HHR Health and Human Rights

DREXEL UNIVERSITY Dornsife School of Public Health

FXB Center for Health & Human Rights at Harvard University

From Choice to Justice: Disrupting the Binary Political Logics of Assisted Reproduction

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Abstract

Reproductive rights and reproductive justice paradigms have long been viewed as incompatible, largely because of their divergent orientations to the notion of choice. According to this oppositional framing, reproductive rights approaches have centered the right of (white, middle-class, heterosexual) women to choose not to have children while reproductive justice organizing has focused on gendered, racialized, and classed obstacles to control over whether and how to have and raise children. Amid increasing examination of assisted reproductive technologies (ARTs) vis-à-vis human rights principles, I see an opportunity to narrow the perceived gap between the politics of rights and justice. Human rights organizations and scholars are recognizing the stratification of medical infertility rates and ART access, and human rights courts are articulating the right to assisted reproduction as part of a fundamental right to reproductive health. In reframing the opportunity to choose assisted reproduction as a justice issue, I seek to unsettle the traditional bifurcation of these political logics.

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Competing interests: None declared.

Introduction

In 1994, 12 US-based Black women developed the theoretical and activist concept of reproductive justice in order to produce a more thorough account and recognition of "our full reproductive and sexual human rights."[1] Reproductive justice theory and praxis moves beyond the binaristic framework of reproductive rights—and, most notably, mainstream reproductive rights organizations' focus on abortion politics—to embrace an intersectional, human rights-based perspective.[2] Rather than discard the rights framework, reproductive justice understands reproductive rights as embedded within overlapping systems of racism, sexism, classism, colonialism, xenophobia, ableism, heterosexism, and cissexism. The three core tenets of the reproductive justice movement respond to these limitations: "(1) the right to have a child under the conditions of one's choosing; (2) the right not to have a child using birth control, abortion, or abstinence; and (3) the right to parent children in safe and healthy environments free from violence by individuals or the state."[3]

However, reproductive justice is often positioned in opposition to the reproductive rights or choice paradigm. The rhetoric of reproductive choice, which emerged in response to anti-abortion forces, has been roundly critiqued for its basis in the lived experiences of mostly white, middle-class women who, presumably, have access to multiple reproductive choices.[4] In both abortion and assisted reproduction contexts, rhetorics of choice have occluded the structural inequities that stratify access according to race, class, and geopolitics and reify embedded logics of racism, sexism, colonialism, and ableism.

The reproductive justice critique of assisted reproduction

Assisted reproduction has become a site of contestation for reproductive rights and justice approaches. A number of scholars argue that assisted reproductive technologies (ARTs) increasingly operate coercively within a system that discourages reproduction among low-income women of color.[5] Historically and currently, reproductive technologies—including various forms of birth control and forced sterilization—have been used to limit the reproduction of Black, Indigenous, and people of color in the Global North, as well as those otherwise deemed genetically "unfit." Additionally, all pregnant people are increasingly pressured to accept individualized reproductive interventions such as prenatal testing, selective abortion, and behavioral modification during pregnancy.[6] Thus, the development of reproductive technologies simultaneously represents increased choice for those who can afford ART procedures and coercive possibilities for many who cannot.

Disability and reproductive justice activists observe that the combined use of assisted reproductive and genetic selection technologies enable the de-selection of disability-linked characteristics, which reinforces both ableist discrimination and the regulation of reproduction.[7] However, others recognize how the rhetoric of prenatal testing and selective abortion of a fetus with potential disability as eugenics colludes with state control of individual reproductive bodies—a hallmark of eugenics itself.[8] Further, an overly simplistic critique of genetic selection technologies may ignore the financial hardship endured by individuals and families while distracting from broader ableist structures.[9]

LGBTQ rights to assisted reproduction have frequently been framed as antithetical to reproductive justice.[10] According to Marcin Smietana and colleagues, there exists a fundamental assumption that ART necessarily exchanges the reproductive choice of a privileged few (i.e., presumably wealthy intended LGBTQ parents in the Global North) for the injustice of many others (i.e., reproductive laborers and those without access to ART).[11] This assumption positions the interests of LGBTQ people in assisted reproduction against those of reproductive justice, writ large.

