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DISABILITY RIGHTS THROUGH REPRODUCTIVE JUSTICE

Eugenic legacies in the abortion wars

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Introduction

As many feminist disability studies scholars have documented, tensions have long existed between dominant pro-choice movements and disability rights perspectives on reproduction and abortion. In mainstream abortion rights discourse, disability has been primarily featured as a crucial rationale for maintaining legal access to abortion, including termination decisions based upon prenatal screening. From the 1980s to the early 2000s, disability studies scholars developed strong and effective social and bioethical critiques by challenging selective abortion based upon disability as *neo-eugenic*. Widely cited scholars, such as Ruth Hubbard (2010), Marsha Saxton (2010) and the bioethicist Adrienne Asch (1999), have been especially influential in interrogating ableist belief systems underlying pre-natal screening and selective abortion, as well as in suggesting social, attitudinal and practice-based interventions to address biases—strategies that highlight the importance of input and leadership from disability rights groups. Hubbard’s (2010) critique connects selective abortion directly to eugenic doctrine that rose to prominence in many modern industrialising nations in the early 20th century. Tracing eugenic categorisations of the “fit” and the “unfit,” constituted by varying designations of disability, she demonstrates the ways eugenicists from the United States, Britain, and, most profoundly, Germany were attempting to proscribe “who should and who should not inhabit the world” (Arendt 1977, cited in Hubbard 2010, p. 114). While not equating eugenics with prenatal screening, Hubbard (2010, p. 115) suggests researchers creating 21st century screening technologies are similarly “engaged in developing the means to decide what lives are worth living,” and, by extension, what lives are not. Similarly, Marsha Saxton (2010) has challenged pro-choice movements to pay more attention to disability by connecting the legacy of eugenics to current medical pressure to test and terminate. She argues that healthcare professionals often have too narrow a view of disability, seeing it as the ultimate source of suffering, with little understanding of the “*social factors* that contribute to suffering” (Saxton 2010, p. 125, italics in original). This narrow view, she points out, has been widely expressed in pro-choice rhetoric, but Saxton (2010, p. 127) argues that “choice doesn’t exist as a neutral option when ‘choice’ is so constrained by oppressive values and attitudes” about disability. Indeed, choice arguments have long depended upon disability as a key justification for abortion rights. Adrienne Asch (1999), who contributed immensely to integrating disability

rights into reproduction debates in her lifetime, argued that prenatal screening situated disability as a stigmatised master status, used to negatively predict a future life. She interrogated medical pressure and parental decision making that viewed disability as “the only relevant characteristic,” and “such a problematic characteristic that people eagerly awaiting a new baby should terminate the pregnancy and ‘try again’ for a healthy child” (Asch 1999, p. 1652). Whereas these scholars actively distance themselves from anti-abortion arguments, such work has been effective in pushing clinical practitioners to gain more insight into disability in order to offer unbiased information in prenatal counselling, and in demanding that critical attention be paid to ableism in mainstream abortion rights advocacy. At this juncture, however, these anti-eugenic arguments have proven so powerful that they are being appropriated by pro-life activists to pursue state-level abortion bans in cases based upon genetic anomaly—widely touted as protection of foetuses identified with Down syndrome. In the last few years, several U.S. states have pursued such bans: North Dakota is the only state that has enacted legislation to prohibit abortions based on foetal anomaly; Louisiana and Ohio have had their legislation enjoined by court order. In 2018, other states, including Missouri, Pennsylvania, Utah and Kentucky (Guttmacher Institute 2019) considered or introduced similar legislation, and the collective efforts are intended to contribute ultimately to challenging *Roe v. Wade* in the Supreme Court.

