

## DEBATE

# Delayed childbearing and reproductive justice

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**ABSTRACT** Contemporary women delay childbearing because achieving the normative prerequisites takes longer than previously due to structural changes such as increasing educational requirements for jobs, rising housing costs and growing employment precarity. Policymakers tend to be concerned about delayed reproduction because of its presumed link with lower completed fertility and potential economic consequences. From a humanistic perspective, a more fundamental issue related to delayed reproduction is that of reproductive justice. Rather than only increasing the number of desired births, reproductive justice prioritises ensuring that people are able to have the children they desire *when* they want to have them. One possible way to address delayed reproduction is to increase the use of medically assisted reproduction (MAR). Although increased use of MAR has the potential to enable more people to have the children they desire, it may also have undesired implications for reproductive justice because access to MAR is highly stratified.

**KEYWORDS** Delayed childbearing • Reproductive justice • Medically assisted reproduction • Social inequality

## Introduction

As mean ages at first birth rise and total fertility rates fall, news outlets appear increasingly interested in reporting on these demographic trends. Headlines range from “The Birth-Rate Crisis Isn’t as Bad as You’ve Heard – It’s Worse” (Novicoff, 2025) to “Why One of the Causes of Falling Birthrates May Be Prosperity” (Taub, 2025) to the “Nation With Lowest Birthrate Is Rocked by Soaring Sales of Dog Strollers” (Yoon and Kim, 2024). A common narrative in US popular media and in some news stories is that women are delaying childbearing because they place too much value on their own leisure and ignore their obligations to society. Women who remain without children experience stigma and are routinely cast as selfish, among other negative attributes. Similarly, women who postpone childbearing are portrayed as engaging in self-indulgent behaviour, and as “taking advantage” of modern contraceptives.

Another narrative about delayed childbearing that is found more commonly in academic literature on infertility holds that women are delaying childbearing because they are insufficiently aware of the relationship between maternal age and infertility. According to some articles, women are “sleepwalking into infertility” (Daniluk, 2015;

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Lemoine and Ravitsky, 2015). This narrative posits that women *would* have children sooner if we (society or public health interventions) could just make them aware of the risks of delay. From this perspective, women are not so much selfish as uninformed and in need of protecting and educating.

It is interesting, though not surprising, that neither of these implicit criticisms are aimed at men. Indeed, scholars of reproduction have noted that reproduction is socially constructed as solely in the domain of women (Almeling, 2015), and this construction holds for infertility as well (e.g., Bell, 2019; Greil et al., 1988). Arguably, the structure of medical infertility treatment further solidifies this social construction, as many medical treatments for infertility, including those focused on male factor infertility, which account for at least a fifth of infertility cases, act primarily on the bodies of women<sup>1</sup> (Kumar and Singh, 2015). Given this institutional reality and related social and cultural narratives concerning infertility, we focus the remainder of our remarks primarily on women.

A more realistic approach to explaining why women delay childbearing would cast women not as perpetrators or victims, but as subjects of social structures. The “motherhood mandate”, or the normative pressure on women to have children, remains strong in many countries, including in the US and across Europe, and women in many of these contexts still report a desire to have two or more children (Hartnett and Gemmill, 2020; Russo, 1976; Sobotka and Beaujouan, 2014). The issue, however, is whether they realise these intentions (Morgan and Rackin, 2010). The life course approach to fertility (Huinink and Kohli, 2014) views the decision to have a first child as contingent upon achieving a number of other life course goals, such as getting an education, finding a well-paying job, achieving economic security and finding a suitable partner.

According to Huinink and Kohli’s (2014) approach, women delay childbearing because achieving these normative prerequisites takes time, and because people now have the ability to delay fertility until these other goals are met. It likely takes longer to meet these prerequisites in contemporary societies than was previously the case because of structural changes such as increasing educational requirements for jobs, rising housing costs and growing employment precarity. A broad literature has explored why women delay childbearing and has found support for the reasons mentioned above, as well as for others such as uncertainty about the future, including uncertainty around personal/microeconomic and societal/macroeconomic contexts, as well as uncertainty about the broader social climate (Badolato et al., 2025; Brauner-Otto and Geist, 2018; Comolli, 2023; Fahlén and Oláh, 2015; Martin, 2017; Vignoli et al., 2020).

