

Relations of Abortion: Crip Approaches to Reproductive Justice

Michelle Jarman

The article challenges the politically reductive ways that disability is leveraged by both antiabortionists and pro-choice supporters—on one side to claim “protection” of all life, and on the other to use disability as a crucial justification for abortion rights. It centers disability for two reasons: first, to demonstrate the deep connections of disability to the ongoing political erosion of access to reproductive healthcare services, which disproportionately impacts women of color and economically vulnerable women; and second, to build on recent scholarship suggesting a merging of critical disability and reproductive justice approaches to reconfigure the dominant pro-choice public discourse on abortion. To bring these two approaches closer together, this article focuses on two key elements of the abortion debate—access and autonomy—from a critical disability studies lens. By foregrounding disability approaches to access and critiques of autonomy, the complicated relational concerns of reproduction are brought into focus. Ultimately, it argues that an interconnected relational context provides a more nuanced approach that both supports women’s access to reproductive options and demands an expansion of the political frame based on choice and rights to include valuing and sustaining lives, challenging precarity, and supporting complex reproductive decisions.

Keywords: abortion access / disability rights / disability studies / prenatal testing / pro-life versus pro-choice / reproductive justice / selective abortion

Over the last several years, especially since the passage of the Affordable Health Care Act, the reproductive rights of women in the United States have come under renewed siege as pro-life politicians have pushed for and enacted severe restrictions on abortion rights, insurance coverage for contraception, access to family planning, nonbiased sex education, and related healthcare. According

to the Guttmacher Institute (2013), 2011 and 2012 marked the highest number of abortion restrictions enacted in single years, at ninety-two and forty-three respectively, since *Roe v. Wade* was passed in 1973. With seventy new restrictions enacted in 2013, the total over the last three years represents more restrictions on reproductive rights than in the entire previous decade (Nash et al. 2014). In 2013, we witnessed some of the most extreme legislation to date. In a bid to become one of a growing number of states to impose gestational limits on abortion access, Texas garnered extensive media attention with Wendy Davis's filibuster and subsequent passage of an abortion ban after twenty weeks; however, the Texas bill was moderate compared to other states. Following in the footsteps of Arkansas, which banned abortions after twelve weeks, in March 2013, North Dakota enacted the first legislation to ban abortions after a heartbeat becomes detectable, which can be as early as six weeks into a pregnancy. In a second measure passed the same day, North Dakota became the first state to ban abortions based on genetic "defects" such as Down syndrome (Eckholm 2013)—a potential precedent that should be of significant concern to both disability rights and reproductive justice supporters. The limits in both states, ultimately overturned by federal courts (Kissel 2014; "North Dakota" 2014), reflect a growing aggressiveness among pro-life supporters. Such efforts culminated in the passage of a twenty-week abortion ban by the House in June 2013. While this bill was not considered by the Senate (Pickert 2013), in 2014 several states, including Mississippi, South Carolina, and West Virginia, passed or were pursuing twenty-week bans (McLeod 2014; Pettus 2014), and the Republican National Committee endorsed a resolution supporting twenty-week bans (Good 2014), signaling that abortion will again be positioned as a polarizing issue heading into the 2016 presidential election. In effect, these and other measures represent a growing hostility to abortion among conservative legislators and an organized effort in many states to increase prohibitions, enact protocols that effectively abolish abortion clinics, and demonstrate increasing political commitment to challenge the protections of *Roe v. Wade* in the Supreme Court (Crary 2013; Eckholm 2013).

I focus specifically on the North Dakota ban based on prenatal diagnoses because it signals a new era of exploiting disability as a pro-life issue while simultaneously reenacting a political divide that has long persisted. Pro-life supporters have always claimed to value *all* lives, including those with disabilities, while pro-choice groups have used medical complications and trauma in pregnancy—including disability diagnoses in prenatal screening procedures—as quintessential justifications for abortion rights. In fact, many abortion groups have argued against twenty-week bans on the grounds that a number of prenatal tests are not conclusive prior to twenty weeks into a pregnancy. As disability is once again mobilized to support the positions of both sides of this divisive political issue, a critical disability approach must be foregrounded not only to expose the manipulation of affirmative disability rhetoric by pro-life supporters, but also

to demand greater engagement with disability rights critiques of reproductive policies on the part of leading abortion rights supporters.

This article draws on reproductive justice and feminist disability studies to challenge several specific strategies of antiabortion activists, including disability-related statutes, time limits based on distorted representations of fetal pain, and unequal erosion of access to reproductive healthcare services—all disproportionately impacting women of color and economically vulnerable women. While it is essential for abortion rights supporters to resist the multiple and varied strategies enacted to limit women's access to abortion, this is also an opportune moment to push back with a more complex discussion of abortion—one that foregrounds disability, economic and racial disparities, and the social precarity produced by increasing political intervention into reproductive practices, the types of information provided, and the availability of care and services. Such a critique would also be mindful of the fact that many women of color, poor women, rural women, and women with disabilities not only face barriers to reproductive care and choices, but these groups also lack access to strong disability services like education supports, employment, housing, robust healthcare, and public spaces more broadly.