This chapter engages with these current debates, especially the use of disability rights and non-discrimination rhetoric by anti-abortion activists, to argue for further bridging of feminist disability studies with reproductive justice frameworks, specifically by situating eugenic histories of racial and disability injustice together. Reproductive justice, a framework developed by women of colour feminists, is capacious enough to not only include disability, but to engage with the complex concerns disability communities bring to these conversations. I build on recent scholarship by Alison Kafer (2013), Alison Piepmeier (2013), Dorothy Roberts (1997) and Sujatha Jesudason (2011), as well as my previous work (Jarman 2015) to highlight the importance of engaging with and continuing to chart the shared territory between disability studies and reproductive justice. To bridge some of this terrain, I focus on three areas: first, by looking primarily at eugenic history, intricate connections between racial and disability injustice are traced; second, bringing that history forward, the chapter explores parallel and overlapping political strategies at the nexus of racial and disability “discrimination”; and, finally, returning to the purported valuing of Down syndrome as a site of analysis, I argue that, in order to advocate for the value of disabled lives, we must move beyond critiques of individual reproductive decision making, and insist on addressing neo-eugenics with demands for political and social structures of support for people with disabilities—beyond the womb.

Historical interdependencies: Racial, disability and reproductive oppression

Reproductive justice was formally defined as a movement in 1994 by women of colour feminists working to articulate their goals in a holistic, historically grounded context. At the time, women of colour had grown frustrated with white women leaders of pro-choice organisations for not integrating their social and policy concerns; further, they saw the mainstream focus on abortion rights as too limiting an approach to address the myriad impacts of racial reproductive oppression. In a recent collection edited by Loretta Ross, Erika Derkas, Whitney Peoples, Lynn Roberts, Pamela Bridgewater and Dorothy Roberts (2017), all leaders and scholars in this movement, they define the framework in straightforward terms:

Reproductive justice is not difficult to understand. It is both a theoretical paradigm shift and a model for activist organising centring three interconnected human rights

values: the right *not to have children* using safe birth control, abortion, or abstinence; the right *to have children* under the conditions we choose; and the right to *parent the children we have* in safe and healthy environments.

(2017, loc 208, italics in original)

These three tenets are grounded in a vision of human rights, and the authors stress that this is an “intersectional” and “dialectical process in which individual, group, corporate and government actions are interdependent to achieve reproductive freedom and control” (Ross et al. 2017, loc 217). This framework supports continued access to abortion but situates this in relation to access to health care and to safe, supportive environments. Reproductive justice also provides a larger context to examine historical oppression and progress; to advocate for health education and care; and to connect specific group struggles through common efforts of national and global reproductive justice efforts. The three tenets of reproductive justice—the *right not to have children*, the *right to have children* and the *right to parent the children we have*—are capacious enough to include the unique historical context and contemporary reproductive issues impacting multiple diverse communities, including people with disabilities and their relational networks. Created and led by women of colour feminists, this framework stresses intersectionality as both process and material experience. My premise is that greater attention to intersectionality—as we look at historical oppression and contemporary debates—will strengthen efforts toward disability reproductive justice.

Reproductive justice finds one of its great strengths and parallels with disability rights in a deep rootedness in history. African American women have a long history in the United States of fighting for autonomy, dignity and control of their own bodies. After all, the management and economic success of slavery depended upon controlling the bodies of those in bondage, and reproductive control was essential to slaveholders’ power. Reproductive control of women took many violent forms: sexual abuse, rape, forced pregnancies, breaking of kinship bonds through removal of enslaved children, and disregard for chosen marriages or partnerships. Enslaved women were treated as sexual property and exploited as vessels of successive generations of enslaved labour. As Dorothy Roberts (1997) points out in her seminal text, *Killing the Black Body*, reproductive control was not purely driven by economics: “Domination of reproduction was the most effective means of subjugating enslaved women, of denying them the power to govern their own bodies and to determine the course of their own destiny” (1997, p. 55). Even in slavery, however, women resisted control and worked within their slave communities to protect children and forge kinship bonds beyond nuclear family systems, which were often impossible to sustain. This legacy of communal bonds has endured in some forms and continues to shape the meaning of family within some African American communities. As Roberts explains, “This flexible family structure has proven to be an adaptive strategy for surviving racial injustice” (1997, p. 54). Situated in the context of reproductive justice, legacies of bondage and racial oppression have shaped rights demands, especially the right to *parent the children we have*. Reproductive justice insists upon historical recognition and strategies that emerge out of resistance to enduring legacies of injustice based upon white supremacy.