While assisted reproductive services are persistently organized around reproductive heterosexuality and LGBTQ people are not the primary users of ART, they have become centerpieces in debates about its ethics and accessibility. For example, gay men's pursuit of egg donation and surrogacy arrangements has come to symbolize the wealth

stratification between the recipients and producers of reproductive material and labor.[12] Further, the inclusion of some LGBTQ people in fertility markets and biomedical services is juxtaposed with the exclusion of many poor women and women of color from basic reproductive and preventative health care.[13]

These conversations, among others, suggest that the interfaces of ART and (in)justice are infinitely complex. However, I contend that assisted reproduction is not necessarily antithetical to reproductive justice. Rather, especially given the burgeoning fertility industry and increasing global usage of ARTs, there is a need for sustained engagement with the social, legal, and economic implications of specific technologies and their surrounding arrangements of power.[14] If we direct our gaze only to the distribution of choice and its enactment by individual actors, it is more difficult to see the conditions of possibility for reproductive options (or lack thereof).[15]

As Laura Mamo and Eli Alston-Stepnitz point out, it is possible to attend to the inequities that structure health care provision and the fertility industry while also resisting the logic that the inclusion of some necessitates the exclusion of others.[16] For example, the recognition that state law and health insurance policies stratify access to assisted reproduction along the lines of class, race, sexuality, and gender identity and, therefore, disproportionately impact poor people, LGBTQ people, people of color, and people living in the Global South does not preclude activist and scholarly attention to similar disparities in access to health care more generally. Further, it is possible to support increased inclusion in reproduction and family-making for LGBTQ people and others who are systematically marginalized from these social arrangements while also seeking accountability to the providers of biomaterial and reproductive labor and interrogating the coercive potentialities of reproductive technologies.[17]

It is from this departure point—the recognition that reproductive justice may be used to simultaneously support and problematize inclusions that align with traditional notions of reproductive choice—that I turn to the potential convergence points of reproductive justice and rights paradigms. LGBTQ-centered assisted reproduction advocacy has been justifiably critiqued for its singular focus on the reproductive options afforded to white, middle-class patient-consumers. However, recent US and international legal developments point toward the expanded understanding of ART as a reproductive justice issue. In the international human rights literature, there is increasing attention to the ways in which "infertility" and the need for ART cleave to lines of race, class, and geopolitics. Simultaneously, international human rights courts and agencies have recognized the rights to family-making and use of ART as components of the right to health. While the pursuit of a human right to assisted reproduction may appear to advance a broader reproductive justice agenda, I caution that such an approach may further entrench disparities in access to medical infertility treatments in the Global South and reify biogenetic normativity—thereby devaluing adoptive families and excluding informal caretaking relationships from social and legal recognition.

Toward a reproductive justice approach to assisted reproduction

Contemporary human rights literature and scholarship increasingly acknowledge global disparities in ART access. The overall provision of ART services does not nearly meet demand; an estimated 20% of the need for ART treatment is fulfilled each year.[18] Despite lengthy histories of in vitro fertilization (IVF) in many countries of the Global South, access disparities between the Global North and Global South persist; ART utilization rates range from over 5,000 cycles per million population in the Middle East (Israel) to 129 cycles per million population in Latin America.[19] Affordability is the best predictor of treatment and is impacted by cost, insurance coverage, and government subsidization.[20] IVF is most expensive in the United States, as ART costs are highly correlated with overall health care costs.[21] However, relative ART costs are highest in low-resource countries, where the cost

of one IVF cycle is more than half of the average annual income.[22] The subsidization of ART treatment varies considerably across countries, from no public financing in at least eight countries to "full" reimbursement (i.e., at least 81% of the cost of one or more cycles) in at least nine countries.[23] The number of publicly funded cycles also varies, from one to unlimited.[24] In countries with generous reimbursement for ART treatment, the utilization rates are five times greater than in other countries of the Global North.[25]

Human rights-based accounts of medical infertility have also begun to include analyses of the impact of poverty, racism, and concomitant structural factors such as unsafe abortions and inadequate health care—particularly in the Global South. There is now ample evidence that medical infertility disproportionately impacts people living in the Global South due to its correlation with poverty, lack of adequate health care, sexually transmitted infections (STIs) and infectious diseases, forced sterilization, and unsafe abortion procedures.[26] Researchers estimate that up to 30% of people in some countries in Sub-Saharan Africa are medically infertile.[27]

