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Layla Dhabaan March 25, 2024

Diasporic Infertility: The Refugee Pursuit of Motherhood & Assisted Reproductive Technology

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Abstract
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This thesis explores the interplay between infertility, reproductive rights, and the refugee experience in the United States. Drawing on interdisciplinary research across public health, bioethics, healthcare ethics, anthropology, and feminist theory, the study delves into an understanding of refugee women's experiences with infertility and reproductive health. It critically examines prevailing reproductive policies and their impact on refugee women, particularly in terms of societal expectations surrounding motherhood and gender roles. The research is guided by the central question: should fertility treatment be granted as an entitlement right for refugees?

In this work, I present an in-depth exploration of the historical context of eugenics and reproductive healthcare in America, focusing on stratified reproduction and its implications on access to reproductive medical services for refugee women. I then transition to examine trauma and bereavement, particularly as they stem from war, and their consequential roles in influencing infertility or driving refugees to reproduce. Through narratives collected via the Photovoice project, which integrates visual narratives and participatory methods, the research delves into refugee women's views on motherhood, identity, and the transformative impact of supportive reproductive healthcare.

Through this evidence I contend that medical interventions related to infertility, like IVF, possess contradictory effects within broader societal systems. While labeling ART as an entitlement right promises democratized access to medical care and addresses historical injustices, it also raises challenges concerning gender ethics and cultural dynamics. The study explores how ART, as a potential entitlement right, might both alleviate and exacerbate societal pressures surrounding compulsory motherhood, particularly for refugee women.

The thesis concludes with reflections on the broader implications of framing ART as an entitlement right. I advocate for a balanced and inclusive approach that not only seeks to equalize access but also considers the impact on cultural dynamics and gender norms. The work contributes to a discourse that not only recognizes the multifaceted challenges faced by refugee women in accessing reproductive healthcare but also advocates for transformative approaches that address historical injustices and current inequalities.

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Introduction

In my time as a labor support volunteer at Embrace Refugee Birth, a nonprofit which guides refugee mothers throughout pregnancy, I had the privilege of hearing several stories about their journey to motherhood.[1] Longing for years to have a child, one mother faced the dual challenges of infertility and the refugee experience in America. Eager to continue her family legacy and symbolize her triumph over conflict, she sought in vitro fertilization (IVF) in hopes for a child. Due to her diagnosis of diabetes, American doctors deemed her ineligible for in vitro fertilization. Faced with healthcare barriers in the U.S and driven by desperation, she resorted to spending thousands of dollars to return to her home country for IVF. Upon returning to the U.S. afterwards, her doctors misdiagnosed her joyous news as kidney cancer instead of a pregnancy. Through multiple tests and unwavering faith, it was eventually confirmed that the supposed kidney cancer was indeed her own child, whom she chose to name Haniya.

Her story is one of many highlighting the barriers that refugee women face in the pursuit of parenthood in America. Cultural misunderstandings, limited access to specialized healthcare, economic challenges, and systemic gaps are not just obstacles; they represent a failure to uphold what should be an entitlement to reproductive health services such as IVF.[2] Refugee women, in their journey to motherhood, must navigate a complex maze of healthcare that often fails to consider their unique circumstances, making an already emotionally charged journey even more challenging.

The term "refugee" may conjure images of families on a boat drifting overseas, malnourished children from Yemen, or a war-torn photo of a neighborhood in Beirut. In

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[1] Embrace Refugee Birth is a nonprofit organization based in Clarkston, Georgia, dedicated to educating, advocating, and empowering refugee women throughout their pregnancy and pursuit of motherhood.

[2] Tali Filler, Bismah Jameel, and Anna R. Gagliardi, "Barriers and facilitators of patient-centered care for immigrant and refugee women: a scoping review," *BMC Public Health* vol. 20, no. 1013 (2020): 2-11.

exploring definitions of a refugee, it's crucial to grasp the diverse definitions that encapsulate the complexity of a refugee's status and experiences. The legal definition of a refugee is a person "who is outside their country of origin for reasons of feared persecution, conflict, generalized violence, or other circumstances that have seriously disturbed public order and, as a result, require international protection."[3] For the sake of this thesis, I define a refugee as someone forcibly displaced from their homeland due to war or political persecution, but I recognize that this definition is not static. In this thesis, the term "refugee" is frequently used, but I acknowledge that it is a generalization that cannot currently be lifted due to the lack of empirical knowledge regarding the diversity of refugees.

Involuntary childlessness due to infertility can significantly disrupt an individual's life, leading to economic, psychological, social, and medical repercussions.[4] Motherhood and reproduction are significant experiences for women within multiple cultural, religious, and biological spheres. Historically, motherhood has held a central place in the identity of women across many societies.[5] This project critically examines how prevailing reproductive policies impact refugee women in distinct ways. My research is guided by a central question: should fertility treatment be granted as an entitlement right? In what ways would categorizing ART as

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[3] "The definitions of 'refugee' in international law have historically evolved as instruments of control, often prioritizing state rights over individual refugee rights: "International refugee law has evolved as a means of control over the refugee. The first principles on which it has been built place the rights of the state above those of the refugee. Insofar as there is such a thing as a 'right of asylum,' it is a right vested in the state rather than the refugee. As such, from the perspective of seeking a protection regime that places the needs of the refugee at its center, it is a system that is fundamentally unreformable." See Simon Behrman, "Refugee Law as a Means of Control," *Journal of Refugee Studies* Vol. 32, No. 1 (2018): 42.

[4] Tara M. Cousineau and Alice D. Domar, "Psychological impact of infertility," *Best Practice & Research Clinical Obstetrics and Gynaecology* Vol. 21 No. 2 (2007): 298.

[5] This emphasis on motherhood extends to various cultures, as Arthur Greil mentions "Among the Yoruba the adult woman's role depends on motherhood because children are essential to the continuation of lineages," and "in Chad there is pressure to prove one's fertility soon after marriage; menstruation is regarded as a 'bad sickness,'" see Arthur L. Greil, Kathleen Slauson-Blevins, and Julia McQuillan, "The experience of infertility: A review of recent literature," *Sociol Health Illn.* vol 32, no. 1 (2010): 152.

an entitlement right impact refugee women's expressions of identity, parenthood, and gender roles? Theoretically, I examine the normative aspects of categorizing ART as an entitlement right and how this categorization might influence refugee women's experiences in identity formation, parenthood, and gender roles. Empirically, I explore the practical realities faced by these women in accessing ART. By integrating these perspectives, my project aims to understand the motivations driving the pursuit of ART among refugee women and scrutinize the broader societal expectations around motherhood. This project examines the motivations driving the pursuit of assisted reproductive technology (ART) and unpacks the implications of societal expectations regarding motherhood. Centering the experiences of refugees, I explore how labeling access to ART as an entitlement right can simultaneously alleviate and exacerbate the pressures associated with those expectations.

This project integrates interdisciplinary research from the fields of public health, bioethics, healthcare ethics, anthropology, and feminist theory to advance a more nuanced understanding of refugee women's experiences of infertility and reproductive health. By putting these fields of study into conversation, I contribute a more intersectional understanding of ethical challenges and considerations surrounding ART for refugee women. I contextualize this research within the history of reproductive healthcare, especially its entanglement with social inequalities tied to race, class, and gender. By weaving together these interdisciplinary bodies of research, my objective is to shed light on the interconnected nature of identity, reproductive rights, and systemic inequalities. Through this exploration, I aim to contribute to a discourse that not only recognizes the multifaceted challenges faced by refugee women in accessing reproductive healthcare, but also advocates for a transformative approach. This approach addresses historical injustices and challenges the current inequalities perpetuated by the commercialization of

medical interventions. Recognizing the interconnection between individual choices and broader societal transformations, I explore the benefits and drawbacks of labelling fertility an entitlement right, with a focus on refugee women and an emphasis on free access to ART. At the individual level, it is essential to acknowledge the complexity of decision-making for or against specific interventions, especially for refugee women. Simultaneously, at the macro-level, there is a need to address unjust social, economic, and political institutions and norms that contribute to disparities in access, as well as ethical considerations related to ART.

By reading public health data side-by-side with medical ethics research, I argue that ART should be unequivocally extended as an entitlement right to all individuals in the United States, emphasizing the need for inclusive access, especially for refugee women. Furthermore, the commercialization of IVF and other assisted reproductive technologies raises ethical questions that demand attention. The current landscape of reproductive healthcare often prioritizes the wealthiest, reinforcing existing social inequalities and sidelining those who are socioeconomically marginalized.

By integrating anthropological insights on individualism and parenthood as identity, I offer a cultural framework to comprehend the diverse ways individuals construct their sense of self in the context of parenthood. I explore how notions of identity influence decision-making around reproductive health among refugee women, recognizing the intersectionality of cultural norms, personal values, and societal expectations in shaping individual perspectives on fertility treatments.

Finally, I leverage the power of visual narratives through photovoice, a participatory method created by Caroline Wang and Mary Ann Burris.

> Photovoice is described as “a process by which people can identify, represent, and enhance their community through a specific photographic technique. As a practice based

> in the production of knowledge, photovoice has three main goals: (1) to enable people to record and reflect their community's strengths and concerns, (2) to promote critical dialogue and knowledge about important issues through large and small group discussion of photographs, and (3) to reach policymakers."[6]

Utilizing feminist theory to acknowledge women as experts on matters impacting them, Photovoice was justified by Wang and Burris contending that research about women should be conducted "by and with women, rather than on women."[7] I use this method to amplify the voices of refugee mothers, providing a platform for them to express their experiences of parenthood.[8] This participatory method becomes a crucial tool for public health expression, shedding light on the lived realities and challenges faced by refugee women navigating infertility. Contrary to the field's overwhelming use of quantitative data and research methodologies, this approach emphasizes the importance of their perspectives in shaping healthcare narratives. This method enables participants to harness visual imagery and narratives to foster social change and a deeper understanding of their lived experiences.

The central claim of my thesis is that medical interventions related to infertility like IVF inherently possess contradictory effects. These effects, such as reinforcing inequality and creating and relieving suffering, are deeply embedded in the broader societal systems in which these interventions are produced and utilized. Importantly, I contend that these contradictions cannot be neatly resolved analytically. Labeling ART as a fundamental entitlement right holds the promise of democratizing access to essential medical care. By recognizing ART as an

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[6] Caroline C. Wang and Mary Ann Burris, "Photovoice: Concept, Methodology, and Use for Participatory Needs Assessment," *Health Education & Behavio*r vol. 24, no. 3 (1997): 1.
[7] Diane Macdonald, Karen Peacock, Angela Dew, Karen R. Fisher, and Katherine M. Boydell, "Photovoice as a platform for empowerment of women with disability," *SSM - Qualitative Research in Health* vol. 2, (2022): 1.
[8] Originally, my plan was to conduct interviews with infertile refugee women. However, I've encountered considerable challenges due to the stigma surrounding infertility, which has made it difficult for me to engage women in discussions about these sensitive issues. Additionally, finding a cohesive community of these women has been a challenging task. In parallel, I have been involved as a research assistant in a Photovoice project focused on refugee mothers, which has provided me with valuable insights into their perspectives on motherhood.

entitlement right, there is an opportunity to level the historically stratified medical system, ensuring that fertility treatments are accessible to a wider demographic. Moreover, this approach acknowledges the intricate connection between infertility and its root causes, such as trauma, war, and colonization, paving the way for comprehensive healthcare solutions.

However, the potential advantages are not without their challenges. When scrutinized through the lenses of gender ethics and cultural considerations, a more complex narrative emerges. On one hand, ART as an entitlement right may exacerbate cultural attitudes and societal pressures surrounding compulsory motherhood, potentially intensifying expectations placed on women. Particularly concerning is the gender normative pressure to have children among refugee women, as highlighted by gender ethics discussions. This dual perspective underscores the need for a balanced and inclusive approach when framing ART as an entitlement right, considering not only its potential to equalize access but also its impact on cultural dynamics and gender norms.

Chapter Outlines:

This project is divided into four chapters. Each chapter grapples with the question of how labelling ART an entitlement right would impact refugee women through a different perspective.

The first chapter examines how the history of reproductive healthcare in the United States prefigures stratification in access to reproductive medical services. In laying the foundation for our exploration, the first chapter provides a comprehensive understanding of stratified reproduction, which resonates throughout the subsequent discussions. Stratified reproduction delineates the unequal distribution of both social and biological reproduction within different

populations, and in this framework, middle and upper-class women have greater access to assisted reproductive technologies like IVF or comprehensive prenatal care, whereas economically disadvantaged women, including refugees, may face barriers to these services. The concept highlights contrasting pressures: while upper-class (often white) women are urged to reproduce, low-income or marginalized women of color are discouraged from doing so, shedding light on the unequal access to reproductive healthcare.

I delve into the establishment of the dichotomy between birth control and assisted reproductive technologies, unraveling how these contrasting approaches have contributed to the stratification evident today. Examining the role of organizations like Planned Parenthood in birth control and reproduction inhibition, I aim to uncover their impact on stratified reproduction. Additionally, I will explore how the use of IVF and fertility treatments may also play a role in shaping these patterns of social stratification. In the second section, I discuss the impact of stratified reproduction on refugee women in America, examining the unique levels of inequality compared to other women.

The second chapter addresses issues of embodied trauma resulting from the experiences of refugees before and after arriving in the United States. This chapter grapples with cultural bereavement and the question of reparative justice, and how access to ART might be imagined as a form of reparations for the colonialist origins of various refugee experiences, including infertility. I will explore how ARTs might potentially help women grappling with this complex trauma—or how it might not. I raise a critical question: Can framing ART as an entitlement right serve as “reparations” for America's historical colonial force against several refugee-origin countries? This force frequently compels women to flee, subjecting them to maternity-related trauma. The resultant embodied trauma exhibits itself in various ways, impacting reproductive

health, physical well-being, and spanning across generations, and should indeed be contemplated as a potential contributor to infertility problems.[9]

In the third chapter, I discuss the Photovoice project, where a group of refugee women tell their lived narratives of motherhood through photography. These images serve as a powerful tool to convey their unique experiences as mothers in America. By contextualizing their lived experiences alongside these visuals, I showcase how the intersection between motherhood and identity unfolds. Drawing upon both cultural narratives documented in research literature and my own personal experiences, I highlight the profound importance of motherhood as a means of affirming identity in the lives of individuals within these cultures. The term "identity-affirming" suggests that successfully undergoing ART and achieving pregnancy may be a significant and positive affirmation of one's identity, particularly for individuals aspiring to become mothers. In this way, ART may not only be seen as a medical solution but also as a means of reinforcing and validating a person's identity.

However, I contrast these anecdotes with the concept of compulsory motherhood, which refers to the societal expectation or pressure placed on women to become mothers, and often

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[9] An example of such impacts of war on current refugees in America is the diaspora from Iraq: "Overtime a number of serious health risks and dangerous conditions became linked to DU exposure," encompassing a spectrum from cancers to neurological disabilities, birth defects, and perinatal deaths [...] Extending the scope to Fallujah, Iraq, the review responds to reports linking increases in congenital birth anomalies and cancer to DU contamination following battles in 2004 [...] Babies born in Fallujah are exhibiting high rates of mortality and birth defects," revealing a dire situation where a significant percentage of newborns faced deformities and mortality. See Tariq S Al-Hadithi, Jawad K Al-Diwan, Abubakir M Saleh, and Nazar P Shabila, "Birth defects in Iraq and the plausibility of environmental exposure: A review," *Conflict and Health* vol. 6, no. 3 (2012): 3.

portrays motherhood as essential to the role for women. I thus take a turn in this chapter to argue that it is possible that some women's aspiration to become mothers could stem from a compliance with the idea of compulsory motherhood. I raise the question: what comes first—the internal desire for a religious, cultural, and biological path towards motherhood, or societal pressure to bear children, driven by gender norms defining women's roles?