Within the history of state-sanctioned reproductive coercion, especially at the intersection of disability and race, the eugenic era represents a dramatic period that ushered in national surveillance of marked body-minds, as well as systematised reproductive and population control. Eugenic ideology, in its focus on racial betterment, was inherently a white supremacist movement; however, in pursuing scientific credibility, eugenicists developed tools for ranking human biology—and human value—based widely upon disability. Eugenic social interventions mobilised in two directions: positive eugenics, promoting hereditarily beneficial marriages and

voluntary reproductive management; and negative eugenics, which used ever-expanding taxonomies of “deviancy” to enact reproductive controls.

Harry H. Laughlin (1919), a zealous eugenicist, described positive eugenics as the “constructive, aristogenic, or eugenics-proper phase—which aims to secure the high-fertility and fittest matings among the more talented families” (1919, p. 1). Positive eugenics was reinforced across the country with “fitter family” contests that rewarded white families for aesthetic superiority and hereditary fitness; in other words, they demonstrated an absence of illness and disability and embraced eugenic self-regulation. Positive eugenics also pursued racial purity. Eugenicists were singularly preoccupied with anti-miscegenation. Dorothy Roberts (1997) provides a revealing example from the Second International Congress of Eugenics in 1921: more than half the presentations focused on “the biological and social consequences of marriages between people from different ethnic groups” (Roberts 1997, p. 71). These concerns reinforced racial divisions, and were codified in legislation; by 1940, thirty states had enacted laws barring interracial marriage (Roberts 1997, p. 71). Buttressed by the ideological tenets of positive eugenics, negative eugenics focused upon cutting off “dysgenic” bloodlines; in other words, hereditary lines thought to carry any number of eugenically identified traits increasingly used to mark individuals as socially inadequate. Ultimately, negative eugenics focused upon restricting reproduction, and sought “to cut off the descent-lines of those individuals who are so meagrely or defectively endowed by nature that their offspring are bound to...entail a drag upon the more effective members of society” (Laughlin 1919, p. 1).

By positioning the existence of cognitive and physical impairment as a growing national threat, eugenicists developed methodologies of defining, diagnosing and regulating “deficient” bodies and minds. Disability studies scholars have rightly brought attention to the ways eugenicists produced and leveraged a negative potency of disability to justify discrimination and extreme social control of not only disabled people, but also of immigrants, people of colour, women, the poor and anyone caught up in criminal justice or detention systems. In *Cultural Locations of Disability*, Sharon Snyder and David Mitchell (2006, p. 71) argue that eugenics oversaw a crucial “historical transition from a ‘curative’ promise of rehabilitation to an increasingly ‘custodial’ proposition,” in which people labelled pathological were brought into ever more restrictive environments. They refer to this trajectory of eugenic regulation as the emergence of “diagnostic regimes” (Snyder and Mitchell 2006, p. 70), a phrase that aptly describes the authority eugenicists attempted to gain over people’s lives. Indeed, eugenicists solidified their authority with diagnostic categories and precise terminology. They actively sought to dismantle overly broad designations in favour of greater specificity. For example, they replaced wide-ranging categories of “degeneracy” and “dependency” with particular, putatively medical designations of the “socially unfit”: “idiot,” “imbecile,” “feeble-minded” and “defective” became accepted eugenic diagnostic terms. Eugenic categories, however, like their predecessors, proved to have very blurry boundaries. Social issues such as poverty, homelessness, alcoholism and many forms of criminal activity were suddenly attributed to eugenic causes, and individuals were easily categorised under the broad umbrella of “feeble-minded” (Davenport 1912, pp. 20–29).

With this background in eugenic ideology, I want to focus on two domains of reproductive control to further examine intersections of disability and race in the early to mid-20th century: the expansion of birth control under the leadership of Margaret Sanger, and the growth of state-sponsored eugenic sterilisation programs. Margaret Sanger occupies a complicated historical position in reproductive rights. She devoted her professional life to promoting birth control and securing access to contraception for women throughout the world, but, as many scholars have noted, she did so by forging questionable partnerships with eugenicists, and certainly by dehumanising people with disabilities. Indeed, Sanger mobilised the threat of disability and

disease—which she often equated with poverty—to promote greater restrictive oversight from middle-class progressives over the burgeoning ranks of the poor and those marked by mental and physical disability. Even her rhetoric of liberating women from involuntary motherhood depended upon what she considered the greater promise of eradicating disability. In public addresses, Sanger offered eugenic birth control as a panacea to myriad social problems, which she increasingly described in economic and biological terms:

[T]he example of the inferior classes, the fertility of the feeble-minded, the mentally defective, the poverty-stricken classes, should not be held up for emulation to the mentally and physically fit, though less fertile, parents of the educated and well-to-do classes. On the contrary, the most urgent problem today is how to limit and discourage the over-fertility of the mentally and physically defective.