Against this backdrop, regional human rights courts are increasingly recognizing access to assisted reproduction as part of a human right to start a family or become a parent. For example, the Inter-American Court of Human Rights has determined that the Supreme Court of Costa Rica's 2000 prohibition of IVF violated the human rights to private and family life; found and raise a family; and nondiscrimination on the basis of disability, financial means, or gender.[28] Similarly, the European Court of Human Rights has held that the right to personal autonomy encompasses decision-making "to become and not to become a parent"—including through IVF treatment—and is protected under the private and family life provisions of article 8 of the European Convention for the Protection of Human Rights and Fundamental Freedoms.[29]

Several national entities have also recognized a right to assisted reproduction as consistent with the rights to health care or to form a family. In 2009, Portugal's National Health Service began integrating medically assisted reproductive services into its public hospital system subsequent to the passage of Law 32/2006, which interprets the provision of these services as consistent with the Portuguese constitutional principles of universal access and free health care.[30] In 2012, the Brazilian Unified Health System recognized the right to start a family as a human right, and the Brazilian government initiated a universal ART program within the National Health System.[31] Argentina and Uruguay also recognize the right to found a family as a human right and have enacted policies that provide universal access to ARTs.[32]

These legislative and judicial projects reflect an internationally recognized right to reproductive health, part of a larger fundamental human right to health, as well as principles of nondiscrimination, equality, and privacy.[33] There is a fairly extensive history of recognizing reproductive rights as human rights, stretching back to 1968 when the Final Act of the Tehran Conference on Human Rights declared that "parents have a basic human right to decide freely and responsibly on the number and spacing of children and a right to adequate education and information in this respect."[34] Since then, the Convention on the Elimination of All Forms of Discrimination Against Women and other instruments have upheld rights to family planning, infertility resources, bodily autonomy and reproductive decision-making, sexuality education, nondiscrimination in access to health care, and pregnancy and childbirth services.[35]

Given this robust foundation, there may be an opportunity to expand the human right to health, and reproductive health and decision-making more specifically, to include a right to assisted reproduction. However, I argue that a reproductive justice framework demands greater attention to the structural inequalities that condition access to ARTs and related reproductive health services and families' legal and social legitimacy. In the next section, I take up two issues that would be insufficiently addressed, at best, by a fundamental right to assisted reproduction: (1) how the separation of ART and infertility discourses further entrenches the global stratification of services by obfuscating

continuities across geopolitical contexts while furthering technological exceptionalism, and (2) how the pursuit of a human right to ART may reify the biogeneticism that continues to dominate family law and devalues other family forms—particularly those that feature nonbiological ties.

Assisted reproduction and infertility

With few exceptions, assisted reproduction and infertility have been viewed as separate issues, and attention to infertility has taken on different characteristics based on geopolitical context.[36] Efforts to present and address the scope and human rights impacts of infertility largely leave intact the prevailing biomedical definition of infertility, situate structural causes of medical infertility—such as gender-based violence, environmental toxins, and subpar reproductive health education and care—in the Global South, and include ART access as an afterthought.[37] Meanwhile, many national ART policies in the Global North presume both heterosexuality and medical infertility, often denying access or funding to single people or same-sex couples.[38] Although ART services in the Global North cater mostly to heterosexual patient-consumers, critical scholarship tends to position LGBTQ individuals as the primary benefactors of both national and transnational ART procedures and accompanying gamete transfer and surrogacy arrangements.

Heterosexuality is presumed when discussing the causes, consequences, and treatment of infertility in human rights literature, which focuses on the Global South. The World Health Organization's definition of infertility as a medical condition assigned when a clinical pregnancy does not occur after 12 months of regular, unprotected intercourse maintains the centrality of heterosexuality and the separation between issues of infertility and assisted reproduction.[39] Although a 2023 research paper sponsored by the Office of the United Nations High Commissioner for Human Rights proposes a reconceptualization of infertility to encompass social and structural causes, the remainder of the paper focuses on the causes and consequences of preventable infertility (i.e., medical conditions of infertility the likelihood of which may be reduced through social and structural changes).[40] Thus, while connections are made between social and medical dimensions of infertility, the biomedical focus remains intact.