Building upon the arguments presented in the previous chapters in the conclusion, I scrutinize whether ART can be perceived as a fundamental entitlement right for refugee women or if it leans more towards a societal privilege for only some women. To broaden the discourse, I introduce various definitions of fertility.

Drawing on the insights gained from discussions on stratified reproduction, postcolonial theory, feminist theory, personal narratives, and the challenges posed by compulsory motherhood, I align each with the ethical considerations of entitlement rights. This exploration aims to ascertain whether providing universal access to fertility care is both ethical and beneficial for all individuals. Central to this inquiry is the definition of a human right, strategically used to evaluate the potential impact of different conceptualizations of fertility on the empowerment, self-perception, and overall growth of refugee women in America. By scrutinizing the interconnected effects of infertility and involuntary displacement on extended families and communities, including embodied trauma, economic struggles, legal and social challenges, health concerns, and long-term uncertainties, I strive to underscore the urgency and importance of framing ART as an entitlement right.

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By framing ART as a fundamental entitlement right, the dissertation envisions democratizing access to essential medical care and addressing historical injustices. However, it critically acknowledges the potential challenges, particularly concerning gender ethics and cultural considerations. The examination prompts a call for a balanced and inclusive approach that not only equalizes access but also considers the broader impact on cultural dynamics and gender norms. Through an extensive exploration of diverse perspectives on fertility, the study advocates for a redefined understanding that respects the human rights of all individuals, especially those who have experienced involuntary displacement. The concluding reflection questions prevailing labels and statistical categories associated with infertility, urging a reconsideration that goes beyond reducing nuanced experiences to medical terms. Ultimately, this comprehensive investigation strives to contribute to a transformative discourse that seeks justice, equality, and ethical considerations in the realm of reproductive healthcare for refugee women.

Chapter 1: Stratified Reproduction in History

To understand the cultural and medical context in which refugees seek access to reproductive healthcare, it is crucial to set the stage by exploring the historical context of reproductive health in America and the evolving approaches to both encourage and prohibit reproduction. Coined by Shellee Colen in the 1980s, “stratified reproduction” sheds light on the ways in which societal structures and power dynamics contribute to differential access to reproductive technologies, healthcare, and family planning resources.[10] Rooted in racialized images of motherhood, stratified reproduction reveals a stark social problem. For example, according to sociologist Dorothy Roberts, prevailing narratives depict black mothers as "unfit, uncaring, and immoral," acting as boundaries that shape societal discourse and perpetuate assumptions about citizens' moral standing.[11]

The persistence of stratified reproduction becomes evident when examining group differences in reproductive control and access to reproductive health. Women of color find themselves in a paradoxical situation – overrepresented among those dealing with infertility yet underrepresented among those receiving essential medical services. As historian Linda Gordon notes, this discrepancy reflects societal values dictating who is deemed “deserving” of motherhood.[12] In such a framework, middle and upper-class women might have greater access to assisted reproductive technologies like in IVF or comprehensive prenatal care, whereas economically disadvantaged women, including refugees, may face barriers to these services.

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[10] Faye D. Ginsburg and Rayna Rapp, *Conceiving the New World Order: The Global Politics of Reproduction* (Berkeley, CA: University of California Press, 1995), 77.
[11] Dorothy E. Roberts, “Kinship Care and the Price of State Support for Children,” *Chicago-Kent Law Review* vol. 76, no. 3 (2001): 1621.
[12] Dorothy E. Roberts, “Racism and Patriarchy in the Meaning of Motherhood,” *Journal of Gender & the Law* vol. 1, no. 1 (1993): 1-38.

Reproductive health is a subject that illuminates the stratification experienced by lower-income women. Within the field of healthcare, the experiences of infertile white women are thoroughly scrutinized while those of infertile refugees and marginalized women are merely glanced over.[13] This reflects the longer history of overlooking marginalized women in medical contexts.[14] It reveals a gap in the development of theories that inform public discourse, with the lived experiences of refugee women noticeably absent. While feminist thinkers and advocates of women's health applaud advancements in addressing infertility and empowering women, refugee women are mentioned only in passing or within footnotes of such studies.[15] Their absence from the literature is not a result of refugee women's immunity to struggles with infertility, but it is a result of the consensus of writers that infertility is not the most pressing issue for refugees. Literature addressing refugees tends to concentrate on their psychological well-being and general health barriers and traumas, overlooking other aspects. The early history of reproductive healthcare, encompassing the evolution of birth control, abortion, and IVF, indicates that despite the initial goal of empowering all women, the disparities in access have deepened the divide among women of different races and classes. This chapter examines that history to demonstrate how and why refugee women have been excluded from conversations about reproductive health, infertility, and IVF access through stratified reproduction.

Healthcare disparities in America are deeply rooted in historical and current social and economic inequalities, further exacerbated by ongoing racial and ethnic discrimination. These

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[13]Tariq S. Al-Hadithi, Jawad K. Al-Diwan, Abubakir M. Saleh, and Nazar P. Shabila, "Birth defects in Iraq and the plausibility of environmental exposure: A review," *Conflict and Health* vol. 6, no. 3 (2012): 2.
[14]Kristina Gupta, "Medical Entanglements: Rethinking Feminist Debates about Healthcare," *Rutgers University Press* (2019), 23-24, 25, 26, 31, 33-34, 38, 39, 113-114, 116, 120, 121.
[15] Antoine A. Abu-Musa, Loulou Kobeissi, Antoine B. Hannoun, Marcia C. Inhorn, "Effect of war on fertility: a review of the literature," *Reproductive BioMedicine Online* vol. 17 Suppl. 1 (2008): 43-53, and Noreen Maconochie, Pat Doyle, and Claire Carson, "Infertility among male UK veterans of the 1990-1 Gulf war: reproductive cohort study," *BMJ* (2004): 2.

disparities are strikingly evident in the realm of reproductive healthcare, where the high cost of treatment and limited service access disproportionately affect minorities, making infertility treatments like IVF less accessible to them.[16] Studies emphasize the need for more comprehensive and transparent patient data on race and ethnicity to better understand and address these disparities.[17]

The concept of stratified reproduction is fundamental to contemporary reproductive health in America. It illustrates how political, economic, and social forces categorize people, valuing the reproduction of some while devaluing others. This stratification is particularly pronounced among lower- and working-class women experiencing infertility. They face conflict due to intersecting ideologies of the "motherhood mandate" and "intensive mothering," which are based on a white, middle-class, heterosexual standard.[18] This leads to the marginalization and systematic devaluation of women unable to fulfill these ideals, marking women of low socioeconomic status as "bad" mothers and setting them up for failure against societal expectations of "good mothering."[19]

Furthermore, the concept of "Transnational Mother Blame," refers to a pattern of blaming mothers across international contexts, especially prevalent in situations involving migration and globalized economic circumstances.[20] It builds on traditional ideas that women have simultaneous responsibility and incapacity to ensure their family's health. This is notably evident

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[16] As Chandra and Martinez mention, "Racial and ethnic disparities were evident in the payment for family planning services. Hispanic and non-Hispanic black women were more likely to use Medicaid for these services (24% and 30%, respectively) than non-Hispanic white women. This points to racial and ethnic differences in healthcare access and affordability," See Anjani Chandra, Gladys M. Martinez, William D. Mosher, Joyce C. Abma, and Jo Jones, "Fertility, family planning, and reproductive health of U.S. women: data from the 2002 National Survey of Family Growth," *Vital Health Stat* vol. 23 *(*2005): 2.

[17] Melissa F. Wellons and Victor Y. Fujimoto, "Race matters: a systematic review of racial/ethnic disparity in Society for Assisted Reproductive Technology reported outcomes," *Fertility and Sterility* vol. *9*8 (2012): 405.

[18] Roberts, "Racism and Patriarchy," 33-34.

[19] Roberts, "Racism and Patriarchy," 33-34.

[20] Alyshia Gálvez, "Transnational Mother Blame: Protecting and Caring in a Globalized Context," *Medical Anthropology* vol. 39, no. 6 (2020): 488-502.

among Mexican mothers in the U.S., who become part of a broader racialized underclass and are often labeled as incapable and irresponsible, implicitly pressuring them not to reproduce due to a perceived inability to provide adequately for their children.[21] This scenario underscores the societal and structural pressures refugee and immigrant mothers face, particularly those from marginalized communities, which significantly influences their reproductive choices and further exacerbates the disparities in reproductive health care.

Section 1: The Origins of Birth Control & New Eugenics

To understand the profound influence of historical shifts in eugenics on reproductive choices and the resulting disparities in reproductive healthcare, we must delve into the history of women pressured *not* to reproduce. The shift in eugenic laws and practices in the post-World War II era involved a significant transformation from compulsory measures to an emphasis on voluntary sterilization and reproductive choice.[22] This change was influenced by the growing unpopularity of compulsory sterilization laws and a broader social and political shift following the atrocities of the Nazi regime during World War II.[23]

The failure of compulsory sterilization laws led to a shift in eugenic strategy. Moya Woodside, a British sociologist, argued that effective eugenic laws in democratic countries

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[21] " As Rayna Rapp explains, "Transnational "mother blame" attributes simultaneous responsibility to and incapacity of women to ensure their family's health in a neoliberal globalized transnational context in which mobility and flexible care arrangements are both necessary and constrained [...] in the US Mexicans become part of a more generally racialized underclass. In either national context the result is mother-blame for the structural violence and health disparities of poverty. This very old scenario is now wrapped in a newer neoliberal vocabulary of 'capacity' and 'responsibility;' Mexican mothers differently racialized on both sides of the border are often labeled as lacking both." See Rayna Rapp, "Race & Reproduction: An Enduring Conversation," *Medical Anthropology* vol. 38, no. 8 (2019): 725-732.

[22] Carey, "Racial Imperatives," 433-447.

[23] Carey, "Racial Imperatives," 433-447.

should not be compulsory but instead should respect free choice.[24] This perspective influenced the development of new laws from 1950 to 1967, which respected some form of reproductive choice, at least in appearance.[25]

As a result, pro-eugenic organizations transformed their strategies and rhetoric.[26] These organizations moved away from political lobbying and began to focus on funding research that demonstrated the benefits of improving the population's "quality." These organizations identified less controversial legal reform programs, which they believed would achieve the same effects as openly eugenic programs. During this period, population control reform became an ideal program for pro-eugenic organizations.[27] The platform that resulted from these changes better accounted for individual choice but was also more openly racist than earlier eugenic legal reform projects.

The new reform efforts redefined reproductive choice. Many individuals considered socially inadequate were viewed as incapable of making correct reproductive decisions.[28] Pro-eugenic organizations advised their volunteers to manipulate information about birth control or sterilization to ensure that the "right choice" was made, especially among those deemed socially inadequate. Consequently, while overt eugenic influence on the law appeared to

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[24] Mary Ziegler, "Reinventing Eugenics: Reproductive Choice and Law Reform After World War II," *Cardozo Journal of Law & Gender* vol. 14, no. 319 (2008): 319-340.
[25] Ziegler, "Reinventing Eugenics," 322-323, 326-327.
[26] This is explained as the Human Betterment trainers "were instructed to ensure that indigent patients made the right reproductive choice. First, Human Betterment volunteers were advised to approach women immediately after they had delivered children, a time when the women were thought most likely to agree to sterilization [...] Hospital officials, like leaders of Human Betterment, were accused of being racist and of maintaining ties to the eugenic legal reform movement of the earlier twentieth century. Defending her organization in the face of attacks by Catholic and African-American leaders, Smith argued that the program benefited 'the poor and uneducated... for whom surgical birth control is the only answer.'" See Ziegler, "Reinventing Eugenics," 343.
[27] Ziegler, "Reinventing Eugenics," 336, 343-344.
[28] Ziegler, "Reinventing Eugenics," 332-333.

diminish post-World War II, the ideologies and practices merely transformed, continuing to impact reproductive laws and policies subtly.[29] For example,

> The Population Council was formed partly by leaders of the eugenic legal reform movement who intended to create a new kind of organization in response to post-war politics: an organization that would prevent overall population growth and preserve the "quality" of the population.[30]

The Human Betterment organization, for example, instructed its volunteers to ensure that indigent patients made the right reproductive choices, particularly focusing on sterilization.[31] They targeted women immediately after childbirth, a time when they were most likely to agree to sterilization. The organization emphasized the advantages of the procedure using simple and abstract language. This strategy was part of a larger effort to change the political meaning of sterilization, framing it as a matter of entitlement rights and personal choice rather than a compulsory eugenic measure. This evolution in Human Betterment's approach represented a significant change in the relationship between eugenics and law post-World War II, diverging from the traditional narrative. The leaders of Human Betterment did not alter their fundamental goals or methods; instead, they shifted their rhetoric. This strategic change implied that as it was framed within the context of reproductive choice, eugenic sterilization could still be supported.[32]

W.E.B. Du Bois offered a perspective in the Birth Control Review, remarking that "the mass of ignorant Negroes still breed carelessly and disastrously."[33] His approach advocated a fertility policy steeped in paternalism, emphasizing the need for "proper birth control" to attain a level of societal respectability. This perspective stood in stark contrast to the prevailing racial

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[29]Ziegler, "Reinventing Eugenics," 332-333.
[30]Ziegler, "Reinventing Eugenics," 332-333.
[31] Ziegler, "Reinventing Eugenics," 339, 343.
[32] Ziegler, "Reinventing Eugenics," 343.
[33] Andrea Patterson, "Germs and Jim Crow: The Impact of Microbiology on Public Health Policies in Progressive Era American South," *Journal of the History of Biology* vol. 42, no. 3 (2009): 539.

anxieties of the time, which feared an excessive hyperfertility among Black populations. However, defying these racist notions, the reproduction rates among Black communities experienced a notable decline during the Jim Crow era, a trend that has continued to the present.[34]

Margaret Sanger, a pioneering American birth control activist and the author of *Woman and the New Race*, played a crucial role in the early reproductive rights movement.[35] In 1916, she opened the first birth control clinic, which later evolved into the Planned Parenthood Federation of America, an organization dedicated to providing reproductive health services and education in the United States.[36] Sanger's work extended beyond advocacy to practical initiatives, such as the establishment of the "Negro Project" in collaboration with W.E.B. DuBois, Mary McLeod Bethune, and Rev. Adam Clayton Powell.[37]

This project aimed to reduce mistrust in a racist healthcare system by placing Black doctors and nurses in charge of birth control clinics.[38] In 1921, Sanger founded the American Birth Control League with figures including Lothrop Stoddard and other eugenicists, advocating for birth control as a means of women's liberation from the constraints of housewifery, rather than a tool of oppression.[39] Her efforts significantly contributed to the empowerment of women, particularly in controlling the timing and number of children they wanted, a freedom further solidified by the legalization of abortion in 1973.[40] However, a pivotal question arises: can

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[34]Dorothy Roberts, *Killing the Black Body,* (New York: Pantheon Books, 1997), 339, 343, 344.
[35] Margaret Sanger, *Woman and the New Race*, (New York: Truth Publishing Company, 1920).
Rayna Rapp, "Race & Reproduction: An Enduring Conversation," *Medical Anthropology* vol. 38, no. 8 (2019): 725-732.
[36] Dorothy Wardell, "Margaret Sanger: Birth Control's Successful Revolutionary," *American Journal of Public Health* vol. 70, no. 7 (1980): 736-742.
[37] Star Parker, Christina Daniels, Catherine Davis, and Ifeoma Anunkor, "The Effects of Abortion on the Black Community," *Policy Report* (2015): 339, 343.
[38] Roberts, "Racism and Patriarchy," 17-18.
[39] Carey, "Racial Imperatives," 741.
[40] Alexander Sanger, "Eugenics, Race, and Margaret Sanger Revisited: Reproductive Freedom for All?," *Hypatia* vol. 22, no. 2 (2007): 210-217.

women's liberation be constructed upon the regulation of their bodies? This inquiry prompts a deeper exploration of what empowerment truly signifies for women.