Following recent scholarship calling for more substantial bridging between reproductive justice and disability frameworks, I suggest a broader, complexly relational approach to abortion. Emerging out of women of color collectives, reproductive justice frameworks have always been articulated in relational terms: women's decisions and reproductive needs are situated in connection to families, cultural contexts, and histories of oppression. Additionally, a focus on economic access and community resources has long challenged the rhetoric of individual choice. The reproductive justice movement has been built on collaborating and building coalitions across differences and understanding the perspectives of diverse communities in an effort to map out political strategies that support the needs of all women, but this kind of relationality is rarely championed in mainstream pro-choice discourse. Feminist disability perspectives also insist on the complexities of interdependence in thinking about reproduction. Disability justice frames challenge ableist ideas that mothers or children with disabilities should be de-valued or de-selected based on disability diagnosis; they also foreground the relationality among cultural beliefs about disability, the availability of services, and community support of women's reproductive decisions. My use of *relationality* centers around women within specific contexts of experience, embedded in families, communities, and histories. This approach also allows a critique of recent pro-life political strategies, specifically the ways that pro-life discourse largely decontextualizes the fetus, stripping this entity of any relationships—especially to the woman in whose womb the fetus resides. Further, antiabortionists elevate this decontextualized fertilized egg to a status deserving unilateral protection, even as a symbolic animation of life itself. In response, an approach of complex

relationality allows for much-needed engagement with the tensions between valuing life and supporting abortion.

In an effort to bridge reproductive and disability justice frames, I focus on two key elements of the abortion debate: *access* and *autonomy*. By applying disability conceptualizations of access and disability critiques of autonomy to mainstream discourse on abortion, the kinship and sociopolitical concerns of reproduction are brought into central focus. A relational context based on access and interdependence provides a more nuanced approach that supports women's access to reproductive options and demands an expansion of the enduring political frames of choice and rights to include valuing lives, sustaining relations, and supporting complex reproductive decisions—whether they be to terminate or to bring a pregnancy to term.

Crip Relations to Reproductive Justice

Over the past several decades, bioethicists and feminist disability rights advocates have made significant contributions to debates on abortion and reproduction. Many scholars have challenged the underlying eugenic impulse of prenatal screening, genetic testing, and potential new technologies aimed at identifying fetal “abnormalities,” usually with an aim to offer mothers and partners the option to terminate. Renowned biologist Ruth Hubbard (2010) explicitly connects new genetic approaches to reproduction to a long history of eugenics, both in the United States and Nazi Germany. She argues that normalizing these processes of “selection” should be understood within a larger context of *biopolitics*—of controlling who should and should not be allowed to exist. Hubbard does not argue against the right to access abortion; she supports abortion for women “because it involves a decision about our bodies and about the way we will spend the rest of our lives” (117). Her argument is aimed at the broader scientific/medical imperatives to monitor and control human production:

[F]or scientists to argue that they are developing these tests out of concern for the “quality of life” of future children is like arguments about “lives not worth living.” No one can make that kind of decision about someone else. No one these days openly suggests that certain kinds of people be killed; they just should not be born. Yet that involves a process of selection and a decision about what kinds of people should and should not inhabit the world. (ibid.)

Along the same lines, disability studies scholar Marsha Saxton (2010) argues that selective abortion and screening technologies are informed by a very narrow medical understanding of disability. She insists that as these narrow frames of disability continue to shape standards of care, they threaten not only to control women's bodies, but to control “the products of women's bodies” (127). Echoing Hubbard, Saxton stresses that these technologies now act as “quality controls” and “admission standards” for humanness (ibid.) and

warns that those interested in disability justice must pay close attention to the growing acceptance of and demand for predictive testing.

The late bioethicist Adrienne Asch (1999), a leading voice in disability rights and reproductive politics, extends this critique. She rightly points out that when medical professionals promote prenatal screening and termination, they situate disability as “the only relevant characteristic” (1652), and relevant only as a tragic, negative reality. Asch further explains that this approach perpetuates a cultural bias, positioning disabled lives in absolute opposition to desirable lives: “Professionals fail to recognize that along with whatever impairment may be diagnosed come all the characteristics of any other future child. The health professions suggest that once a prospective parent knows of the likely disability of a future child, there is nothing else to know or imagine about who the child might become: disability subverts parental dreams” (ibid.).¹ Disability scholars and rights advocates have long railed against such reductive medical assessments of disability; instead, they have challenged medical professionals to consider their own biases, and to provide diagnostic information about disability as a neutral difference—as a difference worth understanding and investigating beyond the clinical encounter, preferably in consultation with disabled people themselves.

