and a segregated healthcare workforce, among other factors (Sutton et al.; Davis).

Geography is another factor that leaves certain groups vulnerable to poor maternal health outcomes. Maternity care "deserts," which are areas that lack maternity resources and care, affect over 2 million women in the United States and increase the risk of pregnancy-related complications, particularly in rural regions (Fontenot et al.; Bartick et al.). This geographical isolation leads to higher MMRs in rural areas compared to urban ones because these communities lack access to skilled birth attendants, emergency obstetric care, and basic prenatal services. When mothers have to travel long distances to healthcare facilities with inadequate medical supplies, there is a greater risk of complications during pregnancy (Majebi et al.). MMRs also vary significantly by state, with Southern states, particularly ones like Alabama, Mississippi, and Georgia, experiencing disproportionately high MMRs compared to other states (Fleszar et al.). This can be attributed to varying reproductive health policies from state to state.

Analyzing the trends and inequalities within maternal mortality demonstrates how the social and political conditions of the United States have an impact on reproductive health outcomes for millions of women. The persistence of preventable maternal deaths, specifically among populations already facing systemic disadvantages, highlights flaws within the American healthcare system and its tendency to leave particular groups of people vulnerable to negative reproductive outcomes. An example of policy aggravating these outcomes is the flawed system of reporting maternal deaths in the United States, given that it wasn't until 2003 that the pregnancy checkbox was added to death certificates. Even then, it was not uniformly added and only half of the states had it as of 2015. These discrepancies have led to inaccurate reporting of maternal mortality, which has made evidence-based prevention efforts increasingly difficult (Villavicencio et al.). Reproductive policy has the power to inhibit or enable maternal well-being, a power that should not be abused by the government or overlooked by the people. Paired with unequal resource allocation, it can act as a barrier to certain populations accessing safe reproductive healthcare, essentially excluding them from possessing the same reproductive privileges as other women.

ASSISTED REPRODUCTIVE TECHNOLOGY AND STRATIFIED REPRODUCTION

While inequalities within maternal mortality reveal the barriers to obtaining proper reproductive care for certain populations, scientific discoveries and resulting technologies in the modern age have broadened the scope of reproductive healthcare to new levels. This process is called biomedicalization, which builds

upon medicalization, or the expansion of medical jurisdiction into aspects of life previously beyond its realm. Biomedicalization is unique in the sense that it has transformed the capabilities of medicine through various computer and technoscientific inventions, providing social problems with medical solutions (Clarke et al.). These trends have also extended into reproductive healthcare, expanding the possibilities of ART and providing more options for families struggling to have children. That being said, any new technology raises the question of affordability and accessibility to all, demonstrating how access to reproductive healthcare can be stratified based on various factors. This section will provide an overview of two of these reproductive technologies, in vitro fertilization (IVF) and surrogacy, and the inequalities that exist within this lucrative industry.

In vitro fertilization (IVF) is the most common ART procedure and has redefined a human's potential to procreate since its clinical introduction in 1978 (Mackay et al.; Kushnir et al.). It is the process in which embryos are created outside of the body by combining eggs and sperm. If fertilization is successful, an embryo is typically transferred into the uterus to establish a pregnancy. This transfer can take place during the same cycle as the eggs are retrieved (fresh transfer) or at a later time using frozen embryos (frozen transfer), with one cycle usually taking between 2-5 weeks from start to finish. While IVF was originally developed to aid infertile couples, it has expanded to include same-sex couples, individuals who wish to become single parents, and individuals using an egg donor or surrogate (Northwestern Medicine).