Yet, amidst the revolutionary changes for women's health and autonomy, Sanger's advocacy for birth control takes a compelling turn. Despite Sanger's intentions to empower women with birth control, some of her work may highlight ulterior motives. The American Birth Control League aimed to address issues like poverty caused by "reckless procreation" and the rapid increase of those deemed "least fit" to reproduce. It focused on promoting birth control as crucial for "national and racial progress," advocating for the creation of a "well born" race, and supporting the sterilization of individuals considered "insane and feebleminded."[41] This group of eugenicists sought to shape society through methods like segregation, sterilization, and even abortion to control what they perceived as "inferior" races.[42]

Sanger and other advocates of birth control were seen as intrinsically eugenic, enabling "fit" mothers to have fewer but better children, while reducing the number of "degenerate" children from "poor" mothers.[43] In her book, Sanger defined freedom as "the liberty for her and her socialite friends to have as few children as they wished," while also emphasizing the freedom to control reproduction for those with "differing ideas" who "needed" birth control.[44] For Sanger, those women with "differing ideas" included many women of low-income levels. Sanger stressed this issue, saying "the most urgent problem today is how to limit and discourage the over-fertility of the mentally and physically defective."[45]

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[41] Jane Carey, "The Racial Imperatives of Sex: Birth Control and Eugenics in Britain, the United States and Australia in the Interwar Years," *Women's History Review* vol. 21, no. 5 (2012): 733-752.
[42] Carey, "Racial Imperatives," 741.
[43] Carey, "Racial Imperatives of Sex," 733-752.
[44] Angela Franks, *Margaret Sanger's Eugenic Legacy: The Control of Female Fertility* (Jefferson, NC: McFarland, 2005): 38.
[45] There has been debate about whether Sanger actually made the statement, but it was cited in American Medicine papers. This illustrates the dominant attitudes during pivotal times when determining who should have access to

The abortion clinic is a place where poverty has become medicalized for many women. Roe v. Wade was intended to eliminate the unequal access associated with privilege. On the surface, it appeared to democratize access to abortion, theoretically making it widely available to all women. However, a closer examination of how and when abortion services are provided reveals persistent inequalities. While women generally have access to abortion, there remains an imbalance in the types of care available. Some receive care in hospitals, while the majority receive care from specific outpatient facilities, highlighting ongoing disparities in access to abortion services.

While abortion is technically accessible to most women, disparities in the type of care available point towards a nuanced form of medical stratification.[46] The persistent inequalities evident are not just about legal access but also about the practical and financial realities of obtaining an abortion. This includes the challenges faced by women in impoverished circumstances or those living in areas where abortion clinics are scarce or heavily regulated.[47] The very medicalization of abortion, where it is enmeshed in a web of healthcare bureaucracy, insurance complexities, and socioeconomic barriers, disproportionately impacts lower-income women such as refugees. This situation underscores a grim irony: the clinics, imagined as sites of emancipation and healthcare, can inadvertently become areas where poverty is medicalized.

On the other end of the spectrum are women for whom abortion care is less encumbered by financial constraints or geographic limitations. These women, often with access to private or public health insurance or sufficient out-of-pocket funds, live in areas where abortion services

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these services and the underlying reasons. See Karen Hardee-Cleaveland and Judith Banister, "Fertility Policy and Implementation in China, 1986-88," *Population and Development Review* vol. 14, no. 2 (1988): 245-286.

[46] Kisha K. Patel, "My Body Not My Say: How Roe v. Wade Endangers Women's Autonomy," *Politics Honors Papers, Ursinus Colleg*e vol. 5, no. 1 (2017): 1-45.

[47] Ederlina Co, "Abortion Privilege," *Rutgers University Law Review 74,* no. 1 (2021): 1-54.

are less restricted and more readily accessible.[48] Their experiences with abortion align more closely with ordinary healthcare, contrasting sharply with the experiences of those for whom abortion access is a multitude of socio-economic and legal barriers.

This dichotomy in experiences underscores a broader narrative of privilege and disparity in healthcare access. This selective support for birth control was based on social and economic class, with less educated or poorer women often being subjected to more stringent birth control measures under the guise of eugenics and further stratifying reproduction.[49] The paradox emerges as we delve into history: the very roots of birth control, instrumental in women's liberation, are entangled in the threads of eugenics and a stratified system, deciding who should and should not reproduce.

Section 2: The Origins of IVF

In addition to understanding which women are *discouraged* from reproducing, it's important to also consider those who are *encouraged* or even *pressured* to do so. Just as access to abortion services varies significantly across different socioeconomic groups, so too does access to ART and IVF. ART, encompassing treatments like IVF, surrogacy, and other fertility techniques, often mirrors the disparities evident in the wider healthcare system, including those seen in abortion clinics. One example of this broader disparity is with the IVF industry.

This brings us to the IVF and fertility care sector, which offers insights into these pressures. IVF, originally developed as a solution to infertility—a recognized medical

[48] Amir, "Bio-Temporality and Social Regulation," 48.
[49]Carey, "Racial Imperatives of Sex," 734-735, 747.

condition—originally aimed to help women with fallopian tube issues.[50] Understanding this context sheds light on the varied expectations women face regarding reproduction.

IVF constitutes a complex sequence of procedures and stands out as one of the most widely recognized forms of assisted reproductive technology. This intricate process involves the use of medications and surgical interventions to facilitate the union of sperm and egg, followed by the implantation of the fertilized egg into the uterus. The initial phase of IVF necessitates the administration of fertility medication to induce ovulation, prompting the ovaries to produce multiple eggs in preparation for fertilization.[51] Subsequently, the eggs are delicately retrieved from the body through a minor surgical procedure performed by a medical professional.

The period of reproductive justice and reform coincided with new educational and professional opportunities opening up for women in higher education. The emergence of IVF in America during the 1980s represented a progression in the experiences of white upper-class women following World War II.[52] These women, who had primarily inhabited the private sphere, were transitioning to professional careers. In contrast, lower-income women and women of color had long been engaged in lower-paying roles.

As more women entered the workforce, the birth rate saw a nearly fifty-percent decline in the twentieth century, leading to a trend of delayed childbearing.[53] This delay, however, resulted in an epidemic of infertility. In 1982, Time magazine introduced the term "biological clock" to

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[50] Deborah Lynn Steinberg, “The Eugenic Logics of IVF,” *Women's Studies International Forum* vol. 20, no. 1 (1997): 35.
[51] Kyle J. Tobler, Yulian Zhao, Ariel Weissman, Abha Majumdar, Milton Leong, and Zeev Shoham, "Worldwide Survey of IVF Practices," *Archives of Gynecology and Obstetrics* vol. 290, no. 3 (2014): 561-568.
[52] Ashley M. Eskew, MD and Emily S. Jungheim, MD, “A History of Developments to Improve in vitro Fertilization,” *Missouri Medicine* vol. 114, no. 3 (2017): 156-159.
[53] Suzanne C. Tough, Christine Newburn-Cook, David W. Johnston, Lawrence W. Svenson, Sarah Rose, and Jacques Belik, “Delayed Childbearing and Its Impact on Population Rate Changes in Lower Birth Weight, Multiple Birth, and Preterm Delivery,” *Pediatrics* vol. 109, no. 3 (2002): 399-403.

alert women about the limited time during which they were fertile.[54] The ensuing moral panic, primarily among white women, prompted media advertisements urging them to take control of their reproductive timelines. Unfortunately, this media portrayal created the impression that infertility was predominantly a concern for white women professionals, sidelining women of color and others in the conversation.[55]

While IVF was originally developed to address fertility issues like blocked fallopian tubes, which many low-income women experienced, the promotion of IVF shifted towards empowering women to take control of both their professional and personal lives. Despite the potential of IVF to significantly benefit low-income women and women of color, a critical contrast emerges when considering that around 20% of infertility cases in America at that time were attributed to sexually transmitted infections (STIs).[56] These infections, often linked to healthcare and socioeconomic inequalities, could lead to tubal infertility – precisely the issue IVF was designed to address. However, the media paid minimal attention to the infertility challenges faced by women in these demographics.[57]

Medicalization, the process where non-medical issues are treated as medical problems, has significantly shaped the understanding and treatment of infertility. Through this shift, the medicalization of infertility is heavily influenced by stereotypes that depict infertility as an affliction primarily of the white and wealthy. This is contrasted with the portrayal of poor women of color as excessively fertile and unfit to mother, thereby justifying their exclusion from infertility narratives and treatments. Such stereotypes are embedded in various social institutions,

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[54] Merav Amir, "Bio-Temporality and Social Regulation: The Emergence of the Biological Clock," *Polygraph* vol. 18 (2006): 48-68.
[55]Eskew and Jungheim, “History of IVF,” 156-159.
[56]Eskew and Jungheim, “History of IVF,” 156-159.
[57] Eskew and Jungheim, “History of IVF,” 159.

including the medical establishment, reinforcing the norms of family and motherhood and further entrenching structural inequities within motherhood.[58]

Since its introduction into the clinical world in 1978, IVF has changed the path for the ability of the human species to procreate. Improved access for women to career and educational opportunities has consequently delayed timing for childbearing and decreased fertility rates globally. IVF has been seen as the “last best hope” for a child in the population of infertile couples.

Yet as the demand for IVF grew, the industry increasingly shifted towards a more commercial business model, focusing on profitability rather than being solely a universal healthcare treatment. The financialization of fertility involved significant equity investments in clinics and technologies, especially in cryopreservation methods like egg freezing.[59] This shift implies a future-oriented, risk-focused perspective where IVF is not just about treating current infertility issues but also about proactively managing potential future infertility.

This commercialization of IVF is evident in the high costs associated with the procedure. Certain conditions categorized as "essential health services," spanning mental health, diabetic care, substance abuse treatment, and maternity services, are mandated for coverage by both employers and private health insurers.[60] However, the inclusion of fertility services in these mandates varies by law, and the cost of fertility services such as IVF can sum up to $14,000 per one cycle—while most women have a successful outcome only after six or more IVF cycles.

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[58]Dov Fox, “Privatizing Procreative Liberty in the Shadow of Eugenics,” *Journal of Law and the Biosciences* vol. 5, no. 2 (2018): 359.
[59] Lucy van de Wiel, "The Speculative Turn in IVF: Egg Freezing and the Financialization of Fertility," *New Genetics and Society* vol. 39, no. 3 (2020): 306-326.
[60] Jennifer F. Kawwass, Alan S. Penzias, and Eli Y. Adashi, “Fertility—a Human Right Worthy of Mandated Insurance Coverage: The Evolution Limitations and Future of Access to Care,” *Fertility and Sterility* vol. 115, no. 1 (2021): 29-42.

ART services are now offered by a range of centers, including large corporate clinics, independent private practices, nonprofit academic centers, and community-based clinics. Large corporate clinics, often part of larger networks or owned by private equity, have substantial resources for advanced technologies and extensive marketing, whereas nonprofit academic centers and community-based clinics do not.[61] The consolidation trend in ART involves larger corporate entities absorbing or merging with smaller, independent, and nonprofit centers, posing significant challenges. This competition risks smaller practices either closing down or being absorbed, leading to a market with fewer service providers.[62] Such consolidation could explain the increased costs for ART services due to reduced competition and make these services less accessible, especially in areas where local clinics close. This shift not only impacts affordability but also limits the diversity and personalization of care, particularly affecting those in remote or underserved areas.[63] This, in turn, could lead to increased service costs exacerbating the financial burden on patients, diminishing accessibility, and limiting the diversity of available medical care, disproportionately impacting marginalized groups.[64]

This business-oriented approach has implications for the essence of fertility treatment. Where IVF was initially conceived as a medical intervention for infertility, it is increasingly viewed and promoted as a proactive, lifestyle choice, appealing to a broader demographic, including those not currently facing fertility issues.[65] The introduction of financial products such as subscription plans and fertility insurance, targeted at employers and individuals, further

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[61]Van de Wiel, "Speculative Turn in IVF," 306–326.
[62] Gallagher et al., "Medicine in the Marketplace," 2-17
[63] Alexander Borsa, B.A., and Joseph Dov Bruch, Ph.D., "Prevalence and performance of private equity-affiliated fertility practices in the United States," Fertility and Sterility vol. 117, no. 1 (2022): 124-130.
[64] Gallagher et al., "Medicine in the Marketplace," p. 2-17.
[65] van de Wiel, "Speculative Turn in IVF," 308-321.

highlights this shift. These offerings commodify fertility and turn it into a speculative asset, aligning it more with financial planning than with healthcare needs.[66]

This substantial cost becomes an immediate barrier to reproduction for families with lower incomes. Additionally, the combination of medical side effects, the financial burden of covering infertility treatments, and the emotional stress stemming from the uncertainty of success can result in emotional, physical, and financial exhaustion.[67] Due to the considerable expenses associated with IVF, numerous individuals resort to seeking financial coverage from their insurance providers. However, the extent of insurance support for infertility diagnosis and treatment varies significantly depending on the specifics of their plan. The lack of categorization of infertility treatment as an "essential health benefit," which plans are obligated to cover under the Affordable Care Act, underscores the fact that states have the authority to decide whether or not to mandate insurance coverage for these treatments.[68]

While the Ethics Committee of the American Society for Reproductive Medicine recognizes establishing a family as a fundamental entitlement right, the field of ARTs, especially IVF, has transformed into commercial enterprises.[69] Such a commercialization trend raises ethical and societal questions. It challenges the traditional principles of medical practice, which prioritize patient care over profit. The aggressive marketing strategies and financial models

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[66] van de Wiel, "Speculative Turn in IVF," 317.
[67] Judith F. Daar, "Accessing Reproductive Technologies: Invisible Barriers Indelible Harms," *Berkeley Journal of Gender Law & Justice* vol. 23 (2008): 72.
[68] The authors of this paper define the concept of Essential Health Benefits, as they say "'The ACA directs HHS to define the Essential Health Benefits Package within broad parameters. Those parameters include general categories of services that must be part of the Essential Health Benefits Package: (1) doctor visits and other 'ambulatory patient services'; (2) 'emergency services'; (3) 'hospitalization'; (4) 'maternity and newborn care'; (5) 'mental health and substance abuse services'; (6) 'prescription drugs'; (7) 'rehabilitative and habilitative care and devices'; (8) 'laboratory services'; (9) 'preventative and wellness services and chronic disease management'; and (10) 'pediatric services including oral and vision care.'" See Troy J. Oechsner and Magda Schaler-Haynes, "Keeping It Simple: Health Plan Benefit Standardization and Regulatory Choice under the Affordable Care Act," *Albany Law Review* vol. 74, no. 1 (2010-2011): 257.
[69] Chi Chiu Wang Chan and Pak Chung Ho, "Infertility, Assisted Reproduction and Rights," *Best Practice & Research Clinical Obstetrics and Gynaecology* vol. 20, no. 3 (2006): 380.

employed by these fertility companies potentially exploit vulnerabilities and anxieties related to fertility, pushing treatments to a wider, sometimes less informed audience.[70] This commodification risks turning a crucial healthcare service into a luxury commodity, accessible primarily to those who can afford it, thereby exacerbating inequalities in access to healthcare.