In her book *Feminist, Queer, Crip*, feminist disability studies scholar Alison Kafer (2013) addresses this issue of disabled futures explicitly, arguing that our dominant ideas about disability are intensely caught up in a “curative imaginary,” which she defines as “an understanding of disability that not only *expects* and *assumes* intervention but also cannot imagine or comprehend anything other than intervention” (27; emphasis in original). Understanding the curative imaginary is crucial because this naturalized approach informs both the medical/genetic impulse to prevent disability and a collective inability to imagine a robust and rich future in which disabled people actively contribute to the tapestry of cultural life. Kafer insightfully argues that this curative approach leads to the troubling mainstream assumption that everyone desires the same futures—a better future where disability is notably missing. She marks this disavowal of disability in two ways: “first, the value of a future that includes disabled people goes unrecognized, while the value of a disability-free future is seen as self-evident; and second, the political nature of disability, namely its position as a category to be contested and debated, goes unacknowledged” (3). These interlocking elements are important and relevant to understanding the absence of *crip* perspectives (a term used by scholars and activists to highlight the political nature of disability) in mainstream abortion rights discussions. In relation to Kafer’s points, progressive abortion rights supporters endorse such a self-evident future when they uncritically support diagnostic screenings or cite the presence of disability as an uncomplicated justification for (often later-term) abortions.

Disability rights advocates understand that some women will choose to terminate a pregnancy based on disability diagnosis, genetic screening, or other medical complications, but they also situate these “choices” within a larger, predominantly ableist cultural context. Priya Lalvani (2011), for example, has documented persistently negative framings of disability among doctors and medical personnel in their interactions with expectant mothers. She interviewed women who received a prenatal diagnosis of Down syndrome, some who terminated and others who went on to have the child, but they overwhelmingly reported clinical interactions “steeped in assumptions of negative outcomes for families of children with Down syndrome” (283). Expectant mothers described three types of responses, all of which contributed to a construction of “otherness”: first, expressions of sympathy combined with expectations that the birth would be a burden; second, affirmative assertions of the “special” nature of the child or the parents and family; and third, invasive questions about testing results and subtle or overt pressure to terminate the pregnancy (283–84). Within this context of prognosis and forced decision-making, prospective mothers quickly come to understand that they must actively engage in meaning-making to resist such commonplace ableist scripts.

In the interest of crip reproductive justice—one in which disabled futures are not only imagined, but embraced—abortion rights supporters should actively defend women’s access to abortion and work toward ensuring that women facing such decisions have access to information about disability services and supports, access to members of the disability community, and access to other resources required to address the complexity of such a decision.² Women undoubtedly need political support to maintain access to abortion; however, within a worldview where disability is primarily seen as negating future potential, women often need *more* political support to decide against abortion and imagine rich futures for themselves and their children. Feminist disability approaches support women’s access to reproductive options, accurate, unbiased medical information, and quality healthcare; but equally important, they pursue a more complicated discussion of abortion, one that contextualizes disability within an ableist history and a future predicated on removal. In this demand for a contextualized, relational understanding, disability rights supporters share a parallel, often interconnected approach with the reproductive justice movement led by women of color. In fact, unlike scholars such as Saxton, Asch, and Hubbard, who have not actively connected their work to women of color activism, recent disability studies scholars like Kafer (2013), Alison Piepmeier (2013a, 2013b), Faye Ginsburg and Rayna Rapp (2013), among others, purposefully link disability scholarship to reproductive justice. In imagining “accessible futures,” Kafer specifically encourages “greater familiarity with, and support of, reproductive justice movements and frameworks on the part of disability studies and activism.” She further explains that

reproductive justice insists upon a cross-movement approach to reproductive issues, recognizing that questions of reproduction cannot be disentangled from those of race, class, and sexuality, not to mention poverty, welfare, health care, social services, environmental justice, and so on. Disability is an essential piece of this assemblage, and reproductive concerns about disability cannot be untangled from these other factors. (162)

In an effort to expand on these linkages, I turn to the rhetoric of individual choice. Reproductive justice activists have long critiqued the insufficiency of pro-choice/pro-life frameworks, pointing out that “choice” has never been distributed equally, and that women of color and minority communities have had to fight for choices that most economically resourced, nondisabled white women have never been denied—especially to have and keep their children. In effect, reproductive justice activists are deeply grounded in histories and futures: remembering often bitter histories of reproductive control and coercion imposed on women of color, they endeavor to challenge current inequities and prevent new forms of injustice in the future. To that end, as reproductive justice scholar and activist Kimala Price (2010) explains, the three core values of the movement include abortion rights, but only as part of a larger picture. These values assert “the right to have an abortion, the right to have children, and the right to parent those children.” And perhaps most important, “women must be able to freely exercise these rights without coercion” (43).