Heterosexuality is also central to human rights cases challenging IVF prohibitions, predominantly in the Global North. Only heterosexual couples have brought successful challenges in regional human rights courts to laws that either completely ban IVF or restrict the procedure to infertile couples.[41] Laws and policies that prohibit, restrict, or deny funding for IVF to those who cannot prove medical infertility (i.e., lesbians and single women) have withstood international human rights challenges, although several have been altered through national legal and legislative processes.[42] It is also noteworthy that each case in the European Court of Human Rights and Inter-American Court of Human Rights has featured disability as an organizing conceptual framework. Most prominently, and in keeping with the World Health Organization's definition, denial of medical intervention for the disease of infertility constitutes discrimination on the basis of disability. In one case, *Costa and Pavan v. Italy*, a heterosexual couple was found to have a right to access both IVF and genetic selection procedures in order to select an embryo that did not carry the disease of cystic fibrosis.[43]

This heterocentricity reflects both the material and symbolic effects of (neo)colonialism and racialized imperialism: (1) the conditions of poverty, environmental racism, and inadequate health care produce higher rates of medical (i.e., heterosexual) infertility in the Global South, and (2) in the neocolonial imaginary, the ongoing conditions of racism and coloniality—e.g., poverty—are routinely used to other those living in the Global South. By dislocating structural causes of medical infertility, including health care inequalities, to the Global South and creating the expectation of access to IVF (which becomes synonymous with ART) only for those in the Global North, the human rights literature, human rights case law, and scholarship fail to grapple with structural arrangements of power in

the Global North and render expansive reproductive assistance unimaginable for (LGBTQ) people in the Global South.

I contend that the gaps that exist across human rights and scholarly literature on infertility and ART may be addressed using a reproductive justice paradigm that unsettles medical infertility as a necessary prerequisite to reproductive assistance. Some argue that treatment for the disease of infertility should be universally accessible.[44] However, this argument neither extends to family composition-related or anatomical infertility, which is disproportionately experienced by LGBTQ and single people, nor suggests that access to ART—which is the most expensive, technologically complex, and rare category of assisted reproductive treatment—should be expanded.[45]

As Laura Briggs notes, both assisted reproduction and infertility are shaped by economics and racial politics.[46] A growing group of people facing family composition-related infertility is going into debt to finance ART services, while low-income people, people of color, and people living in the Global South are more likely to experience infertility due to environmental factors, underlying medical conditions, and lack of access to health care.[47] Taking this one step further, I argue that structural and medical infertility cannot be disentangled from one another or issues of reproductive justice. While ART is framed as a choice when financially attainable, it is an increasingly necessary treatment for all forms of infertility due to environmental toxins, poverty, and barriers to health care.

Additionally, both infertility and ART access are overdetermined by race, class, family form, and geopolitics (i.e., (neo)colonial power relations). Historically, single, poor, and LGBTQ people, as well as people with HIV or disabilities, have been denied access to ART services.[48] Treatment and funding exclusions, some of which are justified by the absence of medical infertility among LGBTQ and single people, remain codified in many legal schemes.[49] Discrimination in ART settings is commonplace and undoubtedly underreported in the Global North and mostly unreported in the Global South.[50] Many people cannot afford the high costs of ART, and only 1% of those who express an interest in IVF are able to access it.[51] People of color and poor people living in the Global North are less likely to have health insurance and therefore more likely to be impacted by ART cost barriers.[52]

The bridging of assisted reproduction and infertility under a reproductive justice paradigm may expand access to ARTs while highlighting their continuity with other forms of reproductive care. As discussed above, while there is no enumerated international human right to assisted reproduction, international human rights bodies have advised state parties to provide universal "infertility" prevention, diagnosis, and treatment.[53] The de-hierarchization of medical and family- and social-structural infertility would enable ARTs to be viewed as a set of reproductive health tools that should be available across gender, sexuality, and geopolitical boundaries and under a variety of circumstances. If ARTs are viewed as one among a set of treatment options independent of medical indication, they are more likely to become financially accessible and receive more institutional, regulatory, and financial support. However, this move simultaneously risks the further medicalization of ARTs and diminished access for some LGBTQ and single people.

In order to more fully recognize infertility and ARTs as justice issues, infertility must be unmoored from its biomedical foundations. The American Society for Reproductive Medicine recently published a new definition of infertility that incorporates the "need for medical intervention"—including ARTs—to achieve pregnancy, either individually or with a partner.[54] While the definition still leaves heterosexual intercourse as the unnamed but presumed norm, it decenters the biomedical causes and thus disrupts the hierarchy of medical and structural forms of infertility. The society's definition supports, but does not guarantee, policy changes at the state level that would provide insurance coverage for LGBTQ and single people seeking ART services.[55] It appears to be a first step in decentering heterosexuality and complicating the assumptions that animate ART practices and scholarship.