Thus, cost remains the largest barrier to access to infertility care such as IVF. The lack of uniformity in fertility practices leads to a unique set of prerequisites and covered services defined by insurance companies across the country. As said by Jennifer Kawwass, medical director of the Emory Reproductive Center, "If inclusion, exclusion, and coverage were universally uniform and based on scientific evidence, practice operations could be streamlined to meet inclusion criteria and provide accurate estimates of out-of-pocket costs."[71] Today, patients of color often rely on public insurance for healthcare more frequently than their white counterparts. It's worth noting that IVF isn't necessarily covered by any public insurance. This issue is further underscored by delays in physicians referring patients for specialized fertility treatments.

Women today continue to experience the impact of past societal attitudes towards reproduction. Consider the case of Jodi as an example. Jodi, a 25-year-old woman, visited a low-income health center for general medical services in the twenty-first century.[72] Despite being a virgin and not planning motherhood at that time, Jodi was pressured into using contraception, a prerequisite for receiving health services. This practice wasn't just an isolated incident; it reflected a deep-seated belief that low-income women are overly fertile and must be regulated. Such a policy at the clinic symbolizes a wider, implicit eugenic logic aimed at controlling the reproduction of poor women.[73]

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[70] van de Wiel, "Speculative Turn in IVF," 306-326.
[71] Kawwass et. al, "Fertility–a Human Right," 31.
[72] Ann V. Bell, "Beyond (financial) accessibility: inequalities within the medicalisation of infertility," *Sociology of Health & Illness* vol. 32, no. 4 (2010): 631-646.
[73] Bell, "Inequalities in Medicalisation of Infertility," 637.

This situation is compounded in doctor-patient interactions, as seen in the case of Michelle, another 25-year-old woman.[74] She never sought medical consultation for her fertility issues because her physicians had consistently discouraged her from becoming pregnant. This discouragement wasn't based on medical necessity but rather on a biased perception of who should be allowed to become a mother. As a result, Michelle internalized this exclusion, feeling that she was not entitled or fit to pursue motherhood.[75]

Such explicit exclusions in healthcare policies contribute to a stratified reproductive landscape where access to fertility treatments is not just a matter of affordability but also of navigating prejudiced systems that make assumptions based on socioeconomic status. The experiences of women like Jodi and Michelle highlight how reproductive healthcare can be used as a tool for social control, effectively enforcing childlessness on certain populations. These examples illustrate how eugenics principles were implicitly woven into the beginning of birth control and reproductive policies, often under the pretext of improving societal health but effectively leading to stratified reproduction.

Section 3: Refugee Experiences of Stratification

In the public mind, the image of infertility almost never includes women of color. Refugees are often disempowered in their reproductive choices and are not seen as "deserving" reproducers in America. Despite encountering the greatest obstacles to infertility treatment, refugees remain the least researched in terms of both care and access to infertility services.[76] The

[74] Bell, “Inequalities in Medicalisation of Infertility,” 631-646.
[75] Bell, “Inequalities in Medicalisation of Infertility,” 631-646.
[76] As mentioned by the authors, “"A PubMed search with the terms: 'infertility care refugee,' 'infertility care immigrant,' 'infertility access refugee,' and 'infertility access immigrant' yielded only four relevant papers in total about the access to care for refugees. The three articles included in this paper described the immigrant/refugee

infertility literature reflects a clear divide: while extensive research focuses on the experiences of white, middle-class individuals seeking treatment in industrialized societies, another body of work examines infertility in resource-poor "developing" nations.[77] These contrasting realms illustrate what can be termed "two worlds" of infertility. In one world, the biomedical model dominates, providing abundant medical solutions and accessible care, along with viable alternatives to motherhood. Conversely, in the other world, a coexistence or competition between the biomedical model and holistic health concepts prevails.[78] Here, access to medical care is limited, and alternatives to motherhood appear less attainable. What is absent from this discourse, however, is an exploration of the intersectionality of these experiences, particularly concerning refugees residing in America.

In addition, there has been a notable disparity in the focus between ethnic disparities in access to sexual health and contraceptive services compared to infertility treatment. This discrepancy may reflect a prevailing, implicit, racist notion that minority ethnic women are perceived as "hyper-fertile."[79] Thus, hegemonic perspective on infertility portrays it as a trauma exclusive to rich white individuals, and while research has extensively examined barriers faced by ethnic minorities in accessing sexual health and contraceptive services, a similar level of attention has not been afforded to exploring the challenges they encounter in accessing infertility

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experience in the United States. The fourth article was not discussed because it focuses on immigrants in a non-United States population (Canada), which is beyond the scope of this paper," See Erika Tiffanie Chow and Shruthi Mahalingaiah, "Clinical Vignettes and Global Health Considerations of Infertility Care in Under-resourced Patients," *Fertility Research and Practice* vol. 2, no. 4 (2016): p. 4.

[77] Marcia C. Inhorn, "Global Infertility and the Globalization of New Reproductive Technologies: Illustrations from Egypt," *Social Science & Medicine* vol. 56, no. 9 (2003): 1837-1851.

[78] Inhorn, "Global Infertility and NRTs," 1848.

[79] Chow and Mahalingaiah, "Clinical Vignettes and Global Health," p. 4.

treatment.[80] This skewed emphasis underscores broader systemic biases and raises critical questions about equitable healthcare access for marginalized communities.

In America, the availability of ARTs is significantly influenced by socioeconomic and racial disparities. For instance, only a limited number of states provide full or partial insurance coverage for ARTs. Insurance providers often decline coverage for IVF and other ART procedures, considering them "elective" treatments for infertility, a condition not deemed life-threatening.[81] Refugees face greater restrictions when it comes to accessing healthcare options. Initially, they may request short-term health insurance known as Medical Assistance for Refugees, which lasts a maximum of eight months but does not include coverage for infertility treatments.[82] Alternatively, they can seek help through programs such as Medicaid or state safety nets such as Health Safety Net in Massachusetts.[83] However, these safety net programs typically only cover diagnostic costs associated with infertility. If they do not qualify for these programs, refugees must seek assistance from alternative sources or purchase insurance independently through the marketplace. For this demographic, access to infertility care remains difficult, as fertility preservation is often out of reach.

This situation particularly impacts low-income ethnic minority groups, including African Americans, Latinos, Native Americans, Arab Americans, and South Asians, highlighting a stark class- and race-based inequality in accessing ART.[84] Among disadvantaged minority populations,

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[80] Lorraine Culley, Nicky Hudson, and Floor van Rooij, "Marginalized Reproduction: Ethnicity, Infertility and Reproductive Technologies," *London: Routledge,* (2013): 70.
[81] Reprint: Where has the quest for conception taken us? Lessons from anthropology and sociology☆
[82] Chow and Mahalingaiah, "Clinical Vignettes and Global Health," 2-7.
[83] Chow and Mahalingaiah, "Clinical Vignettes and Global Health," 2-7.
[84] Rosario Ceballo, "The only black woman walking the face of the earth who cannot have a baby," in *Women's Untold Stories: Breaking Silence Talking Back Voicing Complexity, eds. M. Romero and A.J. Stewart* (New York: Routledge, 1999), 3-19.
Gay Becker, Martha Castrillo, Rebecca Jackson, and Robert D. Nachtigall, "Infertility among low-income Latinos," *Fertility and Sterility 85* (2006): 882-887.
Seline Szkupinski Quiroga, "Blood Is Thicker than Water: Policing Donor Insemination and the Reproduction of Whiteness," *Cambridge University Press* (2007).

such as refugees, there is a significant unmet need for IVF, characterized by higher rates of infertility but notably lower levels of IVF use.

Arab Muslim families, like many others, are among the diverse refugee populations worldwide. For example, in her work interviewing Middle Eastern Muslim refugee couples, researcher and anthropologist Marcia Inhorn uncovered troubling instances of reproductive racism.[85] Many of these couples faced intrusive questioning about their childbearing intentions and desires, alongside clear cases of iatrogenesis—harm caused by medical professionals. These discriminatory practices, compounded by barriers to accessing ART, exacerbate their already difficult circumstances, potentially leading to further displacement. This highlights the pressing need to confront reproductive racism and ensure equitable access to reproductive healthcare for all.

The post-September 11th landscape has also significantly altered the visibility and perception of not only Arab Americans within U.S. society, but also Muslims and other immigrants.[86] From being largely "invisible," Arab Americans and refugees/immigrants have become more prominent, albeit often negatively, in social and political discourse. This shift has spurred increased research on Arab Americans and American Muslims, focusing on identity, politics, and experiences of discrimination. However, this increased visibility has also perpetuated stereotypes, such as the caricature of Arab American and Muslim men as hypersexual and hyperfertile, often perceived as polygamous with multiple wives.[87] These

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Marcia C. Inhorn and Michael Hassan Fakih, "Arab Americans, African Americans, and infertility: barriers to reproduction and medical care," *Fertility and Sterility 85*, no. 4 (2006): 846.
[85] Inhorn and Fakih, "Arab and African American Infertility," 852.
[86] Filomena M. Critelli, "The Impact of September 11th on Immigrants in the United States," *Journal of Immigrant & Refugee Studies 6*, no. 2 (2008): 147.
[87] Sophia Rose Arjana, *Muslims in the Western Imagination* (New York: Oxford University Press, 2015), 3.

stereotypes can lead to the neglect of their legitimate reproductive health needs, including the real infertility issues they might face within stable monogamous unions.

Refugees and internally displaced persons hold the same fundamental right to health as those in stable situations. The 1994 International Conference on Population and Development (ICPD) Programme of Action specifically included displaced populations in its affirmation of the link between existing human rights treaty provisions and reproductive rights.[88] However, the capacity of these displaced populations to exercise their reproductive rights is severely compromised due to their circumstances.

The recent ruling by the Alabama Supreme Court, which classifies frozen embryos as children under state law, also represents a significant shift in the American government's control over reproductive autonomy, particularly impacting low-income women seeking IVF treatment, including refugees.[89] This decision is poised to escalate the costs of IVF, already a prohibitively expensive procedure, due to potentially increased clinic protocols. Additionally, the ruling may lead to the closure or relocation of fertility clinics within Alabama, further limiting access and necessitating additional travel expenses for treatment. The legal and ethical complexities introduced by this ruling can add to the procedural burden and emotional strain for patients.[90] It may also affect insurance coverage and financial aid, making IVF even less accessible for low-income individuals. This ruling not only makes IVF more inaccessible and expensive but also symbolizes a broader trend of increasing governmental control over reproductive choices, adding a layer of legal and psychological challenges, and disproportionately affecting low-income refugee women who are seeking fertility treatments. This ruling is representative of

[88] Judy Austin, Samantha Guy, Louise Lee-Jones, Therese McGinn, and Jennifer Schlecht, "Reproductive Health: A Right for Refugees and Internally Displaced Persons," *Reproductive Health Matters* vol. 16, no. 31 (2008): 10-21.
[89] Rebecca S. Feinberg, Michael S. Sinha, and I. Glenn Cohen, "The Alabama Embryo Decision—The Politics and Reality of Recognizing 'Extrauterine Children'," *JAMA* vol. 331, no. 9 (2024): E1-E2.
[90] Daar, "Accessing Reproductive Technologies," 18-82.

a more controlling system against reproductive autonomy and fertility care, marking a concerning trend in the governance of reproductive health and rights in America.

Chapter 2: The War on Fertility

> Mother: This is my daughter, my Embrace baby. I feel blessed because of my first daughter...” she trailed off, tears welling up. “I'm crying because Embrace has become my family. I don’t have family members here. My mom is in Africa, and I lost my dad. When I had my baby, I was all alone. That's why I'm so emotional. Sorry.
> Embrace Employee: We feel like you're a part of our family.
> Mother: Thank you. Being a single mom of two is not easy, especially now, with the way things are. Everything is expensive, so Embrace's help means a lot. You know, we get car seats, diapers—that's a big help. I feel like my daughter is so lucky because, when I was pregnant, I discovered Embrace.

This exchange was among many at the Embrace Refugee Birth house, where refugee mothers shared their struggles and displayed photos illustrating the significance of Embrace's support. Established in 2010, Embrace Refugee Birth Support, a component of the non-profit organization Friends of Refugees, provides a comprehensive and culturally sensitive pregnancy support program tailored for refugees.[91] Mariam’s story in the photovoice project featured a picture of her baby, encircled by a heart.[92] She recounted her journey of loss—losing family in Sudan due to war and being separated from her mother. In this conversation, she spoke about how supportive reproductive healthcare and motherhood empowered her, offering a sense of meaning and belonging after fleeing her home country. Her story underscores the impact of cultural bereavement and the vital role of supportive communities in healing and building new connections.

Section 1: Cultural Bereavement

[91] Elizabeth A. Mosley, Michelle Pratt, and Ghenet Besera, “Evaluating Birth Outcomes From a Community-Based Pregnancy Support Program for Refugee Women in Georgia,” *Frontiers in Global Women's Health* vol. 2, no. 1 (2021): 2.
[92]For this project's objectives, I intend to assign new names to the refugee participants to safeguard their safety and privacy.

The embodiment of trauma can manifest as cultural bereavement. This term, coined in 1991 by psychiatrist Maurice Eisenbruch, describes a condition that goes beyond culture shock.[93] The experiences of refugees do not merely fit under the categories of emotions, mental health, or PTSD. Instead, the concept encompasses a complex manifestation of mental health, identity crises, and mourning a loss of cultural norms or loved ones.[94] Eisenbruch first engaged with this topic in 1983 while working with an Indo-Chinese children's mental health service in Boston.[95] He found Cambodian refugees to be a particularly relevant group for study. These individuals had endured the traumatic loss of their society and culture, and were compelled to rapidly adjust to a new country. Dr. Eisenbruch defined cultural bereavement as the experience resulting from the loss of social structures, cultural values, and self-identity.[96] Affected individuals or groups often remain mentally rooted in their past, feel visited by supernatural forces from their history, experience guilt over leaving their culture and homeland, and find that memories of the past, including traumatic images, frequently intrude into their daily lives.[97]

With refugees, there arises a complex manifestation of mental distress, often involving mourning the loss of cultural identity and family history through the elimination of one's bloodline.[98] Bereavement is further complicated by transnational grieving, or grieving from a distance, and it can be unacknowledged by Western counterparts who do not share in the

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[93] Maurice Eisenbruch, "Cross-Cultural Aspects of Bereavement. II: Ethnic and Cultural Variations in the Development of Bereavement Practices," *Cultural Medicine and Psychiatry* vol. 8, no. 4 (1984): 315-347.
[94]Myeong Sook Yoon, Nan Zhang, and Israel Fisseha Feyissa, "Cultural Bereavement and Mental Distress: Examination of the Cultural Bereavement Framework through the Case of Ethiopian Refugees Living in South Korea," *Healthcare* 10, no. 201 (2022): 8-17.
[95] Eisenbruch, "Cross-Cultural Bereavement," 316.
[96] Eisenbruch, "Cross-Cultural Aspects of Bereavement," 315-347.
[97] Eisenbruch, "Cross-Cultural Aspects of Bereavement," 331.
[98] Meierhenrich, Jens, "The Trauma of Genocide," *Journal of Genocide Research* vol. 9, no. 4 (2007): 549-573.

experience.[99] As such, it can be more difficult for refugees to express, speak openly about, or even process such grief.

One way to address this mourning is through the continuing bonds theory.[100] This theory offers insight into how refugees mourning the loss of their culture or homeland can find solace and adapt in their new country through family and cultural practices. It suggests that "the bereaved should be able to make effective use of continuing bonds as a way of coping in "affect regulation," indicating that maintaining these connections can act as a stabilizing force.[101] This enables individuals to move toward a new life while still feeling "held" by their past, which can include refugees mourning the loss of previous children. This is particularly significant for refugees, as starting families and reinforcing cultural values in a new country can serve both as a way to honor their heritage and as a step towards adapting to their new environment.