Although women tend to overestimate the success rates of infertility treatments and some groups (e.g., Black and Hispanic women in the US and Canada) have more limited fertility knowledge, women enrolled in college or graduate programs are generally aware of the risks of postponement, with many women reporting fear that their “biological clock” is running out (Deatsman et al., 2016; Kudesia et al., 2017; Maher et al., 2022; Meissner et al., 2016; Sabarre et al., 2013; Swift and Liu, 2014). In sum, it seems clear that women are neither “selfish” nor “stupid”, but are instead caught in a web of institutional contexts that

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<sup>1</sup> We note here that we use “woman” and “women” throughout the paper as broad terms to encompass people with any gender identity who give birth. We acknowledge that not all persons who give birth identify in this way.

make having the children they want difficult. It should also be clearly stated that regardless of these institutional contexts, deciding to have or to not have children, feeling uncertain about that decision and/or postponing childbearing ought never be regarded as “selfish” or “stupid”, especially if we regard reproductive autonomy as a human right.

## Delayed reproduction as an issue of reproductive justice

Policymakers tend to be concerned about delayed reproduction because it is assumed to lower completed fertility, despite some demographic evidence calling this association into question (Beaujouan and Toulemon, 2021). A decline in total fertility may, in turn, have undesirable impacts on the “dependency ratios” of social welfare programs funded by working taxpayers (for example, in the US, the Supplemental Nutrition Assistance Program, Medicaid and Social Security) and on the labour supply. However, from a humanistic perspective, a more fundamental issue related to delayed reproduction is that of reproductive justice. Reproductive justice is a term coined by Black women (Luna, 2020; Ross and Solinger, 2017; SisterSong Women of Color Reproductive Justice Collective, n.d.) that holds that it is a human right to have as many or as few children as one wants and to raise the children one has safely and sustainably. Similar language can also be found in the report of the International Conference on Population and Development in Cairo, 5–13 in 1994 (United Nations, 1995). Delays to reproduction, especially those that result in mistimed births or fewer births than desired, are indicative of a lack of reproductive justice, irrespective of the causes of the delays. Thus, any proposed policy changes should focus not just on increasing the number of births, but also on ensuring that people are able to have the children they desire *when* they want to have them.

## An overview of medically assisted reproduction

In this section of the paper, we will focus on the US context because this is where we have done most of our research. We also acknowledge that the implications of MAR for reproductive justice will vary across contexts. MAR is a term that encompasses a broad array of treatments ranging from ovulation medication to intrauterine insemination (IUI) to assisted reproductive technologies (ART) such as in-vitro fertilisation (IVF) (Zegers-Hochschild et al., 2017).

Use of MAR, and specifically of ART, is increasing rapidly. A recent analysis of US survey data showed that treatment-seeking for infertility has increased in the United States, with interest in infertility testing, artificial insemination and IVF growing especially rapidly (Tierney et al., 2024). Currently, ART births account for between 2% and 7% of births in low-fertility countries (ESHRE et al., 2024; Tierney and Cai, 2019). Even though an increasing percentage of births in low-fertility countries are the result of MAR, most analysts agree that the increased use of MAR will be insufficient to offset fertility declines or population ageing (Chanfreau et al., 2025; Habbema et al., 2009; Lazzari et al., 2021, 2023; Leridon, 2004; Tierney, 2022).