These core values resonate in the interconnected histories of those women most directly affected by reproductive control and injustice in the United States: women of color, indigenous women, poor women of all ethnicities, and women with disabilities. Dorothy Roberts (2011), a leading legal and race scholar, highlights the way that race has been used to shape reproductive violence: “Forced sterilizations, eugenicists’ favorite remedy for social problems, were an extension of the brutality inflicted on black Americans. Slaveholders’ total dominion over the bodies of enslaved Africans—including ownership of enslaved women’s wombs, which they exploited for profit—provided an early model of reproductive control” (37). Other groups, including indigenous women, immigrant women, and queer women, have also faced unique yet interconnected histories in relation to reproductive injustice, and these histories shape our collective futures. It is far beyond the scope of this essay to trace these legacies in detail, but I weave my focus on disability into larger conversations of race and economics to call attention to relations of injustice demanding attention, even as my focus falls on specific aspects of reproductive equity.

For example, race, economics, and disability are often intricately related in genetic futures. As Roberts points out, we are witnessing increasing economic and cultural pressure toward “biocitizenship,” which includes an imposed expectation of making “responsible” genetic choices. Echoing the concerns of disability scholars, she warns that we are rapidly entering an era wherein we will be

more *obliged* than *free* to make choices about reproduction: “Using reprogenetics to select the traits of children may become more of a general duty than a privileged choice” (217). As the United States heads in this direction, informed by a curative imaginary, Roberts articulates two problems worth considering. First, she asks, “will making the wrong genetic choices disqualify biocitizens from claiming public support?” (221). Second, connected to this question, she worries that if prenatal screening technologies are widely accepted as the new standard of care, women will be exposed to new types of reproductive coercion: “In the future, the government may rely on the expectation that all pregnant women will undergo genetic testing to justify not only its refusal to support the care of disabled children, but also its denial of broader claims for the public provision of health care” (*ibid.*). Disability activists share these concerns and provide a unique perspective on the ways that the threat of disability will continue to shape medical standards. Although Roberts is not primarily concerned with disability issues, she notes the distinct connection between genetic promises of “prevention” and public support of disability and healthcare. In effect, disability and reproductive justice supporters will benefit from even greater collaboration in mapping out just futures for all women.

Relational Access, Relational Precarity

Reproductive justice groups like SisterSong, Generations Ahead, and other collectives have been more responsive than mainstream feminist pro-choice groups in integrating disability perspectives into their activism. Indeed, reproductive justice activists are modeling not only theoretical frameworks, but also methodologies that promote the inclusion of women who have historically been marginalized. Sujatha Jesudason and Katrina Kimport (2013) describe the process of dialogue in an activist meeting focused on the uses of reprogenetics, convened by Generations Ahead. The participants organized into affinity groups like indigenous women, Latina, African American, Asian, and a disabilities affinity group. Members of each group were able to articulate their hopes and concerns about new reproductive technologies and provide personal and community perspectives. As the authors describe, “[a] reproductive justice framework demands a different methodology, one that explicitly attends to power” (214). Further, they stress that this methodology centers the experiences and knowledge of “women speaking for themselves at the nexus of multiple oppressions and in the context of their community lives” (215). The multiple and layered concerns, insights, and histories that emerge from such an approach are crucial to developing policies and practices based on shared issues and shared values that resist protecting one group’s choices at the expense of others.

In theory and practice, reproductive justice frameworks are capacious enough to include the interests of disability rights, and as disability comes to more centrally shape state and national abortion debates, feminist disability

scholarship can provide disability-specific frameworks that inform public resistance to increasingly aggressive pro-life strategies. In proposing a crip critique, I focus on two key aspects of the mainstream, public abortion debate that also resonate within disability studies: *access* and *autonomy*. First, *access* is a powerful political and justice-oriented term, but from a disability perspective it is always complicated by contextual factors and, in practice, must be negotiated relationally. I argue that the relational process of access, informed by disability, adds an important dimension to political conversations about abortion access more broadly. Second, although feminists have long stressed the importance of relational thinking in personal and political contexts, the rhetoric of *choice* depends on and reifies a conception of individual autonomy that is too narrow to capture the interrelated forces at play in reproductive decisions. Disability scholars have made important critiques of over-individualization and offer unique contributions to feminist perspectives. Drawing from these insights, I suggest foregrounding relational decision-making as a way to frame the political support needed for pursuing reproductive justice for all women.

This focus on relations places my project in kinship with Kafer's (2013) relational/political model. She maps out multiple ways that this approach might allow us to reconsider the whole "terrain of disability" (7). For this discussion, I am most interested in expanding on her seemingly simple, yet in practice quite complex, idea that "disability is experienced in and through relationships" (8). In many ways and at varying levels, the experience of disability is shared: parents, children, siblings, partners, relatives, allies, caregivers, and others invested in the lives of disabled people also experience disability through these significant relationships. However, from a reproductive standpoint, these often sustaining personal relations compete with wider economic, medical, and political structures that influence women's concepts about disability and abortion. In addition, a framework based on complex relationality is ever attentive to how social relations are constituted, shaped, distorted, and even severed through public discourse around reproduction and disability.