The theory also clarifies that holding onto objects or traditions linked to one's culture "may serve as a transitional object in the movement toward internalization or represent keepsakes that are part of an enduring continuing bonds connection associated with the reorganization phase."[102] This suggests that for refugees, engaging in cultural practices or celebrating cultural values, such as motherhood, can be a way to maintain a connection to their past.[103] This aids in their psychological adjustment and integration into a new society. Thus, the continuing bonds theory provides valuable insights into how refugees can navigate the complex

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[99] Eisenbruch, "Cross-Cultural Aspects of Bereavement," 315-347.
[100] Henry, Hani M., William B. Stiles, and Mia W. Biran, "Loss and mourning in immigration: Using the assimilation model to assess continuing bonds with native culture," *Counselling Psychology Quarterly* vol. 18, no. 2 (2005): 109-119.
[101]Therese McGinn, "Reproductive Health of War-Affected Populations: What Do We Know?" *International Family Planning Perspectives* vol. 26, no. 4 (2000): 174-180.
[102]McGinn, "Reproductive Health," p. 174-180.
[103] One means of "maintaining the bond was by giving birth to a child of the same sex and at times even giving the name of the dead child to the newborn." This highlights the practice of giving birth to another child as a means of maintaining a tangible connection with the deceased child. Akhlas Ismail and Rachel Dekel, "Continuing Bonds of Bereaved Muslims Mothers," *Death Studies* vol. not specified, no. not specified (2023): 1-12.

process of mourning cultural loss while embracing new familial and cultural bonds in their adopted homeland.[104] These methods can play a role in preserving family lines and cultural heritage, which are important aspects of an individual's identity, providing continuity and connection to one's culture and past. For example, in a study on bereaved Muslim mothers, those who lost a child "emphasized their need to continue the relationship by giving the same name to the child born to them afterward."[105] This practice of naming a newborn after a deceased child is mentioned as a way to keep the presence and memory of the deceased child alive within the family.[106] For refugees, creating families in their new country can be a powerful way to ease some tensions and lead to a redefinition of what "home" means. This illustrates the adaptive use of continuing bonds in forming new connections while maintaining cultural values.

Section 2: War's Biological Toll

Reflecting on how the continuing bonds theory aids refugees in adapting to new environments, it's important to consider the complex relationship between forced migration, war, and fertility. There are contrasting beliefs in this area. Some suggest that fertility might increase among refugees due to a desire to replace lost family members.[107] Conversely, others believe fertility decreases because of the stresses and uncertainties inherent in refugee life. Research indicates that people affected by war have diverse attitudes towards childbearing, with various factors influencing their decisions on fertility.[108]

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[104] Henry et al., "Loss and Mourning in Immigr," p. 119.
[105] Ismail & Dekel, "Continuing Bonds Bereaved Muslim Moth," 6.
[106] Ismail & Dekel, "Continuing Bonds Bereaved Muslim Moth," 6.
[107] Ismail & Dekel, "Continuing Bonds Bereaved Muslim Moth," 6.
[108] McGinn, "Reprod Health War-Affected Pop," 174-180.

Research has shown that refugee women tend to have a lower rate of preeclampsia compared to women born in America.[109] This phenomenon could be due to the "healthy migrant effect," where individuals who are refugees or migrants tend to experience better health outcomes than the host country's native population.[110] Another factor might be that refugee women typically give birth at younger ages, which is influenced by their cultural and familial practices.[111] However, over time, there's a tendency for the health of refugee women to deteriorate compared to American-born women.[112] This trend underscores the intricate interplay of cultural, psychological, and physical factors in the lives of refugees, particularly as they relate to family creation and health.

Refugees face not only the typical biological factors that can lead to infertility but also suffer additional fertility challenges stemming from the trauma and difficulties of war.[113] These include untreated chronic diseases, often a result of exposure during conflicts or inadequate living conditions in refugee camps.[114] Regardless of their country of origin, refugees consistently grapple with a range of health issues. These include persistent illnesses, mental health problems, unaddressed infectious diseases, nutritional disorders, substance misuse, and often, a complex interplay of these conditions.[115] Additionally, refugee women are more likely to experience pre-term birth and have increased risks of stillbirth, congenital deformities, and spontaneous

[109] Preeclampsia is a medical condition occurring in pregnancy, marked by elevated blood pressure and often accompanied by organ damage, typically to the liver or kidneys. See Harakow, Hvidman, Wejse, and Eiset, "Pregnancy Complications Among Refugee Women," *Acta Obstet Gynecol Scand* vol. 100, no. 4 (2021): 649-657.
[110] McGinn, "Reproductive Health War-Affected," 174-180
[111] Harakow et al., "Preg Comp Among Refugee Women," 649-657.
[112] Harakow et al., "Preg Comp Among Refugee Women," 649-657.
[113]Stephen A. Matlin, Anneliese Depoux, Stefanie Schütte, Antoine Flahault, and Luciano Saso, "Migrants' and refugees' health: towards an agenda of solutions," Public Health Reviews vol. 39, no. 27 (2018): 1-55.
[114] Matlin et al., "Migrants' and Refugees' Health," 27.
[115] Matlin et al., "Migrants' and Refugees' Health," 27.

abortion.[116] These conditions significantly decrease the risks of the child's survival, and thus puts the state of motherhood for the woman in jeopardy.

Depression, a common response to trauma and stress, may also play a crucial role in the development of menstrual irregularities, including oligomenorrhea—a condition characterized by less frequent menstrual cycles.[117] Syrian refugee women in Turkey, for example, are experiencing significant reproductive health challenges, which revealed a strong link between traumatic experiences and the onset of oligomenorrhea.[118] This condition was significantly associated with factors like decreased sexual function, the active involvement of their husbands in the civil war, and higher depression scores.[119]

Meanwhile refugees facing depression and mental illness often encounter a medicalized approach to mental health in America, where antidepressants are a preferred mode of treatment. However, studies indicate that the use of antidepressants, particularly selective serotonin reuptake inhibitors (SSRIs) can adversely affect male fertility.[120] These medications, commonly used for long-term treatment of depression and other disorders in males of reproductive age, have been linked to decreased sperm concentration, motility, and increased DNA fragmentation, alongside causing significant sexual side effects such as decreased libido and erectile dysfunction.[121] Thus, ART provides an avenue for refugees whose fertility may be indirectly affected by the long-term use of antidepressants, ensuring that their journey towards parenthood is not hindered by the essential treatment of their mental health condition.

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[116]Hawa-Idil Harakow, Lone Hvidman, Christian Wejse, and Andreas H. Eiset, "Pregnancy Complications among Refugee Women: A Systematic Review," *Acta Obstet Gynecol Scand 100,* no. 4 (2021): 649-657.
[117] Caner Köse, Büşra Körpe, and İsmail Burak Gültekin, "New Onset Oligomenorrhea as a Consequence of Trauma among Syrian Women Refugees in Turkey," *Health Academy Kastamonu,* vol. 8, no. 2 (2023): 206-215.
[118]Köse et al., "New Onset Oligomenorrhea," 206-215.
[119] Köse et al., "New Onset Oligomenorrhea," 209.
[120]Lauren A. Beeder and Mary K. Samplaski, "Effect of Antidepressant Medications on Semen Parameters and Male Fertility," *International Journal of Urology 27* (2020): 39-46.
[121] Beeder & Samplaski, "Eff Antidepressants on Semen," 39-46.

Section 3: ART in Post-Genocide Restoration

In the context of genocide, such as that experienced by Rohingya refugees, their experience encompasses both physical destruction and cultural loss, plays a crucial role in shaping the desires of affected communities to reproduce and sustain their families.[122] The terror, pain, and hopelessness inflicted by such acts of genocide, which seek to erase not only lives but also cultural identities, create a deep-seated need within survivors to preserve and continue their heritage.[123] This desire to reproduce and form families becomes a means of preservation and healing from generational trauma, as well as a way to carry forward the legacy of a culture facing existential threats. Through childbearing, these communities aim not just to increase their numbers, but also to maintain and rejuvenate their cultural and social fabrics, reasserting their identity and resilience in the face of overwhelming adversity.

Posthumous reproduction, particularly Israel's Posthumous Sperm Retrieval (PSR) program, underscores a unique approach to addressing community and cultural traumas from genocide through the replenishment of populations.[124] First approved in 2003, the program reflects the importance placed on procreation in Israeli society, a sentiment deeply rooted in the nation's history and experiences, including the collective memory of the Holocaust.[125] This

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[122] The magnitude of this catastrophe is encapsulated in descriptions of "mass human rights violations and atrocities including the burning of villages and crops, executions", "organised massacres accompanied by sexual violence", and the horrifying instances where "buildings, crops, and whole villages [were] burned using petrol and rocket launchers, sometimes with people still inside". These atrocities not only signify the physical destruction but also the deep psychological scars borne by the Rohingya people. See Melanie O'Brien and Gerhard Hoffstaedter, “Enduring Effects of the Rohingya Genocide,” *Social Sciences 9*, no. 209 (2020): 3-5.
[123] Amina Hadžiomerović, “Family After the Genocide: Preserving Ethnic and Kinship Continuity Among Second-Generation Australian-Bosniak Immigrants,” *Journal of Muslim Minority Affairs* vol. 42, no. 3 (2022): 310.
[124] Ruth Landau, “Posthumous Sperm Retrieval for the Purpose of Later Insemination or IVF in Israel: An Ethical and Psychosocial Critique,” *Human Reproduction* vol. 19, no. 9 (2004): 1952-1956.
[125] Landau, “Posthumous Sperm Retrieval,” p. 1952.

initiative not only addresses the demographic impacts of conflict but also serves as a means of healing and continuity for a community grappling with loss. The program, while evoking mixed reactions and ethical debates, is seen as a way to create "living memorials" to those lost, thereby contributing to the healing of community and cultural wounds.[126] For many Jewish Israelis, the act of reproduction is viewed as a crucial means to increase the Jewish population, particularly in light of the Holocaust and centuries of Jewish persecution.[127] This desire to expand Jewish families is often driven by the generational trauma of the Holocaust genocide: "The survival of the community as a whole meant the survival of individual Jews, and a threat to the individual meant a threat to the community as a whole."[128] Within this perspective, the concept of "family" becomes more than a social unit; it represents a locus of belonging and a center for both individual and communal regeneration.

While infertility is often viewed primarily as a women's issue within the realm of reproductive health, it frequently affects men as well, particularly in the context of war, violence, and inflicted trauma. For Palestinian refugees, male infertility arises through various means. The stress and trauma associated with war were commonly cited as causes of infertility.[129] This connection is made by the fact that "in most cases the Lebanese Palestinians [refugees] linked this violence to their infertility citing il harb (the war) as its main cause. Many men believed that their infertility somehow stemmed from their injuries by bullets, shrapnel or genital torture; the stresses and fears of war, loss of homes, [and] economic impoverishment."[130] Exposure to

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[126] Yael Hashiloni-Dolev, "Posthumous Reproduction (PHR) in Israel: Policy Rationales Versus Lay People's Concerns a Preliminary Study,*" Culture, Medicine, and Psychiatry* vol. 39 (2015): 634-650.
[127] Hashiloni-Dolev, "Posthumous Reproduction in Israel," 639.
[128]Barbara Swirski, "Economic Aspects of the Pro-Natalist Policies in Israel," in *Women in Israel: Studies of Israeli Society, eds. Yael Azmon and Dafna Izraeli* (New Brunswick: Transaction Books, 1993), 289.
[129] Daphna Birenbaum-Carmeli and Marcia C. Inhorn, "Masculinity and Marginality: Palestinian Men's Struggles with Infertility in Israel and Lebanon," *Journal of Middle East Women's Studies* vol. 5, no. 2 (Spring 2009): 23-52.
[130]Daphna Birenbaum-Carmeli and Marcia C. Inhorn, "Masculinity and Marginality: Palestinian Men's Struggles with Infertility in Israel and Lebanon," *Journal of Middle East Women's Studies* vol. 5, no. 2 (2009): 23-44.

environmental toxins during warfare is mentioned as a possible contributing factor to infertility. The combination of stressful work conditions and the psychological toll of the geopolitical situation is highlighted, as a Palestinian man describes his situation: "The stress, the exposure to gases in the type of work I do [manual labor], the exposure to the sun. I think maybe the work is the most important; the work is stressful. But also it's from too much thinking—the politics, the situation."[131]

While limited resources are available to quantitatively support individual testimonies, communities counter this issue by providing free IVF under jeopardizing circumstances. Palestinian families seeking to continue their bloodlines rely heavily on IVF as their solution to infertility.[132] For these families, having children is not just a personal choice but a matter of social respect, national identity, and religious duty. These sentiments are often amplified in the face of trauma and destruction. One example of this dynamic is found among the wives of Palestinian political prisoners.[133] Denied conjugal visits by prison authorities, these women, determined to start families, often have no physical contact with their incarcerated husbands for years. In response, they resort to methods like smuggling sperm hidden in tubes or old pens out of prisons.[134] This allows them to conceive children through IVF using their long-term incarcerated husbands' sperm. Such actions are driven by a desire to instill hope and ensure the continuation of their bloodline, circumventing the limitations imposed by their husbands' imprisonment and the ticking of the biological clock.[135]

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[131] Birenbaum-Carmeli and Inhorn, "Masculinity and Marginality," 42.
[132] Birenbaum-Carmeli and Inhorn, "Masculinity and Marginality," 26.
[133] Mohammed Hamdan, "'Every Sperm is Sacred': Palestinian Prisoners Smuggled Semen and Derrida's Prophecy," *International Journal of Middle East Studies* vol. 51 (2019): 525-545.
[134] Hamdan, "Every Sperm is Sacred," 529.
[135] Hamdan, "Every Sperm is Sacred," 541.

Although these communities are intertwined in contentious ways, the fact that reproduction has played a role in the visions for how they carry forward is an important pattern to note. The approaches to reproduction, whether through initiatives like Israel's Posthumous Sperm Retrieval program or Palestinian families' reliance on IVF amid challenging conditions, reveal a deep-rooted commitment to continuity and regeneration. These strategies underscore the intertwining of community, identity, and trauma in the realm of reproductive health and decision-making. In both cases, the act of procreation emerges not merely as a personal choice but as a poignant response to historical and ongoing traumas, reflecting a collective determination to heal, persist, and flourish despite adversity. The concept of using ART/IVF as a form of resilience and continuity can be extended to refugees who have endured significant trauma, loss of family members, and disruption of family lines. Just as some Jewish and Palestinian families use IVF to preserve their bloodlines, refugees in similar situations, including those in America, may find empowerment and solace in such treatments. Just as IVF treatments are subsidized in Israel and provided for free in Gaza's IVF clinics, offering similar subsidies to refugees in America could be a significant step. For refugees who may face fertility issues, potentially exacerbated by the stresses and hardships of displacement, affordable access to IVF and other fertility treatments could be crucial in helping them conceive and raise families in their new environments. Similarly, these programs address the demographic and emotional impacts of conflict. Providing reproductive support to refugees could help mitigate the effects of their losses. In these contexts, becoming a parent is more than just a personal desire; it represents an act of resilience and defiance against the hardships and trauma experienced, offering a sense of continuity and hope for the future.