(Sanger 1921, p. 5)

Like eugenicists, Sanger often conflated disability with poverty, criminality and disease, implying that birth control could function as a cure-all for the social problems of her day.

Her orientation toward eugenics, disavowal of disability, and support of population control contributed to a complicated record on race. In notable ways, Sanger worked to empower African American communities, and she resisted using designations of disability, as a disqualifier, to promote racism. In fact, in the 1930s and 40s, she worked closely with leaders of the African American community to support the establishment of locally run family planning clinics in Harlem and the Bronx (Roberts 1997, pp. 79–82). At the same time, Sanger actively promoted two eugenic ideas that negatively affected communities of colour and people with disabilities. First, she relentlessly linked social problems to excessive reproduction and, although her suggested solutions involved empowering women, these arguments were easily appropriated by social reformers zealous to control specific populations. Second, Sanger unapologetically figured disability as the ultimate marker of the foreign, which, in her usage, implied unwanted and threatening. These philosophical orientations allowed her to justify population control measures and unsafe birth control trials, including sterilisation programmes outside of mainland United States, including Puerto Rico, as discussed below. Ultimately, Sanger provides a context for thinking about justice; her belief that certain types of people should not reproduce or be produced rendered it impossible for her to pursue justice in reproduction. In these eugenic social calculations, empowerment of some depended upon injustice for countless *others*.

One of the most destructive and enduring legacies of eugenics has been involuntary sterilisation. From the early years of the movement, eugenicists promoted surgical reproductive control over the “feeble-minded.” For example, physician S.D. Risley (1905, p. 97) warned, with the hyperbolic flair common to eugenicists, that allowing feeble-minded people to procreate would unleash a “Pandora’s box” that would “permit the escape and free riot of monstrous, indescribable things.” People housed in hospitals and schools for the feeble-minded, people caught within the “diagnostic regimes” of eugenics, were already vulnerable to extra-legal sterilisations, but eugenicists wanted to extend their reach. Concerned about the population of “borderline” individuals, who could pass as “normal” and threatened society with their disproportionate fecundity, eugenicists believed additional methods, beyond institutional segregation, had to be pursued. By 1911, Henry Goddard, the Director of the Eugenics Records Office, urged political leaders to put a sterilisation law “upon the book of every State.” In his estimation, this would be the only means by which “normal” society could “get control of the situation” (p. 514).

Eugenicists enjoyed impressive early success in the establishment of sterilisation laws. The state of Indiana pioneered the first law in 1907, and, within the next decade, another eleven

states had followed suit. By the end of World War I, fifteen states had legalised sterilisation, and, by 1932, that number had doubled. The most significant event in U.S. sterilisation history took place in 1927 when the Virginia law authorising the sterilisation of inmates “inflicted with hereditary forms of insanity that are recurrent, idiocy, imbecility, feeble-mindedness or epilepsy” (Landman 1932, p. 84) was upheld by the United States Supreme Court in the (in)famous case of *Buck v. Bell*. Nancy Ordover (2003) suggests that *Buck v. Bell* was part of a specific strategy to target women, rather than men, as the primary inmates to be sterilised. Into the 1920s, as eugenicists became more concerned with the reproductive threat of feeble-minded, especially “borderline” women, sterilisation seemed to offer the most flexible and effective means of social control. The trend toward using the new legislation for female control was markedly evident within the first five years of the court’s decision. In 1927, before *Buck v. Bell*, 53 percent of all the sterilisations in the United States had been performed on men; by 1932, this proportion dropped to 33 percent (Ordover, 2003, p. 135), a dramatic shift that continued in some states for many decades. In addition to granting states tremendous power over women’s reproduction, *Buck v. Bell* provided institutional superintendents with a surgical solution to overpopulation and parole. Sterilisation allowed them to release inmates who would have otherwise remained in the institution for years. In this way, doctors could quickly and legally make room for new inmates and save state resources in the process. Further, as women with disabilities continued to be institutionalised into the 1960s and 1970s, they were completely vulnerable to sterilisation.