MAR access, use and outcomes are highly stratified, particularly in the US, but also across high-, medium- and low-income nations ([Ethics Committee of the American Society for Reproductive Medicine, 2021](#); [Lass and Lass, 2023](#); [Lazzari et al., 2022](#); [Tierney et al., 2023, 2024](#); [Tierney and Cai, 2019](#)). Because not everyone has equal access to MAR, increased use of or reliance on MAR could be reasonably expected to exacerbate threats to reproductive justice. Thus far, increased use of MARs in the US has resulted not in increased levels of inequality, but rather in persisting levels of inequality ([Tierney et al., 2024](#)).

A recent review of the literature in highly developed countries confirms that economic barriers are not the only barriers to MAR access and use ([Passet-Wittig and Greil, 2021](#)), which suggests that increased access to and use of MARs will require solutions that are multifaceted and multileveled (e.g., individual, community, national), as we will detail below. We can, therefore, immediately dispose of the expectation that ensuring that all individuals who would like to use and could benefit from MAR have access to it will be either “easy” or a “solution” to low or delayed fertility in the United States. Still, if our aim is to ensure reproductive justice, then increased access to these technologies is necessary because equitable access to and use of these services can enable more people to have the children they desire.

## **Inequalities in MAR as a key threat to reproductive justice**

If MAR is to become a tool of reproductive justice rather than a threat to reproductive justice in the US, we believe the most pressing issue to address is eliminating, or at least narrowing, the existing and persistent inequalities across social groups in MAR access, use and outcomes. Disparities in infertility prevalence, treatment use and treatment outcomes by race, income and education are especially severe and persistent in the US. Specifically, treatment-seeking for infertility is lower among groups with a *higher* prevalence of infertility, including women of colour and women with lower socioeconomic status ([Ethics Committee of the American Society for Reproductive Medicine, 2024](#); [Smith et al., 2011](#); [Tierney et al., 2023, 2023](#)). Further, even after they are in treatment, IVF success rates are consistently lower for Black and Hispanic women and women with lower SES ([Heyward et al., 2021](#); [Jain, 2020](#); [McQueen et al., 2015](#); [Smith et al., 2011](#)).

These inequalities are well-documented in the US, and have remained entrenched since the advent of IVF, mirroring broader inequalities in health. From a reproductive justice standpoint, these gaps represent structural inequalities in the ability of women of colour and women with lower SES who are experiencing difficulties conceiving to have the children they want. In this brief discussion, we identify four key mechanisms that create inequalities in US MAR use, and provide suggestions regarding what changes may be needed to transform MAR from a set of technologies that reinforce stratification into technologies that enable reproductive justice.

The most commonly discussed barrier to MAR use in the US stems from inequalities in economic resources. In the US, infertility treatments are expensive (with or without insurance), and are not uniformly covered for those with insurance ([RESOLVE: The National Infertility Association, 2024](#)). The average out-of-pocket costs with insurance are high,

ranging from around \$1000 for medication-only treatments to between \$25,000 and \$62,000 for one cycle of IVF (Wu et al., 2014). Although we are not aware of any more recent peer-reviewed analyses of out-of-pocket costs for infertility treatments in the US, a recent analysis showed that the average total cost for an infertility “workup” (e.g., tests and imaging used to diagnosis fertility issues) was between \$835 in Oregon and \$2986 in Alaska (Daram et al., 2024). This barrier may be the easiest to design policy interventions for, but such interventions may have less of an impact on disparities than some may hope. For example, research on US insurance mandates for infertility treatment has shown persistent inequalities between racial/ethnic and socioeconomic groups in states with insurance mandates (Bitler and Schmidt, 2012; Correia et al., 2023). Disparities in utilisation also occur in countries with universal health care coverage (Brautsch et al., 2023; Lazzari et al., 2022), as well as within the US among women with insurance coverage via the US Department of Defense (Feinberg et al., 2006). Thus, insurance mandates alone will be insufficient to enable all those who may need these services to use them. While instituting insurance mandates and increasing coverage ought to be pursued as a part of a broader agenda to improve access to MAR treatments as a prerequisite for reproductive justice, additional financial subsidies for those with or without insurance will be needed, and any plan to improve access to MAR must also encompass other sources of inequalities.