The medicalization of infertility, specifically, has made the ability to "solve" infertility a privilege reserved for only some. Stratified reproduction describes the way in which societal structures and policies allow some people's reproductive health to be valued while others' remain devalued, a reality that affects millions of women across the United States (Cheney). Reproductive health access can be stratified along several different lines, including socioeconomic status, geography, and education. The most common explanation for disparities in access to infertility treatments is their enormous cost and little insurance coverage (Bell). Understandably, being of lower socioeconomic status, having a lower median income, and having limited or no health insurance coverage serve as barriers to receiving these treatments. Additionally, ART clinics are typically concentrated in metropolitan or larger regional areas, creating a geographic barrier to infertility care for those living outside of these areas (Mackay et al.; Harris et al.). It has also been found that women with less than a college education had a 79% higher chance of not pursuing treatment compared to college-educated women, demonstrating how one's academic background heavily influences one's ability to reproduce (Eisenberg et al.; Bell). These disparities in access to reproductive technologies shape the reproductive capabilities of different groups of women, a system of inequality that extends beyond just IVF.

Surrogacy is another industry that highlights many of these disparities within reproductive healthcare. To provide context, a surrogate mother is defined as a woman who becomes pregnant and gives birth to a child with the intention of giving the child away to another person or couple. Circumstances that may lead a woman to pursue surrogacy are the absence of a uterus, structural abnormalities of the uterus, severe medical conditions, or sometimes repeated miscarriages or implantation failures (Patel et al.). There are two main types of surrogacy: traditional and gestational. Traditional surrogacy is the practice of

artificially inseminating the surrogate mother with the father's sperm, making her a genetic parent (Patel et al.). Gestational surrogacy, which constitutes the bulk of surrogacy nowadays, involves implanting the intended parents' fertilized embryo into the surrogate mother, who carries the non-biological child to term; this form of surrogacy tends to eliminate the dispute over legal parentage (Cheney). Surrogacy can also be categorized as altruistic or commercial depending on the nature of the transaction. Altruistic surrogacy refers to arrangements in which the surrogate mother does not receive profit and is only reimbursed for pregnancy-related expenses. Commercial surrogacy, by contrast, occurs when the surrogate mother receives a base compensation on top of paid medical expenses. Due to the ethical concerns associated with commercial surrogacy, the United States and Russia are some of the only countries permitting the practice, and it is banned in many European Union countries. Nonetheless, surrogacy has become a booming industry in recent years, catalyzed by the advancement of ART and decreasing childbirth rates across the globe (Cheney). In fact, surrogacy has become one of the main sought-after procedures in fertility tourism (Patel et al.). That being said, with the increasing popularity of international and commercial surrogacy, inequalities have arisen within the industry that call its ethicality into question.

Commercial surrogacy exists within unequal power structures, creating legitimate ethical concerns surrounding its practice. There are generally concerns of exploitation, commodification, and coercion when women are paid to be pregnant and deliver babies, ones that are heightened due to the often large wealth and power gap between intended parents and the surrogate (Patel et al.; Bromfield and Rotabi). These gaps are amplified by transnational surrogacy because differences in socioeconomic status and race become more visible as the scope expands (Jacobson and Rozée; Cheney). Commercial surrogacy can exploit these inequalities because sometimes financial burdens motivate surrogate mothers to engage in surrogacy. Additionally, surrogacy can indirectly commodify women's bodies and expose surrogate mothers to many physical and emotional risks, all while providing them with weak legal protections (Attawet et al.). All that being said, assuming that commercial surrogacy is merely an exploitative industry may be an oversimplified perspective. It ignores the fact that women can have complex motivations and experiences that shape their decision to become surrogates, some of which include financial independence and an opportunity to improve their living conditions (Jacobson and Rozée). Surrogacy also expands reproductive choices and allows individuals or couples to have children when it otherwise would not have been a possibility (Attawet et al.). Ultimately, surrogacy lies in the space between empowerment and inequity, making it a very complex issue that can be dangerously prone to generalizations.