In order to flesh out the importance of relationality to this wider conversation, I suggest broadening the concept of *access* in terms of abortion to include disability insight into this term, which is a keyword of disability advocacy. Disability studies scholar Tanya Titchkosky (2011) defines *disability access* as an "act of perception," and further as "an interpretive relation between bodies." If we think about how access is made invisible for some and visible for others, or ask who is allowed to "grant" access and who is put in the position of asking for it, we witness, in Titchkosky's phrasing, "how we are enmeshed in the activity of making people and places meaningful to one another" (3). She expands on this idea in the following:

Every single instance in life can be regarded as tied to access—that is, to do anything is to have some form of access. This is an important issue to address

in relation to those who are expected and enabled by the social environment, and thus appear as non-disabled and as though they are unconnected to access concerns. The question now becomes: How is it that we regard some aspects of everyday life as an access concern and others as not? (13)

I want to apply this concept of *disability access* as an interpretive relation between bodies to the broader issue of *reproductive access*—not to equate the two, but to focus on how relations are produced and valued while also made precarious.

The legislative success toward ending abortion rights, after all, has been achieved by curtailing access; and not surprisingly, those most affected by restrictions are poor women, women who depend on Medicaid (including disabled women), women in rural communities, and women of color. Restrictions on abortion access began soon after *Roe v. Wade*. In 1976, the Hyde Amendment was passed, which prohibited the use of federal Medicaid funding for abortions. After the Supreme Court upheld this decision, unequal access became an ongoing, crucial reality of reproductive politics. In recent years, pro-life state lawmakers have focused on eliminating funding for abortions or related services; limiting insurance coverage of abortion; requiring special, often onerous requirements for abortion providers and facilities; pre-abortion counseling (which often includes misleading and unsubstantiated health information); ultrasound imaging; waiting periods; parental involvement; and restrictions on telemedicine—specifically designed to make medical abortions less accessible to women in rural locations (Solinger 2013, 80–81).

These extensive restrictions, always enacted under the hollow rhetoric of protecting “life,” largely decontextualize (and depoliticize) the hypothetical unborn from all relations (meanings, significations) to the woman involved, her wider kinship networks, and her access to reproductive services and community support. Most troubling, this rhetoric and the policies enacted under its banner fail to connect their inherent ethic of compulsory birth to wider social supports that would make “life” (parenting, childcare, employment) more sustainable. This chasm between the ideology of “life” and women’s material conditions has come into sharp relief recently in Mississippi, as state lawmakers followed the passage of a twenty-week ban with restrictive medical requirements aimed at closing the only clinic still open in the state. Mississippi already has in place strict restrictions on contraception and reproductive education and struggles with what advocates call “dismal access to healthcare” (Carmon 2014). Staff members at the Jackson clinic describe their clientele as mostly poor women of color, either teenagers not ready for motherhood or mothers with children who do not have the economic resources to raise another child. Pro-choice politicians and advocates rightly push against such moral and political disconnects; opponents of the clinic’s closure, for example, are pursuing arguments that the proposed law is a “breach of access” (ibid.) to abortion—a constitutionally

protected right. This argument is important and could be enhanced by Titchkosky's framing of whose access is enabled and whose is denied. In this case, poor women who have limited access to healthcare or accurate reproductive information are most in need of abortion services. In the face of a clinic closure, the visibility of these women's access needs become magnified while the needs of women who can afford private healthcare or can travel to clinics out of state are hidden and depoliticized.

Judith Butler's (2006) theorization of precarity is useful in thinking about how relations are constructed, made meaningful, and disavowed in abortion discourse. Butler discusses precarity broadly, as a way of thinking about neoliberalism and the reality of living in quasi- or full-fledged military states, but her insights apply to the way abortion policies and rhetoric render certain individuals and groups precarious. She wants to make visible the ways that the "bonds that support life"—those bonds that should be structured to sustain all of us on terms of equality—are made "precarious" (130). Rather than focusing on the ways that everyone, as a body in the world, experiences precarity, she calls attention to the ways that common bonds are broken or severed. In the following quote, taken from a roundtable discussion on precarity (Puar 2012), Butler highlights the risks produced in the current US political environment where conservative politicians leverage austerity measures against the actual well-being of their constituents:

What seems more important . . . is the idea that a "bond" is flawed or frayed, or that it is lost or irrecoverable. And we see this very prominently when, for instance, Tea Party politicians revel in the idea that those individuals who have failed to "take responsibility" for their own health care may well face death and disease as a result. In other words, at such moments, a social bond has been cut or destroyed in a way that seeks to deny a shared precariousness and the very particular ethos and politics that ideally should follow from that. (169–70)

Pro-life supporters claim a shared precariousness with the unborn fetus, but the intensity of this bond with the unborn hinges on severing all sociopolitical bonds with pregnant women, whose decisions are deeply informed by their own precarity. Much as Butler points out the "reveling" of Tea Party politicians at the potential life-threatening results of other citizens' "irresponsibility," pro-life politicians have demonstrated extreme disdain for women who seek abortions for any reason. This was evidenced when public rhetoric descended to a new low during the run-up to the 2012 presidential election, as politicians like Todd Akin evoked questions of "legitimate rape" or suggested that women could biologically resist pregnancy during unwanted intercourse. More recently, Virginia state senator Steve Martin referred to pregnant women as "hosts" rather than mothers (Pow 2014), revealing the level to which some pro-life lawmakers elevate the status of the fetus above the material concerns, integrity, and rights of pregnant women.