A second barrier to MAR use in the US is the existence of differences in social support and social context. Knowing others who have sought treatment is associated with seeking medical care for infertility, and white women and women with higher SES are more likely to report knowing others who utilised medicine to address their reproductive struggles (Greil et al., 2011, 2013). Moreover, many infertility treatments require the participation of both partners in a heterosexual relationship, which makes partner support especially influential for help-seeking. Some research has found less perceived support from partners among Black and Hispanic women and women with lower SES who are experiencing infertility (Bell, 2014; Ceballo et al., 2015; Greil et al., 2011). At the same time, a large body of work has shown inequalities in marriage and union rates for women with lower SES and women of colour in the US (Gibson-Davis et al., 2005; Lundberg and Pollak, 2014), which may present barriers to seeking care and/or may increase the costs of care for these women. Thus, because these groups of women may seek care later due to delayed union formation, or may seek care while single, their costs could increase due to the need for donor gametes and/or the need for more intensive infertility treatments. The root causes of these issues are difficult to address with health policy, as they point to the segregated and unequal nature of US society, as well as to the ways in which the medicalisation of infertility may disproportionately disadvantage some groups of women.

A related and, perhaps, even more important implicit barrier to treatment-seeking in the US is the social construction of infertility. In the US, infertility is largely perceived as a white and middle class condition (Ceballo et al., 2010). This construction, as noted above, is not aligned with the prevalence of infertility in the United States. However, such a belief can be internalised by populations, making it difficult for some individuals to perceive themselves as infertile. Similarly, these populations may also internalise the “controlling images” (Collins, 2000, p. 69) of ideal parents as white, cis-gendered, straight and at least middle class, as well as the racist and classist controlling images that frame the fertility of

marginalised women as “excessive”, or that portray these groups as “hyperfertile” (Roberts, 1997; Rousseau, 2009). Taken together, these constructions of infertility, fertility and parenthood reinforce the idea that women of colour and women with lower socioeconomic status do not experience infertility, and that their desire for motherhood is not valid. As a result, these women may seek care less often, despite having medical needs. Furthermore, other work has shown that physicians underestimate infertility among Black women and women with lower socioeconomic status (Ceballo et al., 2010), which may be another way the social construction of infertility suppresses treatment-seeking among some groups. Qualitative work among Black women and women with lower SES experiencing infertility has shown that internalisation of these constructions by individuals and providers creates a barrier to treatment-seeking (Bell, 2014; Ceballo et al., 2015; Morgan et al., 2025; Taylor, 2018). Addressing the internalisation of these constructions among individuals, regardless of whether they are experiencing infertility themselves or are medical providers, will require a thorough re-evaluation of institutional processes and systems that reinforce such racist and classist norms (Jones, 2000). In other words, the solution to the internalisation of racist and classist controlling images requires systemic change, rather than just change at the individual level.

A final key barrier to MAR use in the US is found in the institutions that provide MAR care. As with all forms of medical care, MAR treatment-seeking and use do not occur in a social vacuum. Within the US, medical institutions have a long history of abusing the reproductive autonomy of women of colour and women with lower socioeconomic status (Owens, 2017; Schickler et al., 2021). This sociohistorical context may create an implicit barrier to seeking treatment for infertility among some groups of women in the US. Additionally, as was mentioned above, provider bias due to internalised norms of infertility likely results in uneven and inadequate referrals to MAR treatments, as some qualitative studies have shown (Bell, 2010, 2014; Morgan et al., 2025). In other words, the quality of the infertility care received may also vary across groups, which would be consistent with a broader literature showing quality of care disparities across racial-ethnic and social class groups in the US (e.g., Ben et al., 2017; Fiscella et al., 2000; Fiscella and Sanders, 2016). To overcome this set of barriers to MAR use, medical institutions must work to address institutional distrust. Other potential ways to overcome these barriers include providing education about social and structural barriers to infertility care, particularly among primary care providers and infertility specialists, and engaging in broader efforts to improve equity in the quality of care received.