A more familiar history of sterilisation involves the systemic targeting of women of colour. As sterilisation programmes expanded in the 1930s and 1940s, the focus shifted from poor and disabled white men and women to women of colour. As Dorothy Roberts (1997) points out, the slow demise of Jim Crow in the South ironically opened the doors of institutions to African Americans. North Carolina provides a case in point, earning the dubious honour of developing one of the most extensive sterilisation programmes in the country. Between 1930 and 1940, of the 8000 eugenic sterilisations performed in the state, 5000 of them were on Black women (Roberts 1997, p. 90). These legal procedures were precursors to massive sterilisation abuses enacted upon communities of colour. I highlight a few of the most egregious examples to provide a glimpse into the ease with which eugenic ideas were again mobilised, well after the atrocities of World War II. Poor, African American women who were on welfare or receiving Medicaid were targeted by doctors across the United States to be sterilised without their knowledge; these “Mississippi appendectomies” became so common, they were often performed with student audiences in teaching hospitals around the country. In the 1950s and 60s, in Puerto Rico, a federally funded educational campaign, in partnership with Planned Parenthood, encouraged women to elect to be sterilised—by not offering other options and promising low-cost procedures. This campaign was so “successful” that over thirty percent of the women of childbearing age were sterilised. During the same period, the US government targeted indigenous families for reproductive and cultural control. The legacy of removing Native children to state boarding schools has caused generational trauma that continues to impact Native families and communities. Adding to the cultural violence of removal, in the 1970s, Native women were targeted for large-scale, federally funded sterilisation initiatives. These programmes, driven by settler colonial legacies, resulted in tens of thousands of indigenous women being sterilised, and in locations where tribal populations were already small, they were, quite literally, genocidal campaigns (Roberts 1997, pp. 90–99; Ross et al. 2017, loc 1133). As we think about these histories in relation to current attacks on reproductive rights, it is crucial to pay attention to state-sponsored, systemic practices that enacted eugenic violence in the past, and that threaten to enable neo-eugenic control over reproduction today.

Eugenic legacies in disability reproductive justice

As this brief history demonstrates, the reproductive control of the eugenic period targeted many different groups, using similar rationales of weeding out deficient traits: promoting reproduction of white, middle-class women while forcibly curtailing the reproduction of women with disabilities, women of colour, poor women, indigenous women, LGBTQ and non-cisgender individuals, immigrant communities and others. The legacies of eugenics continue to impact all of these groups in overlapping, intersecting, yet distinct ways. While it is not within the scope of this chapter to examine the eugenic impact upon all of these groups, the intersections of disability and race/ethnicity are inextricably linked. Because eugenics was driven by a rhetoric of disability and grounded in white supremacy, when disability studies scholars investigate eugenic history to provide insight into contemporary beliefs, we should be vigilant not to understate the racial dimensions of eugenic violence. Reproductive justice, grounded in histories of racial (in)justice, provides a theoretical foundation for intersectional disability scholarship. This approach allows a stronger understanding of individuals with multiple, intersecting identities, and a more robust appreciation of the shared experiences and concerns of diverse communities that have been targeted for reproductive control. For example, after egregious sterilisation abuses in communities of colour, even in recent years, there have been government-sponsored and private incentive programmes for poor (predominantly black and brown) women with substance addictions, as well as for indigenous women, to agree to surgical sterilisation or long-acting contraceptives such as Norplant or Depo Provera (Price 2010, pp. 58–59). Similarly, women with disabilities are often encouraged to undergo sterilisation or to use such contraceptives, and, if these women have guardians, they may or may not be involved in these decisions.