These social, ethical bonds are deeply frayed when women are coerced into childbearing; however, on the other side, precarity is also produced when women feel pressured into long-term birth control, giving up children for adoption, or, in terms of disability, pressured to screen fetuses for impairments or terminate once a diagnosis is made. In order to consider how a perspective of relational access can provide a bridge, it is important to look more closely at specific ways that women are made precarious on both sides of the life/choice debate.

Relational Precarity of Decontextualized Life and “Fetal Pain”

Antiabortion legislation is purportedly enacted to protect the sanctity of life; however, when pro-life supporters celebrate new measures as “victories for life,” as North Dakota governor Jack Dalrymple stated when the bill passed (MacPherson 2013), this generalized “life” is disconnected from the pregnant woman, her kinship groups, and the larger sociopolitical environments to which she belongs. In the case of North Dakota’s ban on abortions due to prenatal diagnoses, lawmakers celebrated a hollow victory for both life and disability. However, such legislation is an affront to access and disability rights; it would render abortions least accessible to those with the fewest resources, and notably, the ban pays no attention to the social context of disability. As feminist scholar Alison Piepmeier wrote soon after the North Dakota ban passed: “If North Dakota really does want it to be ‘a great day for babies in North Dakota’ . . . it should make the state a welcoming place for people with disabilities” (2013b). Indeed, if any state wants to claim victories for nondiscrimination of people with disabilities, they should highlight policies that support parents, families, caregivers, and people with disabilities directly—policies that enhance the opportunities of people with disabilities across the lifespan to participate in and contribute to their communities. Notably, however, supporting the lives of disabled people has never been on the agenda of pro-life groups. As Saxton (2010) has argued, “[i]n the disability community we make a clear distinction between our views and those of anti-abortion groups. . . . [They] have never taken up the issues of expanding resources for disabled people or parents of disabled children, never lobbied for disability legislation. They have shown no interest in disabled people after they are born” (127).

Progressive feminists have long made similar points about pro-life inconsistencies more generally; protecting the unborn rarely translates into policies to support the lives of children, mothers, or underserved groups. Indeed, many of the stated goals of antiabortionists are undermined by their own reproductive health restrictions. The most recent antiabortion initiatives aimed at banning later-term abortions, in particular, are purposefully disconnected from the women seeking these procedures, the reasons behind their decisions, and the sociopolitical, material context shaping their situations. Rather than consider the policies that have exacerbated the need for later-term abortions, such as lack

of access to clinics, mandatory waiting periods, lack of Medicaid coverage, or adequate funds—all of which have been put in place under the political mandate of protecting “life”—pro-life supporters focus their political judgments on the women who seek these procedures (rhetorically magnified as “partial birth” abortions) as simply irresponsible, unethical, or immoral.

The current wave of legislation based on “fetal pain” is but another example of pro-life political strategies aimed at constructing the fetus as an entity under attack rather than an entity already caught up in complex relations. Not only have claims of fetal pain been overwhelmingly discredited by scientific research, but these arguments rely upon constructing the fetus as absolute victim in need of rescue, rendering the needs, concerns, and pain of the mother irrelevant. This strategy has been based on specific misinformation: first, medical and scientific research to date suggests that the brain development—specifically in the thalamocortical pathways (Lee et al. 2005, 949)—of a fetus prior to twenty-four weeks has not reached a level for sensing pain; second, a major argument to validate fetal pain has been the use of fetal anesthesia, but this is used for many reasons not related specifically to pain. Its use in abortion operations supports the mother’s health and does not provide evidence for conscious pain in the fetus (951). Notably, however, such misinformation has led to successful legislation: currently, nine states with twenty-week restrictions have based their laws on claims that fetuses can feel pain by eighteen or twenty weeks after fertilization (Gutmacher Institute 2014). Although *Roe v. Wade* already stipulates that states can regulate abortion based on fetal viability, which has long been established as occurring between twenty-four and twenty-eight weeks, antiabortion activists have worked tirelessly to establish earlier legal protections for the fetus—with personhood status at conception the ultimate goal.