## A few final caveats

As we consider the role of MAR and ART in enabling more women to have the children they desire, three important issues should be noted. First, efforts to improve equity in access to MAR raise the question of whether access to third-party reproduction (e.g., surrogacy, use of a gestational carrier, use of donated gametes) should also be expanded by providing financial support to groups currently unable to afford these procedures. While increasing equity in access to these services is important, the potential harms to and exploitation of

surrogate mothers and gamete donors must also be considered ([Ethics Committee of the American Society for Reproductive Medicine et al., 2018](#); [Hovav, 2019](#); [Kool et al., 2018](#)). A related area for the expansion of MAR use is increasing access to social, or elective, egg freezing. Some countries have sought to expand the affordability of social egg freezing as a means of helping women to have the children they desire. In France, a 2021 revision of the French Bioethics Law covers the costs of social egg freezing, though not the storage costs, for women ages 29–37. Two provinces in Canada and one province in Australia offer tax rebates to women who freeze their eggs. The benefits of freezing one’s eggs at a young age for later use remain uncertain, however, because little is known about the success rates when women use eggs that they elected to freeze earlier ([Ethics Committee of the American Society for Reproductive Medicine, 2024](#); [Katsani et al., 2024](#); [Petropanagos et al., 2015](#); [The Practice Committee of the American Society for Reproductive Medicine, 2013](#)).

As currently practiced, both third-party reproduction and social egg freezing are subject to criticism from the perspective of reproductive justice. In both cases, additional costs are incurred, which makes these uses of ART even more expensive. As we have pointed out, ART is already beyond the reach of many women, especially women of colour and women of lower SES. While mandating insurance coverage and providing financial support to ensure access to third-party reproduction and social egg freezing could create more equity in access, careful consideration of the benefits and potential harms is needed.

Second, increased access to and use of MAR of any kind cannot be a tool of reproductive justice if the women using it are doing so only because they felt unable to have children when they wanted to have them. In other words, increased access to and use of MAR may have the unintended consequence of reinforcing pressures on women to delay having children. For example, if a company provides egg freezing to its employees, but makes no other changes to enable them to balance their worker and parent roles, then this increase in access may reinforce pressure on the employees to delay childbearing, rather than enabling them to time their births as desired. Similarly, providing access to MAR as a “solution” to the societal issues underlying many delayed births may cause an overreliance on these technologies, which currently have relatively low success rates, particularly among older women.

## Conclusion

Clearly, downstream efforts like increasing equity in access to and use of MAR can never be more than “band aids” for a problem that is deeply rooted in social structures. Moreover, neither pro-fertility campaigns nor cash transfers for having children will make it easier for women to have children when they want to. If we frame delayed reproduction as an issue of reproductive justice, interventions that change people’s lives in fundamental ways will be required ([Lutz, 2020](#); [Mills et al., 2011](#)). Improvements in child care and family leave policies have more potential for reducing pressure to delay childbearing ([Bergsvik et al., 2021](#); [Gauthier and Gietel-Basten, 2025](#)), but other changes in social structures (e.g., integrating child care with employment and educational institutions) will be required if women are to feel less pressure to delay having children. One possible approach would

be facilitating the integration of childrearing with education and work. Furthermore, women would need less precarity and uncertainty in their lives, and providing such stability would also require changes in social structures. However, it is also a distinct possibility that the shift to delayed births would continue even with changes to educational and economic institutions because some people simply do not feel “ready” for parenthood at younger ages, or because people are often unable find a suitable partner before reaching their mid- to late thirties. Indeed, countries with many supportive policies like Sweden and France have also seen reproduction shifting to later ages. It is not clear what structural changes would be necessary to address these shifts. Until the structural and cultural issues contributing to delayed reproduction can be resolved, the best strategies to enhance reproductive justice may be to increase MAR subsidies and availability, thereby reducing inequalities in MAR access.

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