Reproductive justice advocates encourage distinct communities to trace and understand interconnected histories in order to highlight overlaps while amplifying their unique concerns. Turning to specific reproductive issues related to disability, in this case, disabled women and parents (including prospective parents) of children with disabilities, the utility of the framework's three reproductive justice tenets becomes evident. The first reproductive claim is "the right *not to have children* using safe birth control, abortion or abstinence" (Ross et al. 2017, loc 208). This assertion invokes a complicated history in disability communities because it brings into focus a deep and enduring social assumption that many individuals with disabilities do not belong in reproductive conversations; they are rarely seen as sexual beings or as potential parents. In *Fading Scars*, Corbett OToole cites earlier research with colleague Tanis Doe which found that, with rare exception, "people with disabilities do not get asked if they want to have children. They don't get asked if they want to be sexual" (2012, National Council on Disabilities, cited in OToole 2015, p. 254). Although this is changing somewhat, as disabled people assert their sexual and reproductive agency, such cultural and professional ableism remains pervasive. Often the silence around sexuality, romance and parenting includes people closest to individuals with disabilities (OToole 2015, p. 254). If family members, teachers, counsellors, doctors and other professionals in a disabled person's life assume asexuality or disinterest in parenthood, they will not effectively provide or seek out sexual and reproductive education. This is especially true for women with intellectual or developmental disabilities, whose reproductive decisions are often made by parents and guardians. These women also suffer much higher rates of sexual abuse than other women, seven times higher according to Bureau of Justice statistics (Shapiro 2018), which can be another factor leading to unwanted pregnancy. Not having children may be appropriate for some disabled women, but having accurate medical information and exercising individual agency in sexual and reproductive decision making—to the greatest extent possible—is also paramount.

On another side of this issue, as more disabled women have asserted their embodied agency, and as disability rights proponents have demanded reproductive choices to have children with disabilities, including hereditary conditions, it is important to resist framing individual reproductive decisions *not* to have children as a rejection or repudiation of disability justice more broadly. If reproductive justice includes the right to not have children, disabled and nondisabled women should be supported to make decisions for themselves. These decisions are uniquely complicated for individuals with disabilities and their families. The deaf community and people with dwarfism, for example, often embrace passing on these traits, and welcoming children into distinct *cultural* communities; in fact, some members of these groups have advocated in specific cases to genetically select *for* these traits (Kafer 2013; O'Toole 2015). By contrast, other people with disabilities make decisions not to have children partly because they live with disability. Katie O'Connell, a proponent of reproductive justice, explains that her experience with disability, especially having severe migraines, distinctly shapes her reproductive decisions:

Controlling my own reproductive future is absolutely vital to me as a disabled woman. It ensures I can stay on my medication guilt-free. It means I don't have to worry about passing a genetic disability onto future children. It means I can continue to afford my medications and not worry about how that money impacts my family.

(2017, loc 5916)

O'Connell points to important, interacting elements that impact her thinking about reproduction: her own physical well-being, a desire not to pass on her disability coupled with the socioeconomic realities of managing her condition. As a disabled woman, O'Connell is also acutely aware of how disability is (mis)used to disqualify women from being parents, so she underscores that her decision should not be appropriated to control other individuals: "Choosing not to have children due to my disability does not mean that I think other people with disabilities should not have children" (O'Connell 2017, loc 5916). Reproductive decisions are complex and contextual, and many factors shape them. Supporting every woman and pregnant person's right to determine their reproductive future also means engaging in complicated discussions, and understanding that individual, materially informed decisions, even those based in part or wholly on not having a child with a disability, may not be ableist or easily categorised as neo-eugenic.

One of the pernicious ableist legacies of the eugenic era is the assumption that disabled people *should not* parent, so the second and third values, "the right to *have children* under the conditions we choose; and the right to *parent the children we have* in safe and healthy environments" (Ross et al. 2017, loc 208, italics in original), are crucial to racial *and* disability justice. Samantha Walsh (2011) provides a telling example of the quotidian presumption that she, as a disabled woman, would *never become* a parent. In a casual conversation with an aesthetician in a nail salon, Walsh began talking about the potential challenges of becoming a parent, but the nail stylist dismissed the topic: "Listen, you don't want kids anyway, so what does it matter?" Walsh transforms this offhand question into a meditation about how she, as a wheelchair user, is *not seen* as a potential parent. The conversation, in her mind, exposed the troubling presumption "that disability is not something that should intersect with the experience of motherhood" (2011, p. 82).