The risk of collapsing these categories is that

important forms of difference will be obscured. Stewart Marvel argues that combining different forms of infertility effaces the nuanced medical, social, and legal positions and needs of varied individuals and couples who seek reproductive assistance.[56] While these needs are vital, and Marvel's proposed four-category schema disrupts the normative relationship between heterosexuality and reproduction, I see alternative value in recognizing the commonalities across the different pursuits of ART services.[57] The detachment of infertility from medical etiology and diagnosis may highlight its social contributors such as poverty, environmental toxins, and racialized imperialism. After all, the medical diagnosis of infertility is neither precise nor inclusive; up to 30% of infertility diagnoses have no identified cause.[58] In turning away from a set of elusive biomedical explanations, the structural commonalities may be more visible.

Together, these moves would complicate the narrative of ART as antithetical to reproductive justice and expand its accessibility while maintaining the critical focus on the power gradients that reproductive material and labor traverse and reinforce. Upon the de-medicalization of infertility and symbolic—if not material—expansion of ART, it may be possible to queer our understanding of ART by unsettling its norms of heterosexual reproduction and biological kinship. Although unseating medical infertility as the necessary prerequisite to ARTs may make reproductive assistance more financially and legally accessible, it does little to destabilize the social and legal dominance of biological kinship or legitimize other modes of family-making. In the next section, I unpack the limitations of pursuing a right to assisted reproduction and explore queer-, justice-oriented alternatives.

Assisted reproduction and biogeneticism

A handful of scholars have critiqued the social and legal supremacy of the (nuclear) biological family and suggested that support for a right to assisted reproduction may unwittingly contribute to this "pervasive *biogeneticism*."[59] Indeed, the development of ARTs is anchored to the notion that the technologies may be used to assist "natural" reproduction (i.e., the procreation of children within a heterosexual relationship and with genetic ties to both parents).[60] Courts have upheld this vision, with the Inter-American Court of Human Rights determining that Costa Rica's IVF prohibition interfered with a heterosexual couple's "decision-making concerning the methods or practices they wished to attempt in order to procreate a biological child."[61]

Others point to the ways in which reproductive technologies both de-naturalize and reinforce the biological underpinnings of reproduction. In their imitation of sexual reproduction, ARTs may reify both the social and biogenetic normativities of the nuclear family. However, they also have the capacity to create new hybrid entanglements of the biological and technological.[62] Even when mimicking the biogenetic ties of the heterosexual nuclear family (i.e., genetic relationships between children and two parents), IVF introduces "a seemingly endless, and inevitably somewhat parodic, *sequelae* of quasi-, semi- or pseudo-biological forms of parenting."[63] With these possibilities comes an uncertainty about the technobiological origins—and, therefore, the naturalness—of any reproduction.[64]

Sarah Franklin highlights these new forms of "biological relativity," created through the familiar merging of technology and biology, as an opportunity to view all reproduction as "strange" and unsettle the normativity of (hetero)sexual reproduction.[65] Similarly, Marvel attends to the "polymorphous reproductivity of queer biokinship," by which multiple arrangements emerge from the convergence of the biotechnological and the familial.[66] The queer parent is someone whose entry into the domain of assisted reproduction bears no relationship to (in)fertility as it is conventionally understood, and whose partiality of biological ties (i.e., usually only to one parent) necessarily complicate traditional notions of biological kinship.[67] Marvel suggests that the centering of the queer family and biokinship may unsettle the presumed nexus of procreative heterosexuality and biological kinship, which forms the basis of US and European family law, while creating space for LGBTQ non-biokinships.[68]

I take up Franklin and Marvel's recognition of

partial, and thus parodic, biological kinship to examine the possibilities for a queer-, justice-oriented human rights approach to assisted reproduction. A reproductive justice approach requires the pursuit of reproductive health care that is accessible to all and accounts for the racialized injustices that shape not only its accessibility and provision but also its differential impacts on individuals, families, and communities. In my approach, I also heed Michael Boucai's warning that the uptake of ARTs by LGBTQ people reinforces the biogeneticism that privileges biological parenthood and devalues adoptive and extra-legal kinship relations.