The one-dimensional focus on fetal pain masks larger material issues at play in women’s lives when they seek later-term abortions; indeed, facts on abortions after twenty weeks reveal a complex story. Of all abortions in the United States, over 90 percent are performed in the first twelve weeks of pregnancy, and only 1.5 percent take place after twenty weeks (Solinger 2013, 67). Of those who have abortions after twenty weeks, most cite compounding difficulties, such as the late determination of pregnancy, partner issues, lack of money, problems getting time off from work, arranging transportation, or other complications trying to access the procedure (Boonstra 2008; Jones and Finer 2012; Jones, Upadhyay, and Weitz 2013). The access or lack of it to abortion clinics and providers affects women in widely disparate ways. Regulations instituted since *Roe v. Wade*, such as mandatory waiting periods, counseling, twenty-week bans, and parental involvement, have created what Gretchen E. Ely and Catherine N. Dulmus (2010, 660) call a “two-tiered system of abortion access.” While these regulations cause inconvenience for middle- and upper-class women, they impose material hardship on poor women, many of whom are women of color.

Instead of focusing primarily on fetal pain, a crip reproductive justice approach would direct political attention to other forms of pain. Disabled women may experience the pain of not being considered “mother material”; the pain of having one’s competence as a mother called into question; or, for women with newly identified genetic conditions, the pain of having to decide not to have children or the pressure to assert one’s right to mother in the face of future impairment (Boardman 2011). Poor women, disproportionately women of color, may experience the pain of unintended pregnancies, the pain of economic, social, and political barriers to reproductive information, services, and care, the pain associated with surgical procedures, and the physical, emotional, and material pain of childbirth and/or forced parenthood. Notably, pro-life restrictions on access to Medicaid funding of reproductive healthcare have had disproportional impacts on poor, nonwhite women. Even as abortion rates have declined over the last three decades, unintended pregnancies are now highest among African American women. Latina women have proportionally less unintended pregnancies, but these are still double those of white women. Among the three groups, the numbers of unintended pregnancies break down as follows: white, 35 per 1,000; Latina, 78 per 1,000; African American, 98 per 1,000 (Cohen 2008, 3). These higher rates reflect specific difficulties in accessing high-quality contraception or problems using methods consistently or effectively—issues directly tied to healthcare affordability and availability, reproductive education, and access to reliable birth control. Given these rates of unintended pregnancy, African American women are more likely to seek out abortions, but also are the most likely to feel forced into parenthood by multiple and complex circumstances (4). The changing demographics of abortion bear this out as well. Although rates are declining in the United States as a whole—from a high of 29.3 per 1,000 in 1981 to an historic low of 19.5 per 1,000 in 2005—again, women of color are overrepresented: currently, only 36 percent of abortion patients are white women. Also, where 12 in 1,000 white women of childbearing age seek an abortion, by comparison, 40 in 1,000 African American women obtain abortions (Guttmacher Institute 2013). Even more troubling, recent demographics indicate that economics and poverty play crucial roles in predicting who will seek abortions in the country today. With the long-standing attacks on Medicaid funding for reproductive services and Planned Parenthood specifically, low income women have far more unintended pregnancies and abortions. As Amanda Marcotte (2013) reports, over 40 percent of women having abortions live under the poverty line, and 69 percent of all women obtaining abortions today have incomes within 200 percent of the poverty line.

Material access to abortion, reproductive healthcare, or insurance coverage is rarely seen as related to disability access. However, if we consider access more broadly, as Titchkosky (2011) suggests, much is revealed about current political relations—and about how we are enmeshed in meaning-making. As access to clinics, abortion services, and even effective birth control has been curtailed

by conservative policies, unintended pregnancies and abortions have increased disproportionately for poor women of color who depend on Medicaid and other government programs. Then, as need rises—largely as a result of structural inequities—the very women who have been denied access are rendered more visible for seeking abortion services. When pregnancy becomes a crisis and a woman seeks abortion services, if she lives in a state with only one remaining abortion clinic several hundred miles from her home or is forced to visit the clinic multiple times, taking off work for each visit, her situation becomes more visible, more tenuous, more precarious. Women with transportation, flexible employment, economic resources, and multiple options for abortion services, by contrast, are also afforded privacy. For these women, access remains; because their needs are easily met, they are largely invisible, largely private. In a parallel configuration, disability access often makes the person with a disability more visible. Requests for reasonable accommodation, more time, alternative formats, interpreters, captioning, audio description, and other features often mark disabled people as distinct. In other words, access becomes more visible when it has to be added in as an afterthought because it has not been considered in the first place. However, if we consider access more perceptually and structurally, we can build it in from the beginning, as integral to the design. In a sense, reproductive justice frameworks bring missing voices to the table in an effort toward the universal design of reproductive politics.