As disability rights activist and scholar Corbett O'Toole (2015) argues, such attitudes are pernicious and widespread. Her research reveals the scope of the problem in stark material terms:

Disabled people are told repeatedly that they should not be parents, that they are not safe with children and that they should not pass on their disability to the next generation. Disabled people are sterilised to stop them from ever getting pregnant. If they do

have children, many disabled parents lose them because someone complains to Child Protective Services, and the people evaluating them as parents do not believe that disabled people should have children.

(OToole 2015, p. 246)

Furthermore, OToole cites research done by the organisation Through the Looking Glass, which critiques the body of scholarly literature on disabled parents on the grounds that most researchers investigate the *problems* in these families; in other words, the research itself is driven by a bias of “presumed incompetence.” Their report goes on to state: “As this stereotype becomes enacted through custody and policy practices, disabled parents experience extraordinarily high rates of family disruption through actual or threatened loss of custody” (2012, National Council on Disabilities, cited in OToole 2015, p. 251). OToole recounts one devastating but all too common example of a physically disabled mother who had devised a safe method of changing her infant’s diaper on her bed, where the child would not be at risk of rolling off. When a social worker visited, she insisted the mother change the baby on a table, but this made the task unsafe—so the social worker used this “fact” to remove the child. Even with an excellent lawyer who provided video evidence of the mother safely changing the baby, this disabled mother lost custody of her child—as well as that of the baby she was expecting.

These few examples are meant to illustrate that parents with disabilities have valuable insights into the coercive, oppressive systems impacting their ability to parent. People of colour with disabilities and people occupying multiple intersecting identities have much to contribute to these intersecting justice movements. As well, disabled people have crucial social knowledge and strategies for creatively navigating gatekeeping systems, building communities of support and establishing new kinship models. Disability reproductive justice provides a framework to integrate the unique insights of disability communities into policy discussions, as well as to demand and integrate stronger networks of support for disabled parents, children and families.

Conclusion: Interdependent reproductive justice

The intersectional history of eugenics and broader reproductive concerns within disability communities provide a crucial context for challenging contemporary efforts to ban abortions based on genetic anomaly—most often based upon a positive screening for Down syndrome. Appropriating the rhetoric of disability rights, supporters of these bans claim to be addressing disability discrimination by resisting eugenic beliefs and practices. Karianne Lisonbee, sponsor of a bill in the U.S. state of Utah, boldly proclaimed, “Utah’s message to the world is that we will not tolerate discrimination” (quoted in Thiessen 2018). Individuals with Down syndrome have also advocated for abortion bans as a way of asserting their inherent value. Frank Stephens, in his testimony before Congress, compared abortion based upon prenatal screening to Hitler’s eugenic programme: “I completely understand that the people pushing this particular ‘final solution’ are saying that people like me should not exist,” then he encouraged representatives to “pursue inclusion, not termination” (quoted in Thiessen 2018). Exposing discrimination and valuing people with Down syndrome are foundational to disability rights, and concerns from individuals such as Stephens must be taken seriously. In fact, exposing the neo-eugenic dangers in biased or ableist promotion of pre-natal screening has been at the heart of disability studies critiques, as demonstrated in the discussion of Hubbard, Asch and Saxton. A crucial distinction, however, is that anti-abortion arguments situate the origin and the responsibility for discrimination with pregnant women; individual reproductive decisions, not larger economic, social and structural support of people with disabilities, become the battleground. This strategy decontext-

tualises reproductive decisions, while condoning state-sponsored control and criminalisation of reproduction—a more troubling legacy of eugenics.

Indeed, as anti-abortion groups claim to be opposing eugenics through legislative bans, a distinction must be made between belief systems that inform individual decisions and state-sponsored reproductive control initiatives. After all, one of the primary objectives of the eugenics movement in the United States was to control women's reproduction, and in the case of targeted groups such as women of colour and women with disabilities, to violate their bodily integrity and self-determination. In proposing abortion bans, anti-abortion supporters are enacting new forms of reproductive oppression and attempting to criminalise pregnant women and the doctors who provide care. If these groups really want to address disability discrimination and social inclusion, they could look at their state funding levels for Medicaid, at programmes supporting people with intellectual and developmental disabilities, at competitive employment programmes and other structural support of disabled people. Rachel Adams, a disability scholar and mother of a son with Down syndrome, made a similar point in an editorial in 2016. At the time, Missouri and Ohio were moving to pass abortion bans, slated as “non-discrimination” laws through their state legislatures. Notably, these same governing bodies slashed funding for programmes serving people with disabilities during that session (Adams 2016). Such state policies could be described thus: non-discrimination in the womb; indifference from birth forwards. Rather than policing pregnancy, governments could play a much more empowering role in reproduction. As Sujatha Jesudason (2011, p. 524) suggests, “a reproductive justice approach advocates for an affirmative role for the government to play in assuring that all women have the social, political and economic power and resources” to bring to bear in making the best and most appropriate decisions for themselves and their loved ones. Government does have a role, but that role should not be coercion, control or criminalisation.