Section 4: America's War on Infertility

The entire burden of caring for war-torn individuals has fallen on the uprooted refugees themselves and their countries of origin. However, the responsibilities of the asylum countries, often including the United States, and their role in creating refugees are often overlooked. One example of this is in the Vietnam war, when the U.S. military's Operation Ranch Hand involved spraying approximately 77 million liters of herbicides, including Agent Orange, over South Vietnam.[136] This was primarily aimed at destroying the dense forest cover and crops used by enemy forces. However, a significant unintended consequence of this action was the introduction of high levels of dioxin, a toxic component of Agent Orange, into the environment and population.[137]

Research has indicated a strong association between exposure to Agent Orange and an increased risk of birth defects.[138] This analysis found that the risk of birth defects nearly doubled with exposure to Agent Orange. The effects were not limited to military personnel; the civilian population of Vietnam also suffered, with the risk intensifying with greater exposure levels and persistent dioxin presence in the environment.[139]

Dioxin's persistence in Vietnam has led to long-term environmental contamination, affecting not only those directly exposed during the war but also subsequent generations. This ongoing exposure has been linked to an increased risk of birth defects in the children and even grandchildren of those exposed to Agent Orange.[140] The contamination has affected both

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[136]Alvin L. Young, *Agent Orange: The Failure of Science Policy and Common Sense*, Studies in History and Philosophy of Science Vol. 58 (Cham: Springer Nature, 2022), 109.
[137] Anh D Ngo, Richard Taylor, Christine L Roberts, and Tuan V Nguyen, "Association between Agent Orange and birth defects: systematic review and meta-analysis," *International Journal of Epidemiology 35*, no. 5 (2006): 1220.
[138]Ngo et al., "Agent Orange and birth defects," 1224.
[139] Ngo et al., "Agent Orange and birth defects," 1220.
[140] Ngo et al., "Agent Orange and birth defects," 1220.

veterans and civilians in Vietnam, with studies showing a higher rate of birth defects among populations in areas that were heavily sprayed.

A more recent example of this is the US invasion of Iraq in 2003, which had long-lasting impacts on the nation and its people. The invasion, motivated by the US government's belief that Iraq possessed weapons of mass destruction (WMDs) and its desire to establish democracy in the Middle East, led to the toppling of Saddam Hussein's regime.[141] As of March 2023, an estimated 1.1 million Iraqis remained internally displaced or live as refugees in other countries.[142] This displacement was a direct result of the chaos and violence that ensued after the US-led invasion. The failure of the US to adequately plan for post-war stability in Iraq led to sectarian violence and ethnic cleansing, exacerbating the humanitarian crisis.[143]

Yet as Americans celebrated the end of the war in Iraq, many Iraqis were bracing for a new battle, particularly in the last decade when physicians and residents of southern Iraqi villages witnessed an alarming phenomenon: a large increase in congenital malformations, especially in areas like Fallujah, which previously witnessed intense combat and bombardment.[144] Reports suggest that the use of certain weapons, potentially including those containing depleted uranium and white phosphorus, contributed to environmental contamination and health crises.[145] The International Journal of Environmental Research and Public Health highlighted a disturbing increase in birth defects in Fallujah, with congenital malformations observed in 15% of all births in 2010, significantly higher than global averages.[146]

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[141] Samira Alaani, Muhammed Tafash, Christopher Busby, Malak Hamdan, and Eleonore Blaurock-Busch, "Uranium and Other Contaminants in Hair from the Parents of Children with Congenital Anomalies in Fallujah, Iraq," *Conflict and Health 5* (2011): 17.
[142] Crawford, Neta C., "Costs of 20 Years of Iraq War," *Costs of 20 Years of Iraq War* vol. 1, no. 1 (2023): 14.
[143] Alaani et al., "Uranium in Parents of Children with Congenital Anomalies," 15.
[144]Alaani et al., "Uranium in Parents of Children with Congenital Anomalies," 17.
[145] Alaani et al., "Uranium in Parents of Children with Congenital Anomalies," 18.
[146] Al-Hadithi et al., "Birth defects in Iraq," 3.

The situation extended beyond Fallujah, affecting other parts of Iraq as well. As journalist Kelley Vlahos poignantly reports, "the litany of horrors is gut-wrenching."[147] The range of congenital malformations observed was both diverse and disturbing, including babies born with "two heads, one eye in the middle of the face, missing limbs, too many limbs, brain damage, cardiac defects, abnormally large heads, eyeless, missing genitalia, riddled with tumors."[148] These descriptions not only highlight the physical toll on the newborns but also underscore the emotional and psychological burden borne by their families and communities.

This situation is not just a health crisis, but also a humanitarian and ethical issue, echoing the arguments made by scholars like Gurminder K. Bhambra, regarding the need for material reparations in the face of such consequences: " The current system of inequality of disadvantage and advantage requires a form of redistribution that recognizes the unjustified advantages deriving from colonial appropriation."[149] In this context, offering ART and IVF to refugees and families affected by these conditions could be seen as a form of reparative justice. This approach would not only aim to alleviate some of the direct health impacts of the war but also address the deeper cultural and familial impacts, acknowledging the profound generational trauma inflicted by the invasion and its aftermath—including the mass ethnic cleansing of Iraqis and the murder of Vietnamese civilians.

The legacy of America's colonialism and imperialism has resulted in profound damage, the effects of which continue to permeate modern societies. This historical context has shaped not only the political and economic landscapes of formerly colonized regions but has also left a deep imprint on cultural and social structures. The consequences of this colonial past are not

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[147] Kathryn English, "Iraq's New War," *Politics Bureaucracy and Justice* vol. 4, no. 2 (2011): 1-5.
[148]English, "Iraq's New War," 3.
[149] Gurminder K. Bhambra, "Decolonizing Critical Theory?," *Critical Times* vol. 4, no. 1 (2021): 74.

merely historical footnotes but active elements in the ongoing disparities and injustices faced by many in the post-colonial world. As Bhambra argues, it is not enough to merely acknowledge these past injustices.[150] Those nations and institutions, such as America, that benefitted from colonialism and imperialism, such as those inflicted onto Vietnam and Iraq, bear a responsibility to actively engage in strategies aimed at rectifying these historical wrongs. This involves both a commitment to epistemological justice, recognizing and integrating the perspectives and histories of those marginalized by colonial narratives, and the implementation of material reparations. In this context, can America's use of colonial force be redeemed by offering access to ART and IVF to refugees as a means to repair generational trauma?

Expanding this discussion to the context of refugees seeking infertility care as a form of material reparation, particularly for those affected by genocide and war induced by America, we can see a direct connection. The loss of bloodlines due to such tragic events represents a deep, irreparable harm to communities and cultures. The call for reparations within the Black American community, stemming from centuries of slavery and systemic injustice, serves as a parallel to the situation faced by refugees affected by war and conflict. Scholars like Dennis Corgill demand to confront the historical injustices that have shaped the present-day realities of Black Americans. Similarly, reparations for refugees must encompass a range of measures aimed at rectifying the impacts of systemic discrimination. Providing infertility care to these individuals can be seen as a form of reparative justice, acknowledging the profound impact of historical events on their ability to reproduce and sustain their cultural and familial lineages. Such reparations are not just symbolic gestures but crucial steps in addressing the structural inequalities and social injustices that have been perpetuated by colonial and imperialist policies.

[150]Bhambra, “Decolonizing Critical Theory,” 73-84.

Only through these concerted efforts can a path toward genuine healing and equitable progress be forged, acknowledging the interconnected histories that shape our present.

Chapter 3: Photovoice and Identity

While numerous studies in reproductive healthcare often rely on numerical data and quantitative analysis to understand various phenomena or issues, a sole emphasis on quantitative metrics when examining refugee reproductive healthcare on a broader scale may inadvertently detach from the contextual realities of everyday life. This chapter endeavors to rectify this by delving into the narratives of refugee women, navigating the realms of motherhood and its identity-affirming factors. In doing so, the aim is to contextualize lived experiences within available photovoice data, while also examining the fundamental relationship between motherhood and identity. This exploration follows biologist Stephen J. Gould's perspective that "the medians and means are the abstractions, and the variation is the reality."[151] By applying this principle, the review will focus on a detailed analysis of photographic case studies and related academic insights, emphasizing the diverse and individual experiences that form the essence of this study.

This approach is enriched through the Embrace photovoice project, which evaluates Embrace's program in a client-centered, holistic, and creative way. It provides a unique opportunity for refugee women to express themselves through the art of photography and writing narratives. As part of this method, refugee mothers in the cohort use cameras or their phones to respond to specific prompts. These prompts are thoughtfully designed to elicit reflections on their experiences with Embrace, such as, "How has your life changed because of Embrace?" or "What are your favorite things about Embrace?" The participants then explain their photographs,

[151] Stephen Jay Gould, PhD, "The Median Isn't the Message," *Medical Narrative* vol. 1, no. 1 (2013); 3.

often drawing parallels between their experiences and the images they capture. This approach allows these women to visually narrate their stories, providing insights into their journeys and the transformative role that this support and their experience of motherhood has played in their lives. As the project research assistant, I actively facilitated discussions with participants, transcribed conversations, and prepared the final photovoice exhibit. Additionally, I took responsibility for obtaining permission to use the photographs in this dissertation, ensuring ethical representation of participants' voices. Additionally, I obtained permission to utilize these photographs for the purpose of this dissertation, ensuring ethical and respectful representation of the participants' voices and experiences.

At the end of this chapter, I will discuss how the evidence from this project has led me to argue that assisted reproductive technology serves not only as a medical intervention but also as a form of identity-affirming care. I will contrast this with the argument that this connection may instead be perpetuated by entrenched gender norms within patriarchal communities, contributing to pressures of mandatory motherhood.

Section 1: Photovoice Narratives

Based on the gathered Photovoice data, I've identified three overarching themes that encapsulate the experiences of refugee women regarding motherhood as a core aspect of their identity: social networks, empowerment, and mitigating loneliness. I will explore each theme through various photographic narratives and supportive academic work.

Theme 1: Motherhood as a Social Network

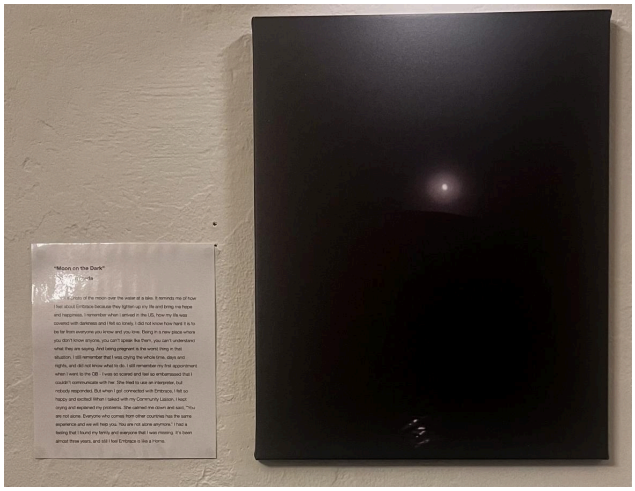

Figure 1. "Moon on the Dark."

In Figure 1, one mother reflects on her initial isolation in America and describes her hopeful connection with other refugee mothers afterwards. Her friend translates,

> First time that she [came] here, she [didn't] know everything, and she [was] alone with herself and doesn't have any friends or family here. She is coming for the first time. This is [to] her luck, and she has a lot of [refugee mother] friends here […] You [all] are like her mom, and taking care of her.

The image of the moon, solitary and overseeing a lake, is a powerful metaphor for the initial loneliness and isolation experienced by refugee mothers upon arrival in a new country. The accompanying narrative speaks to this solitude, highlighting the daunting reality of being alone without friends or family. However, this sense of isolation is transformed through the bonds formed with other refugee mothers. The quote, "You [all] are like her mom, and taking care of her," underscores how these relationships provide a surrogate familial network, replacing

loneliness with a sense of belonging and support. This transition from solitude to connectedness is not just a change in circumstance; it is identity-affirming, reinforcing their roles as mothers and community members.

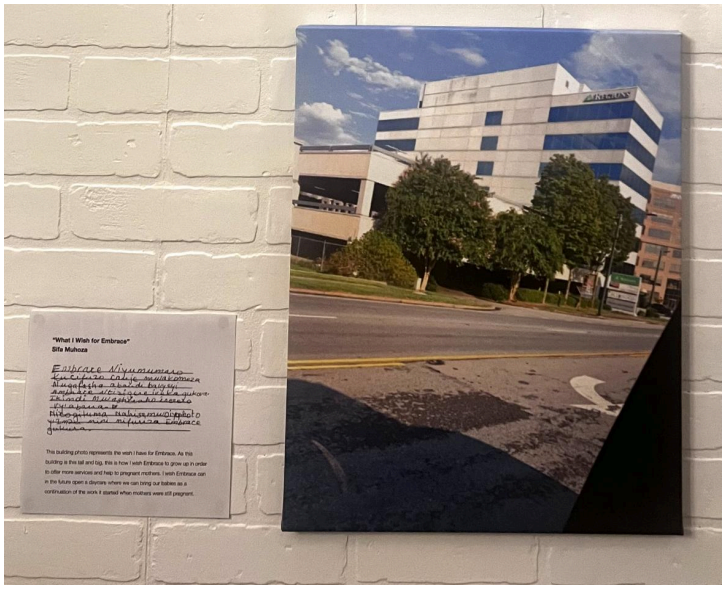

Figure 2. "What I Wish for Embrace."

This mother shared her vision for the future, symbolized through a photo of a building surrounded by trees in Figure 2. Her friend translates,

> [It is a] Building, yes. It's a big house with trees, you see. She told me she compared this one to how Embrace can be, in the future. To grow up, to stretch. Yeah. She said, because Embrace is very important for the community, especially for refugee women mothers, who are pregnant.

This image of a large building signifies her hope for a stronger, more established support system for refugee mothers, a community where they can grow and thrive together. This image, along with the mother's perspective on the significance of Embrace, illustrates the desire for and

the importance of expanding support for mother networks. This is a vision of building something lasting and substantial – a community where refugee mothers can flourish just as the building that stands strong and rooted.

The narratives provided by these mothers highlight the centrality of motherhood in their lives and the role it plays in their social interactions and support networks. As one mother shares, the connection with other refugee mothers in similar situations creates a family-like bond. These connections are not merely based on shared experiences but also on mutual support, where learning from each other – from practical skills like changing diapers to providing emotional support – is fundamental. This mutual aid strengthens their identity as mothers and as resilient members of their community.

High importance is attached to relationships with other refugee mothers, as they share the same experiences and needs, and feel they can support each other through the exchange of experiences and advice and taking care of each other's children. Many refugee mothers, including in the study by Marianne Vervliet, expressed the importance of their bonds with other refugee mothers, as these relationships provided shared experiences, mutual support, and practical assistance.[152]

Theme 2: Motherhood as Empowerment

[152] Marianne Vervliet, Jan De Mol, Eric Broekaert, and Ilse Derluyn, "'That I Live that's Because of Her': Intersectionality as Framework for Unaccompanied Refugee Mothers," *British Journal of Social Work* 44 (2014): 2033.

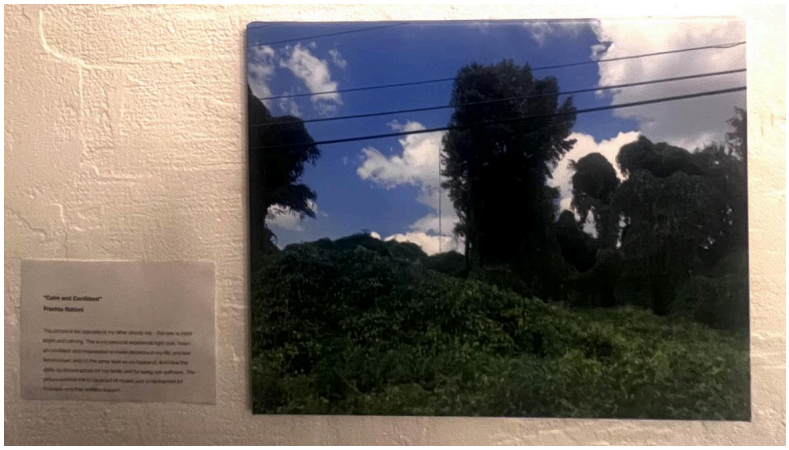

Figure 3: “Calm and Confident.”