Examining the rise of ART, including IVF and surrogacy, as well as the inequalities that influence a woman's access to them, gives us a better understanding of the discriminatory nature of reproductive healthcare. It is also important to analyze how the politicization of reproductive healthcare, or surrogacy, for example, can deepen inequalities within the industry. Prior to the end of China's one-child policy, many U.S.-based surrogacy agencies would cater to Chinese couples who wished to evade China's policy and obtain U.S. citizenship for their children. This was made possible by the United States' liberal surrogacy laws. Even then, surrogacy packages for Chinese customers cost hundreds of thousands of

dollars, effectively restricting access to only serve the Chinese elite (Bromfield and Rotabi). These patterns highlight how technological advancements naturally bring disparities in affordability and accessibility, raising the question of whose ability to reproduce is prioritized and whose is overlooked.

LIMITATIONS

This paper has a number of limitations in its scope and the nature of its findings. The literature is centered on the United States, yet issues of reproductive health have global implications. This paper is not meant to generalize reproductive health issues, and other literature should be examined to gain a broader understanding of the global reproductive health landscape. This review also focuses on declining fertility rates, maternal mortality, and specific reproductive technologies; however, there are many other aspects of reproductive health that were not addressed. Abortion, for example, is an extremely relevant issue of reproductive health, but is beyond the scope of this paper as it was only mentioned briefly in the Introduction and Conclusion. Other research should be consulted to gain a more complete understanding of the controversy surrounding abortion and its undeniable impact on reproductive health in the United States. Finally, this paper reviews the impact of policies on inequalities in reproductive healthcare, but it is not designed to prove causation and should not be interpreted as such.

DISCUSSION AND CONCLUSION

This paper serves as an analysis of reproductive health in the context of heightened political polarization, evaluating how the politicization of reproduction perpetuates, and in some cases exacerbates, the systemic inequalities already present in American society. Examining reproduction through a political lens is not a new phenomenon, but the decline in fertility rates in recent decades has politicized reproduction to new heights, a reality that can have negative repercussions for many women. Whether it be through pronatalist policies, the overturning of *Roe v. Wade*, the failure of the government to accurately report maternal deaths, or the permissive surrogacy laws in the U.S., policy influences our daily lives in more ways than we can imagine.

By performing an in-depth investigation into the literature on maternal mortality, IVF, and surrogacy, as well as the policies surrounding them, this paper sheds light on the inequalities that exist within these realms. It exposes the fact that not all women are presented with equal opportunity to reproduce and to avoid negative reproductive outcomes in the process. Black and American Indian/Alaska Native women are disproportionately impacted by maternal mortality compared to their White counterparts. Access to infertility treatments like IVF is heavily influenced by one's socioeconomic status and geographic location. Unequal power dynamics between surrogates and intended parents raise concerns about the ethicality of surrogacy and its tendency to serve one group of people while failing another. The key takeaway from these findings is that the politicization of reproductive health has been an issue for

countless years; however, it has become clear that certain populations can insulate themselves from these shifting policies while others cannot.

In conducting this analysis of reproductive health literature, it became evident that while existing research provides a comprehensive understanding of individual elements of reproductive health, it is lacking in its ability to tell an interconnected story. There is a breadth of literature on the topics of fertility rates, maternal mortality, and ART when they stand alone, yet what is missing is the thread that weaves them all together: the fact that women's lives, particularly minority women's lives, are constantly up for political contention in ways that do not foreground their well-being. While being knowledgeable about these specific topics is essential, true understanding comes with examining the broader context of these issues and the ways in which they interact to shape people's lives, ultimately revealing how politicizing women's bodies has tangible consequences.

At the end of the day, that is what matters most: the people. In an increasingly polarized time, it is easy to be swept up in the surrounding chaos and lose sight of the negative consequences of the politicization of reproductive healthcare. Declining fertility rates and accompanying inequalities when women attempt to have children affect everyone, not solely those directly involved. Unless society creates a space that protects women and their reproductive rights, the state of reproduction will worsen and serious population concerns will arise. A young boy may have the notion that these issues do not affect him in any way, but what he may not realize is that they can affect someone he knows or cares about, and that matters. Part of having empathy and being a contributing member of society is caring about issues beyond oneself and one's self-interests. Reproductive healthcare is one of those issues.

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