Those concerned with disability and reproductive justice might also learn from women of colour who organised to oppose a similar “anti-discrimination” campaign in their communities. Loretta Ross describes an anti-abortion campaign aimed at women of colour that parallels more recent abortion bans based on Down syndrome. Beginning in 2008, groups organised to introduce abortion bans on the basis of race and sex. Drawing upon statistics documenting that African American women were having higher rates of abortions than other racial groups, anti-abortion organisations began a public campaign claiming that black mothers seeking abortions were enacting eugenic tactics and were selecting to abort based on race. As reproductive justice scholars explain: “Claiming to campaign against ‘reproductive racism’, conservatives use the bizarre ‘abortion is racist’ narrative that disregards the rights, wishes, and needs of women of colour” (Ross et al. 2017, loc 1322). Wealthy, white donors partnered with conservative, pro-life African American leaders to attack African American women seeking abortions. Echoing previous malicious attacks, such as calling black women “welfare queens” or “hyperfertile,” this campaign “placed black women as the destroyers of the black family” (Ross et al. 2017, loc 1300). Conservative legislators, who had always voted against civil rights legislation, were suddenly introducing bills named after civil rights leaders to address the supposed racism of abortion—as if African American women were aborting because their foetuses were black. The strategies in this case are very similar to those in the Down syndrome campaign. Mothers are blamed for enacting eugenics while anti-abortionists cast themselves as champions of justice. In these cases, we need to contextualise the real racial and disability histories of eugenics, and call attention to the eugenic nature of reproductive control and criminalisation of pregnant bodies. Furthermore, like women of colour who confronted abortion bans based upon race, reproductive and disability justice advocates must pursue larger conversations about creating sustainable, supportive

environments for children and parents, as well as resources, within communities that will allow women to make actual “choices” about their bodies, minds and potential families.

In the case of Down syndrome, many women choose to terminate because they see this condition as non-optimal; however, this perception may be driven by ableism, neo-eugenic beliefs or by the material realities and lack of social support afforded people with disabilities. The solution to changing perceptions and challenging ableism in such cases is to educate people about disability rights, insight and experience, not to criminalise reproductive decisions. Alison Piepmeier’s (2013) research revealed that assumptions of ableism, discrimination or neo-eugenic ideology failed to capture the complications of reproductive choices. Piepmeier did a series of interviews with women who had received prenatal diagnoses of Down syndrome during their pregnancies and found that their decision making was very complex. After the screening results, most of the women became concerned about their networks of support, about the social opportunities, prejudices and resources they might, or might not, have available. Piepmeier (2013) determined that reproductive justice frameworks acknowledge this complexity more than pro-choice framings: “Reproductive justice makes room for messier questions and concerns. It emphasises social justice, which removes this decision from an individualised space and makes it part of a broader set of community priorities” (2013, p. 176). Loretta Ross and her co-editors echo this idea: “Reproductive justice is collective and interdependent by definition” (Ross et al. 2017, loc 3251).

As this exploration into the intersectional legacies of eugenics in current reproductive debates demonstrates, the interests of disability and reproductive justice are intertwined, and both movements are enhanced through this interdependence. As recent anti-abortion efforts demonstrate, appropriation of disability rights discourse will continue to be weaponised to enact reproductive control, but disability scholars must resist efforts to pit disability rights against women’s reproductive freedoms. Supporting this process, the three tenets of reproductive justice broaden the focus and insist upon intersectional and community approaches. Ultimately, individual decisions about reproduction depend upon the social and material contexts of disability, gender, race and access to resources and supports—and these contexts will improve only if we focus on supporting lives, not mandating births.

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