Figure 4: **“Hope and Happiness.”**

In the photographs shared by Nasrin, another mother, we see an image of a tree and another image of her son clutching a blossoming plant, symbolizing her journey of empowerment through motherhood and the nurturing of her child. Nasrin’s reflection on one of her pictures speaks about this transformation:

> This picture is the opposite of my other cloudy sky - this one is more bright and calming. This is my personal experience right now, how I am confident and empowered to make decisions in my life, feel like a human, on the same level as my husband, and have the ability to choose goods for my family and for being self-sufficient. This picture reminds me to be proud of myself.

She articulates feelings of self-sufficiency, empowerment, and recognition of her own humanity. These sentiments resonate with the often-dehumanizing experiences refugees endure, suggesting that motherhood can play a crucial role in mitigating these hardships.[153]

In line with this, Vervliet's study reveals that entering motherhood often marks a pivotal moment in the lives of these women: becoming a mother is described as a central turning point in one study, where all lives of mothers result mostly in positive evolutions of their feelings, personality, and future perspectives.[154] It brings about a positive shift in their emotions, self-perception, and outlook towards the future.

Similarly, feminist scholar Tatjana Takseva discusses the concept of maternal ambivalence in Western contexts, challenging the traditional idealized view of motherhood.[155] She argues that motherhood is a multifaceted experience, encompassing a range of conflicted and contradictory feelings. However, acknowledging and accepting this maternal ambivalence can enrich the mothering experience.[156] By embracing feelings of doubt, mothers operate from a position of greater agency and authenticity. This perspective, while acknowledging the complex

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[153] The study discusses how refugees are often dehumanized in the public perception, being seen as less than human and thus unworthy of fair treatment. This dehumanization can lead to greater contempt and lack of admiration for refugees, resulting in less favorable attitudes towards them and towards refugee policies. The authors note that "dehumanizing media depictions of refugees as violating appropriate procedures and trying to cheat the system cause greater contempt and lack of admiration for refugees in general," leading to negative attitudes towards this group. See Victoria M. Esses, Scott Veenvliet, Gordon Hodson, and Ljiljana Mihic, "Justice Morality and the Dehumanization of Refugees," *Social Justice Research*, vol. 21, no. 1 (2008); 11.

[154] Vervliet et al., "Intersectionality as Framework for Unaccompanied Refugee Mothers," 2036.

[155] Tatjana Takseva, "Mother Love Maternal Ambivalence and the Possibility of Empowered Mothering," *Hypatia* vol. 32, no. 1 (Winter 2017); 153.

[156] Takseva, "Mother Love Maternal Ambivalence," 153.

emotions involved in motherhood, also recognizes the empowering potential of embracing these emotions as part of a mother's identity.

This newfound sense of agency, primarily linked to their identity as mothers, appears to fortify them, equipping them to navigate new challenges with increased resilience and strength. This agency is mostly connected to their belonging to the particular category of "being a mother."[157] Encountering a new situation as a mother also seems to challenge their sense of self, leading to a continuous process of "rebuilding selves" and "rebuilding lives.[158]" This transformation directly contradicts the feelings of being stripped of agency as refugees are subjected to new situations. In reclaiming their roles as mothers, these women assert their autonomy and agency, asserting their capacity to shape their own destinies despite the adversities they face.

Theme 3: Motherhood in Alleviating Loneliness

[157] Vervliet et al., "Intersectionality as Framework for Unaccompanied Refugee Mothers," 2036.
[158] Vervliet et al., "Intersectionality as Framework for Unaccompanied Refugee Mothers," 2036.

Figure 5. "Happy Ending."

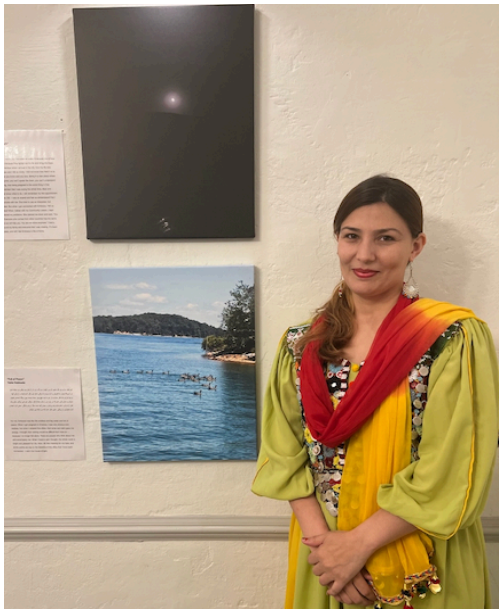

Figure 6. Sahar's Photos.

In Figure 5, Mariam's words and the image of her holding her baby in a heart shape vividly express how motherhood fills the void left by the absence of her own family: "I don't have

family members here. My mom is in Africa, I lost my dad here, when I had a baby, I was alone, so that's why I'm emotional, sorry."

Offering a semblance of home and belonging, she describes the hope given to her by her daughter. She says: "My baby, I always feel happy when I look at her, when she smiles, it makes me happy. It makes me forget all of this what I'm going through."

Her experience underlines how having a child alleviates the loneliness and trials faced by refugee women, providing a source of drive and momentum. Motherhood becomes central to their identity, transforming their lives with newfound purpose and joy. Similarly, another woman describes her photo from Figure 6: "Their smile and calm gave me energy, I thought that nothing would be difficult from now on … because I no longer felt alone."

This transformative power of motherhood is further illuminated in the words of a Guinean refugee mother, "Yes, I feel happy. It's okay, I am with my child. She understands me, I understand her. She can comfort me, I can comfort her. That's how it is. And certainly here [in the asylum center]. When I am sad, she comes to wipe my tears. And I laugh even if I don't want to."[159] The bond with their children not only alleviates loneliness but also brings emotional comfort and a sense of familial connection, even in the most challenging circumstances.

In this context, the role of initiatives like ART becomes crucial. For refugee mothers, ART can be more than a medical procedure; it represents a pathway to empowerment and self-realization. It offers a chance to reclaim a part of their identity that may have felt lost or unattainable, providing them with meaning and a profound sense of self in their new lives. Through this evidence, we can see that motherhood is not just a role they assume; it is a fundamental part of who they are, shaping their sense of purpose and belonging. Through

[159] Vervliet et al., "Intersectionality as Framework for Unaccompanied Refugee Mothers," 2033.

motherhood, these women find not just the joy of nurturing a new life but also the strength to rebuild and reshape their own, even amidst the uncertainty and dislocation of being a refugee.

Section 2: IVF as Identity-Affirming Care?

Reflecting on the importance of motherhood to identity, particularly for refugee women who often see it as a central aspect, ART can be crucial in affirming their sense of self. These technologies address infertility issues, helping to preserve an essential part of their identity.[160] The ethical imperative to reduce healthcare disparities, as noted in discussions about gender-diverse individuals, is equally applicable here.[161]

The concept of gender affirming care is defined as healthcare practices that respect and affirm individuals' gender identities, particularly within the LGBTQ+ community.[162] This form of care acknowledges that gender identity is a fundamental aspect of a person's identity and seeks to provide inclusive and supportive healthcare services that align with individuals' gender identities.

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[160] As a part of their "identity, motherhood was a strength that enabled resistance to structures that shaped the habitus of participants and children." See Julian Grant, and Pauline B. Guerin, "Motherhood as Identity: African Refugee Single Mothers Working the Intersections," *Journal of Refugee Studies* 32, no. 4 (December 2019): 590.
This concept is further expanded as studies show that "having a child is essential for the development of gender identity of women and an adult in many cultures." See Shaghayegh Alamin, Tallat Allahyari, Behzad Ghorbani, Ali Sadeghitabar, and Mohammad Taghi Karami, "Failure in Identity Building as the Main Challenge of Infertility: A Qualitative Study," *Journal of Reproduction & Infertility* 21, no. 1 (Jan-Mar 2020): 50.
"The experience of infertility can cause identity shifts, reductions in self-esteem, feelings of inadequacy, and loss of status." See Siru Lehto, Eija Sevón, Anna Rönkä, and Marja-Leena Laakso, "Narrative Study of the Significance of Infertility and Its Treatment for Maternal Identity," Journal of Obstetric, Gynecologic & Neonatal Nursing 48, no. 4 (July 2019): 453.

[161] In the text by de Vries et al., the authors discuss the critical importance of including gender-affirming health care in health science curricula. This inclusion is essential to address the significant health disparities and discrimination faced by trans and gender diverse (TGD) individuals in healthcare settings: "There is an ethical imperative for health professionals to reduce health care disparities of trans and gender diverse people and practice within the health care values of social justice and cultural humility." See Elma de Vries, Harsha Kathard, and Alex Müller, "Debate: Why should gender-affirming health care be included in health science curricula?," *BMC Medical Education* 20:51 (2020); 2.

[162] Nita Bhatt, Jesse Cannella, and Julie P. Gentile, "Gender-affirming Care for Transgender Patients," *Innovations in Clinical Neuroscience* 19, no. 4-6 (Apr-Jun 2022): 27.

Just as gender affirming care acknowledges and respects an individual's gender identity, identity-affirming care for refugee mothers should validate and support their roles as mothers. Fo the sake of this paper, I define identity-affirming care as a healthcare approach that validates and supports individuals' core aspects of identity, acknowledging the significance of these identities within cultural, social, and personal contexts and seeks to provide inclusive and supportive healthcare services that align with individuals' sense of self. By acknowledging and honoring the role of motherhood in refugees' lives through ART, healthcare providers can create a supportive and empowering environment that fosters resilience, dignity, and well-being among refugee communities. Gender affirming care can lead to significant improvements in the health outcomes and quality of life for LGBTQ+ individuals.[163] Similarly, identity-affirming care has the potential to positively impact the experiences and well-being of refugee mothers and their families.

The 2023 Infertility Report by the Office of the High Commissioner for Human Rights (OHCHR) highlights the intersection of human rights and infertility, emphasizing the need for comprehensive healthcare provision and awareness of human rights obligations.[164] Identity-affirming care acknowledges the unique social and cultural significance of motherhood among refugee women.[165] It is essential to consider how gender stereotypes and societal expectations disproportionately impact women when they face infertility.

Identity-affirming care acknowledges the unique social and cultural significance of motherhood among refugee women. It is essential to consider how gender stereotypes and

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[163] Bhatt, "Gender-affirming Care for Transgender Patients," 23.
[164] Payal K. Shah, Jaime M. Gher, “Human rights approaches to reducing infertility,” *International Journal of Gynecology and Obstetrics,* vol. 162, no. 1 (2023); 369.
[165] Riessman says that psychological theories consider “maternity the central milestone in adult female development. Yet women find ways to compose lives that accommodate and sometimes resist dominant definitions. How is this identity work done as women move into and beyond the childbearing years?” See Riessman, Catherine Kohler. "Positioning Gender Identity in Narratives of Infertility." *Infertility around the Globe: New Thinking on Childlessness, Gender, and Reproductive Technologies* vol. 1 no. 2 (2002): 155.

societal expectations disproportionately impact women when they face infertility. Reports indicate that women, due to gender stereotypes, often bear the brunt of societal judgment and discrimination when unable to bear children.[166] Such stereotypes exacerbate the mental health impacts of infertility, leading to guilt, depression, and even violence.[167] This situation calls for healthcare providers to prioritize not only the physical aspects of infertility but also the psychological and social dimensions, especially for refugee women for whom motherhood is a significant identity construct.[168]

A practical application could involve fertility treatments that are not only medically sound but also considerate of the emotional and cultural dimensions of infertility. This might include counseling services that are attuned to the specific cultural backgrounds of refugee women, helping them navigate the psychological impacts of infertility in a culturally respectful manner.

Healthcare providers, including those dealing with refugee populations, have ethical obligations to prevent, diagnose, and treat infertility, as noted in the OHCHR's Infertility Report.[169] They are called upon to provide inclusive, trauma-informed care, ensuring patients' autonomy in decision-making regarding their bodies and reproduction.[170] The traditional gatekeeping model in healthcare, where providers decide who can access care, raises ethical concerns, especially when dealing with sensitive issues like infertility among refugee women. A shift towards a model that respects patient autonomy and empowers women to make informed

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[166] Shah and Gher, "Human Rights Approaches," 372.
[167] Shah and Gher, "Human Rights Approaches," 372.
[168] Motherhood as an identity is emphasized because "becoming a mother involved progress and not simply change. It raised your status, it brought you up to the level of other adults. Moreover, whether planned or unplanned, each felt the identity of 'mother' was being actively chosen by them." See Lucy Bailey, "Refracted Selves? A Study of Changes in Self-Identity in the Transition to Motherhood," *Sociology* vol. 33, no. 2 (1999): 340.
[169] Shah and Gher, "Human Rights Approaches," 373.
[170] Shah and Gher, "Human Rights Approaches," 371.

decisions about their healthcare is essential. This shift aligns with the current ethical imperatives to reduce disparities and include affirming health practices for diverse populations. It also ensures that care is not only accessible but also resonates with the cultural and personal identities of the women it serves.

Section 3: The Instutition of Compulsory Motherhood

Conversely, it's argued that an overemphasis on motherhood might reinforce gender stereotypes. Feminist theory often scrutinizes the institution of motherhood, questioning whether the desire for motherhood is a result of societal conditioning rather than an autonomous choice. As Gender, Sexuality and Women's Studies Scholar Andrea O'Reilly notes, “motherhood is primarily not a natural or biological function; rather, it is specifically and fundamentally a cultural practice that is continuously redesigned in response to changing economic and societal factors.”[171] These points probe on Tatiana Shchurko's notion of "compulsory motherhood," where women are confined to a role centered solely around reproductive capacity, limiting their broader functions in society.[172] The question arises: what comes first—the internal desire for a religious, cultural, and biological path towards motherhood, affirming identity, or societal pressure to bear children, driven by gender norms defining women's roles? This may suggest that motherhood, and by extension the use of ART/IVF, may be more about conforming to social norms than fulfilling a personal desire.

The concept of compulsory motherhood also underlines the deep-rooted societal and cultural pressures that frame motherhood as central to female identity, dictating that women

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[171] Andrea O’Reilly (ed), *From Motherhood to Mothering: The Legacy of Adrienne Rich's Of Woman Born,* (2004); 5.

[172] Tatiana Shchurko, ""Compulsory Motherhood": T*he Female Reproductive Body as Regulated by the State (Based on the Analysis of Newspaper Sovetskaia Belorussiia)* vol. 4, no. 2 (2012): 258.

should prioritize having and raising children.[173] Medical practices may contribute to this pressure by treating women's bodies as pre-pregnant, urging them to maintain their health in anticipation of future motherhood, regardless of their personal choices. Together, these forces create a pronatalist current that can influence women either subconsciously or directly, suggesting that motherhood is not just a choice, but a duty and a measure of their womanhood.[174] This could be even more pronounced in refugee populations where cultural and traditional norms might be more rigidly upheld.

For infertile refugees from cultures where motherhood is highly valued, the fear of social stigma and psychological sanctions could be a driving force behind the pursuit of motherhood. Motherhood is often a precondition for adult roles and full social participation, as noted by Martha Gimenez, who states, "in American society, like all societies, parenthood is universally prescribed. There are no legitimate or socially rewarded alternatives to the performance of parental roles."[175] This raises important questions: Are these women seeking ART/IVF primarily to avoid social ostracization and fulfill societal roles, or is it a genuine personal desire? Understanding the roots of this motivation is crucial in discussing whether access to ART/IVF should be considered a reproductive right or a reinforcement of patriarchal norms.