I believe that a right to comprehensive reproductive health care must be pursued in conjunction with the rights to family formation and equality. First, it is necessary to understand the division of human rights by type and character (positive versus negative). Whereas negative rights entail freedom from government intrusion (e.g., in family or private life), positive rights require affirmative government action. Additionally, civil and political rights constitute immediate obligations whereas economic, social, and cultural rights may be realized gradually.[69] Thus, while the rights to equality or privacy, including the right to establish a family, may be used to prevent interference with, or require equal access to, ART procedures such as IVF, they would not require the provision of health care. And while the right to health may be used to move states toward affirmative action, it will not result in the provision of immediate care beyond that which is deemed essential.[70]

If pursued within a right to health, ART procedures should be publicly funded and—in accordance with the equality principle—accessible to all. Indeed, at least six European and three non-European countries and territories provide "full" public funding, and many more provide partial funding (1%–80% of the cost of one or more cycles).[71] However, there are at least two concerns raised within a queer reproductive justice framework: (1) this financial support must not come at the expense of other health care provision, including basic reproductive health services, and (2) in order to undermine the common rationale that reproductive technologies are not medically necessary, it is imperative to both reframe health care as a means to well-being rather than solely a remedy for illness or pathology *and* counter the myth of normal or natural reproduction. These two concerns are intertwined and indicate the importance of a gradual and context-specific—rather than universal or unlimited—expansion of (IVF and non-IVF) ART access. The reframing of holistic well-being as the end goal of health care supports the integration and balancing of an array of reproductive health services with other forms of health care.

Importantly, the right to health does not encompass the social and legal dimensions of family formation and recognition. Further, although the right to health has been a successful avenue for addressing preventable medical infertility (e.g., treatment of STIs), it has not been the basis for a successful claim to ART.[72] Rather, both the Inter-American Court and the European Court of Human Rights have recognized decision-making as to whether or not to become a parent as a component of the right to privacy.[73] While most of these cases have involved interference with ART access, and all arguments have been grounded in regional human rights instruments, the European Court has indicated that there is a positive dimension to the right to privacy.[74] This suggests that there may be room to interpret article 10 of the International Covenant on Economic, Social and Cultural Rights—which provides for protection and assistance in the "establishment" of the family, among other family-based rights—as encompassing a positive right to reproductive assistance.[75]

It is necessary—and, I believe, possible—to pursue this right to family formation without prioritizing biological families. Rather than focus on the "right to procreate" or the right to "biological parenthood," we must reconceptualize the right to parent or found a family as inclusive of all forms of kinship, whether (quasi-)biological or not.[76] Here, it is useful to turn to Marvel's "polymorphous reproductivities of queer biokinship" and the recognition that (hetero)sexual procreation is one among many reproductive possibilities. Histories of LGBTQ family-making, as well as "othermothering" and

other community caretaking forms, highlight the social if not legal possibilities for decoupling kinship and biology.[77]

Valuing all families, as advocated by many critical scholars over a number of decades, requires robust financial, legal, and material support for a variety of family forms, with a focus on substantive rather than formal caretaking relationships.[78] Legally, this would necessitate universal access to various types of parental recognition—ranging from second-parent and confirmatory adoption to intended parent provisions and functional parent doctrines.[79] These parental recognition schemes would legitimize families as they currently exist, including relationships between a child and more than two parents or caregivers.[80] Social and financial assistance must be provided so that existing families may adequately support children and other dependents, such that foster care and adoption become options rather than mechanisms of racialized social control.[81]

Conclusion

Although recent scholarship and human rights literature has begun to apply an intersectional lens in analyzing access to reproductive assistance, and specifically IVF, the separation of ART and infertility discourses according to a choice/justice binary persists. In particular, the continued biomedicalization of infertility and attention to ART politics and potentialities in the Global North situates the structural antecedents of infertility—e.g., gender-based violence, STIs, and unsafe abortions—in the Global South and obscures the range of options for (LGBTQ) reproduction. I argue that the separation of ARTs and infertility and biomedicalization of infertility must be addressed through a coordinated set of queer reproductive justice strategies. Upon recognizing the many forms of partial or pseudo-biological kinship enabled by ARTs and disproportionately enacted by queer caregivers, the norms of (hetero)sexual procreation and biological kinship may be subverted.

In addition to upending traditional reproductive expectations, these existing realities underscore the need for legal and social recognition of quasi- and non-biological kinship arrangements alike. The human rights to establish a family and to family life, as well as the reproductive justice tenet of having children under the conditions of one's choosing, provide that all family forms must be supported in their creation and ongoing well-being.[82] When paired with a positive right to reproductive health, these principles support the equitable provision of assisted reproductive services that accounts for specific histories of colonialism, racism, and LGBTQ marginalization. Thus, a reproductive justice approach to assisted reproduction must embrace the initial promise of a theory and praxis that accounts for co-constitutive elements of justice, human rights, and choice.

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