As authors Ann Phoenix and Anne Woollet articulate, "motherhood establishes a woman's credentials as a woman."[176] Societal pressure can make it challenging to discern if the pursuit of motherhood via ART is a personal choice or a response to societal expectations. This suggests that women are often defined by their relationship with motherhood, whether they are

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[173] Tatiana Shchurko, ""Compulsory Motherhood": T*he Female Reproductive Body as Regulated by the State (Based on the Analysis of Newspaper Sovetskaia Belorussiia)* vol. 4, no. 2 (2012): 260.
[174] Anna Gotlib, "'But You Would Be the Best Mother': Unwomen Counterstories and the Motherhood Mandate," *Bioethical Inquiry* vol. 13, no. 1 (2016): 329.
[175] Martha E. Gimenez*, Feminism, Pronatalism, and Motherhood*, (2004); 160.
[176] Ann Phoenix, Anne Woollett, "Motherhood: Social construction, politics and psychology," in *Motherhood: Meanings, practices and ideologies, ed.* vol. 1, no. 1 (1991); 5.

mothers or not. The use of ART might be seen not just as a reproductive right, but also as a means of conforming to these entrenched norms.

While recognizing the societal constructs around motherhood, it is also important to acknowledge that individual experiences and desires can vary greatly. As feminist theory suggests, motherhood as a cultural construction can be challenged and redefined.[177] Thus, the decision to pursue motherhood, even amidst societal pressures, can also be an act of personal agency and empowerment.

The focus, thus, should instead be on empowering women, including refugee women, in diverse aspects of their identities beyond motherhood. This perspective aligns with calls for eliminating intersectional discrimination as outlined in the OHCHR's report.[178] It suggests that healthcare provision must challenge assumptions about fertility and reproduction, particularly those that may put patients at risk of violence and discrimination due to failure in fulfilling traditional roles like motherhood.

[177] Andrea O'Reilly, "Matricentric Feminism: A Feminism for Mothers," *Journal of the Motherhood Initiative* vol. 10, nos. 1 & 2 (2019): 13-26.
[178] Shah and Gher, "Human Rights Approaches," 371.

Conclusion: Defining Infertility and the Question of ART as an Entitlement Right

As I delve into the complexities surrounding the definition of infertility to justify IVF/ART treatment, particularly for refugees, I find myself at a crossroads, grappling with contrasting viewpoints that initially seem irreconcilable.

Infertility has been historically identified primarily as a women's issue. This perspective, underpinned by social constructions of compulsory motherhood, often overlooks the fact that infertility can be a condition affecting men as well.[179] However, regardless of the underlying cause, the burden of infertility tends to disproportionately fall upon women, in part due to the deep-rooted socio-cultural ties between womanhood and motherhood. Feelings of stress and responsibility for infertility is that women's bodies are more scrutinized by the "medical gaze," indicating a larger emphasis on infertility as a woman's issue.[180] For refugee women and women of low income status, however, infertility overall has been overlooked, as the cultural construction of motherhood represents these women as excessively fertile.[181]

Meanwhile, infertility as a reproductive right brings forth a different, yet interconnected dimension. The narrative around reproductive rights has predominantly centered on the right to avoid or end reproduction, such as through contraception or abortion. The rhetoric of

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[179] "Although the gender burden of infertility is particularly pronounced for women, men, too, suffer from their infertility. Male infertility remains deeply hidden in most societies because male infertility is among the most stigmatizing of all male health conditions

[180] Arthur L. Greil, "Infertile Bodies: Medicalization, Metaphor, and Agency," in *Infertility around the Globe*, University of California Press, 2002 (102).

[181] Inhorn and Fakih describe this phenomenon, as they write "ART is being used to enhance the fertility of married white elites, thereby producing "white babies for married couples who are able to pay for them" (18). In the white majority view, infertility is seen as a 'non-issue' for low-income and minority couples, who are seen as being 'hyperfertile' and undeserving of further children."
See Marcia C Inhorn and Michael Hassan Fakih, "Arab Americans, African Americans, and Infertility: Barriers to Reproduction and Medical Care," *Fertility and Sterility*, vol. 85, no. 4 (2006): 845-846.

reproductive rights seldom includes the right to reproduce.[182] The concept of reproductive rights, thus, is incomplete if it does not also encompass the right to conceive and bear children. This understanding implies that access to fertility treatments, such as ARTs, could be considered a fundamental aspect of reproductive rights.[183] The recognition of infertility treatments as a reproductive right challenges the existing framework, which often excludes or marginalizes certain groups based on socio-economic status, race, or gender identity.

The situation becomes even more complex in the context of refugees. Refugees, often grappling with immense socioeconomic challenges and traumas, might find the issues of infertility and reproductive rights particularly acute. Their access to healthcare, including fertility treatments, is frequently limited, and their reproductive rights are often overlooked or deprioritized amidst the myriad of challenges they face.[184] Furthermore, refugee women, bearing the intersecting burdens of infertility stigma and displacement, may experience heightened vulnerability and marginalization from their own communities and American society.[185]

The medicalization of infertility often justifies IVF/ART treatment and insurance coverage, yet this approach can inadvertently reinforce a dichotomy between health and illness that doesn't fully acknowledge the experiences of individuals, particularly refugees. When infertility is strictly categorized as a medical condition, it fosters a pathologizing perspective, implying a deviation from health that must be “corrected,” as mentioned by Kristina Gupta.[186]

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[182] Jennifer F. Kawwass, Alan S. Penzias, and Eli Y. Adashi, "Fertility—a human right worthy of mandated insurance coverage: the evolution limitations and future of access to care," *Fertility and Sterility,* vol. 115, no. 1 (2021): 29-42.
[183] Kawwass et al., Fertil. “- a human right worthy,” pp. 29-42.
[184] Harris, Colette & Smyth, Ines, “The reproductive health of refugees: Lessons beyond ICPD,” *Gender & Development*, vol. 9, no. 2 (2001): 10-21.
[185] Harris & Smyth, "Reprod. health of refugees," p. 13.
[186] Kristina Gupta describes the need to abandon medicalization as a justification, as she states “The disease framework simultaneously drives pathologization and reifies as “natural” the socially constructed distinction between health and illness. By presenting health and illness as natural categories, the framework of disease allows us to avoid acknowledging the reality that what gets defined as health and illness always depends on political and social decision making.”

This stance, while justifying medical intervention and facilitating insurance coverage, risks obscuring the nuanced reality of infertility as a human experience. As such, these interventions often position the resultant child as a "solution" or "outcome" rather than actually addressing the underlying condition. This approach, while providing a path to parenthood, inadvertently objectifies the process and outcome, raising ethical concerns and overlooking the multifaceted nature of human reproduction and family building. This perspective is deeply rooted in a biomedical paradigm that draws a stark line between health and illness, often neglecting the socio-cultural and psychological dimensions that are integral to understanding and addressing infertility.[187]

Catherine Riessman's classic exploration of women and medicalization underscores this stance that exists within scholarly circles.[188] She emphasizes the necessity of demedicalization for certain life experiences, such as routine childbirth, menopause, or deviations from cultural weight norms, advocating that these should not be strictly defined in medical terms.[189] Motherhood narratives have often been confined to a medical context, but moving beyond clinical terms introduces a diverse range of perspectives. This expansion incorporates stories, practices, and insights, such as through a photovoice project, from refugees who might not easily access clinical settings due to limited resources. Therefore, it is crucial to expand our language and approach towards infertility, moving from a disease-centric view to one that emphasizes lived experiences, offering a more holistic approach to infertility care.

See Kristina Gupta, *Medical Entanglements: Rethinking Feminist Debates about Healthcare,* (New Brunswick: Rutgers University Press, 2019), 6-7.
[187] Gupta, *Medical Entanglements*, 5.
[188] Catherine Riessman, "Women and Medicalization: A New Perspective," *Social Policy* vol. 14, no. 3 (1983): 18-24.
[189] Riessman, "Women and Medicalization," 18-24.

Feminist critics argue that IVF, far from being controlled by women, serves to reinforce traditional social values.[190] As sociologist Christine Crow insightfully points out, IVF is "socially shaped to perpetuate traditional social values, it only provides certain socially accepted options for women."[191] This view suggests that IVF and similar treatments support patriarchal norms, pressuring women into conforming to societal expectations of motherhood. Eva Fleischer also raises a poignant question: "How can women decide against IVF, if they are totally dominated by patriarchy, even in their innermost feelings?"[192] This perspective implies that the broader social environment, rife with neglect, abuse, and misinformation, significantly influences women's choices. The desire for a child, often a central theme in discussions critical of new reproductive technologies, is seen as a socially constructed wish rather than a biological necessity. Thus, while increased access to treatments like IVF and ART might seem beneficial, it doesn't necessarily resolve the feminist concerns surrounding autonomy and social conditioning.[193]

However, unless we succumb to the notion that women seeking IVF are simply victims of societal norms, we must acknowledge that their desire for a child can be an authentic wish. Additionally, it's essential to tackle social norms across all demographics, including upper and middle-class white women, before delving into the perceptions surrounding marginalized groups who require greater access to healthcare—a privilege often already available to women of higher socioeconomic status. Our focus should initially be on ensuring equitable healthcare access for all, and only then should we turn our attention to addressing concerns about social norms, should they emerge.

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[190] Lene Koch, "IVF–AN IRRATIONAL CHOICE?" Reproductive and Genetic Engineering: *Journal of International Feminist Analysis* vol. 3, no. 3 (1990): 2-4.
[191] Christine, Crowe. "Women want it. In vitro fertilization and women's motivations for participation." *Women's Studies International* 8, no. 6 (1985): 9-10.
[192] Fleischer, Eva. "Ready for any sacrifice? Women in IVF programmes." *Issues in Reproductive and Genetic Engineering 3*, no. 1 (1990): 9.
[193] Koch, "IVF–AN IRRATIONAL CHOICE?", p. 4.

As such, programs aimed at improving reproductive health for refugees would greatly benefit from collaboration or consultation with women and refugee organizations.[194] The unique advantage of these agencies lies in their closer community ties and deeper understanding of local cultures and needs, compared to larger international or governmental bodies. Emphasizing a participatory approach, the feminist theory suggests involving refugees directly in the planning and implementation of health programs.[195] As such, Photovoice, a participatory method based on feminist theory, has served as a crucial tool to understand the voices of refugees and how meaningful motherhood can be for them, as depicted in Chapter 3. This approach recognizes the importance of refugees' voices, especially women and other vulnerable groups, in determining their own health needs and what their identity is truly constructed by.

Furthermore, the medicalization of infertility, especially within marginalized groups such as refugees, can exacerbate inequalities and access issues. The refugee experience often intersects with various forms of systemic oppression, including limited access to healthcare through stratified reproduction and societal stigmatization, which can compound the challenges of infertility. In this context, while certain reproductive technologies are often normalized and readily accessible to dominant groups, members of marginalized communities, such as refugees, face a starkly different reality. Their access to fertility treatments is often restricted by class and racial barriers.[196] So, how do we navigate the challenge of creating medical interventions that

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[194] This concept was described by Colette and Smyth, as they write "Many of the programmes aiming to provide reproductive-health services for refugees would benefit from being implemented in collaboration with or at least with the advice of women and refugee organizations. Among the advantages offered by these agencies is their ability to work more closely with communities and with a better understanding of local cultures and needs than large international or government institutions," See Harris & Smyth, "The reproductive health of refugees: Lessons beyond ICPD," 10.

[195] Harris & Smyth, "The reproductive health of refugees: Lessons beyond ICPD," 10.

[196] This argument further is strengthened when looking at systems of stratified reproduction, when we consider the unique challenges of certain refugee groups like Arab immigrants, who face not only social crises from infertility but also racial discrimination within predominantly white healthcare systems, and stereotypes around hyperfertility that often lead to their infertility being overlooked. It's probable that these obstacles aren't unique to Arab American refugees and immigrants alone. In stark contrast, infertile low-income women, who are often women of color, face

alleviate suffering without inadvertently reinforcing the very social inequalities we strive to overcome?

Fertility treatment such as ART can both reinforce social inequality through stratified reproduction and relieve individual suffering of aspiring mothers. Recognizing fertility care as a right for refugees is crucial, but this recognition must be coupled with efforts to address the broader socio-political structures that fuel inequality and stratification. We must take steps towards dismantling the notion of compulsory motherhood within refugee frameworks (as well as in middle and upper-class white women), while also constructing a society that acknowledges and supports the cultural identities and experiences of refugee women with motherhood, including their right to cultural bereavement. Simultaneously, we should ensure that refugees have the opportunity to have and raise children in a safe and supportive environment. At the same time, while not opposing infertility treatment such as ART and IVF, we may work to implement guidelines to provide refugees with connections to childfree solidarity networks and alternative family options. This dual approach balances the provision of medical interventions with the promotion of diverse family experiences, moving towards a more equitable and inclusive framework.

Additionally, the lingering colonial and imperial effects of U.S. involvement in wars has significantly contributed to the creation of refugees and, perhaps indirectly, to the infertility issues among these populations.[197] This reality calls for a profound reflection and the need for reparations for refugees. The impacts of war, imperialism, and colonialism have not only displaced people but have also led to health crises, including infertility. Addressing this requires

significant barriers to accessing these same fertility interventions, even when they actively seek them. This situation underscores not just the medical aspect of infertility but also its deep entanglement with socio-economic and racial inequalities.

[197] Abu-Musa et al., "Effect of war on fertility: a review of the literature," p. 2010.

a deep understanding of how these socio-political dynamics contribute to the challenges faced by refugees.

As a model for addressing the needs of other oppressed groups, it is crucial for feminist and queer political movements to engage in thoughtful reflection. While they strive to combat forms of oppression, such as compulsory motherhood, they must also recognize their potential influence on the narrative around cultural identity, especially as it pertains to women from the Global South such as refugees. It's important for these movements to acknowledge and respect the diverse cultural contexts that shape the identities and experiences of these women, rather than imposing assumptions based on their own perspectives. Furthermore, in their efforts to normalize childfree choices as a legitimate option for all women, feminist activists must be cautious not to overlook the complex histories of communities who have been stereotyped as hyper fertile and have faced systemic barriers to their reproductive autonomy due to racist perceptions. This consideration is vital to ensure that advocacy does not inadvertently reinforce or perpetuate harmful stereotypes and inequalities that have historically targeted these communities.

These changes can lead to not only a reduction in the prevalence of infertility caused by such oppressive structures but also a step towards acknowledging and rectifying the injustices faced by refugees and broader communities. As such, these debates within public health, medicine, feminist and identity-affirming fields highlight the periodic and evolving nature of the discussion around identifying infertility and its solutions. These interventions, often developed within frameworks of gender norms, reflect and perpetuate broader systems of inequality such as stratified reproduction. Therefore, it becomes evident that a binary stance for or against considering fertility as an entitlement right for refugees might be too simplistic and may not lead to a definitive resolution. Instead, our efforts might be better directed towards dismantling the

structures that enforce compulsory motherhood and constructing a society that destratifies the diverse needs of women from all backgrounds. This contradictory reality suggests that no neat resolution exists in the discourse around the ethics of fertility treatment.

In concluding this exploration, I want to emphasize that the dilemmas and stratifications we observe in the context of infertility and reproductive healthcare does not just apply to refugees. This thesis, while focused on refugees as a case study, opens up broader conversations about healthcare disparities affecting other groups, such as women of color or non-gender-conforming individuals in the United States. For example, the same analytical lens used here can be applied to understanding and seeking solutions for the disproportionately high maternal mortality rates among minorities in America. Just as we've seen with refugees, these issues are rooted in a complex web of socio-economic, racial, and gender-based inequalities.

Recognizing this allows us to see the complexities of healthcare not just as isolated issues, but as interconnected with the larger fabric of society. As we move forward, it's essential to keep this perspective in mind and to strive for solutions that address not just the symptoms of these injustices, but their root causes. This approach is just one step towards a more comprehensive understanding and, hopefully, a transformation of the healthcare system to be more equitable and just.

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