The Relational Precarity of Decontextualized Choice

In the movement toward reproductive equity many abortion rights supporters endorse a broader dialogue of the issues at stake, including economic and racial disparities; however, the dominant public debate continues to be figured around rights and choice. The pressure to complicate this political conversation is coming from sources beyond disability rights and reproductive justice advocates. Feminist philosopher Bertha Alvarez Manninen (2013) points out that many young women who support reproductive rights in general resist being associated with the pro-choice movement because they think such an affiliation means an absolute devaluing of fetal life. In her interviews with young women, she finds that they want to address the moral complications and emotional aspects of exercising one's decision to terminate a pregnancy. Manninen states that “[m]any women who opt for abortion do so precisely because they understand and appreciate that gestation will not just yield a baby, rather it will yield their baby; gestation and birthing turns one into a mother” (665). Most young women realize the complexity of such a decision and feel that by positioning abortion narrowly as a choice, and even a right, public discourse fails to acknowledge the ambivalence, the pressure, and the contextual realities faced by most women. Ultimately, Manninen argues that the dominant message of abortion supporters must shift somewhat “so that our position is no longer perceived as

inherently incompatible with expressing respect for fetal life, and is one that demonstrates a fuller respect for the women who must make decisions regarding that life” (ibid.). Other feminist scholars, including Susan Bordo (1993), have made similar arguments for some time, but Manninen’s point that her young female students still widely perceive the pro-choice movement as narrowly antagonistic to fetal life remains a telling reminder of the enduring dualistic nature of public abortion discourse.

Supporting abortion does not necessitate a disregard for fetal life; indeed, disability rights and reproductive justice approaches have long integrated the tension between abortion rights and respecting the potential life of the fetus. At the same time, in pursuing her goal of complicating the parameters of the abortion debate, Manninen, like most leading feminists, remains firmly lodged in the paradigm of emancipation through autonomous action. While I certainly do not suggest hindering women’s choices, I do believe that pushing against autonomy and individualism as the paradigm for protecting legal abortion opens up important spaces to talk about access and relations, sustaining or otherwise. Access—that word again. One cannot make sustainable decisions if one does not have access—to resources, transportation, healthcare, kinship support, and, from a feminist disability studies perspective, to unbiased information about disability, preferably from disabled people themselves. By insisting on a paradigm of autonomous choice, abortion supporters too often forsake an opportunity to develop a more complex, inclusive, relational rubric of access, one that integrates disability as a constitutive element of reproductive equity and political futures.

Relational Decision-making / Relational Action

While the protection of personal choice and rights may seem crucial to protecting access to abortion, in practice, these frameworks obscure structural inequities and sociocultural assumptions and pressures, as well as relational and emotional complexities inherent in women’s lives. Feminist disability and reproductive justice approaches resist the inherent over-individualizing impetus of mainstream pro-choice frameworks. Critical disability studies has developed wide-ranging critiques of how individualizing disability, often through positioning it as a “problem” to be addressed through prenatal screening, rehabilitation, medicine, or other specialized treatments, removes the material, sociopolitical aspects of it from view. Similarly, reproductive justice paradigms demand a reckoning with the context of autonomy and choice; they resist focusing on individual women’s choices as irresponsible or virtuous, but ask instead how all women can be provided with adequate prenatal and postnatal supports to actually create a context of sustainable decision-making. Lack in any of these areas impacts women’s choices and decisions; more importantly, the denial of access to these basic supports exposes social precarity—relational bonds with women that have been broken.

Integrating disability more specifically into issues of selective abortion, prenatal screening, supported parenting, and other reproductive debates extends this relational register of meaning. Unless one is acquainted with disability rights frameworks, supporting disability within the context of reproductive decision-making demands new information and often a radical reorientation. Thinking toward parenting a child with a disability also magnifies the need for, or lack of, social and material supports—in one’s family, community, and beyond. In other words, by foregrounding disability in the abortion debate, we also foreground the relational context of decision-making at the personal level and the social relations (cultural meanings, attitudes, community resources) immediately brought to bear on the often-shared reproductive decisions so often figured as “autonomous choices.”

Moving from autonomous choice and individual rights toward a relational context of reproductive decision-making allows for greater understanding of the pressures brought to bear on women as they consider prenatal diagnoses, abortion, and potential futures as a parent. A disability diagnosis brings specific complexities of this decision into focus—complexities unique to disability, but also crucial to cultural debates about abortion more broadly. Through in-depth interviews with several women whose fetuses were prenatally diagnosed with Down syndrome, feminist disability studies scholar Alison Piepmeier (2013a) paints a vivid portrait of the challenge that disability makes to overly individualized pictures of abortion decisions. A major theme she encounters is that women felt isolated and uncomfortable thinking of the decision, either to abort or to carry to term, as one they were expected to make on their own. As Piepmeier explains, “[t]hese women didn’t discuss the individualized decision-making process as empowering, with meaningful options available to them. Instead, they felt frightened and pressured, as if those around them had unpredictable agendas that had to be negotiated and manipulated” (175). In her conversations with these women, the relational nature of their decisions was ever-present. Intimate personal relations were important and complicated; further, when the presence of disability was revealed, the competing meanings that this represented to partners, families, and friends brought new factors into the process. Disability, in other words, did not necessarily make termination more likely, but a prenatal diagnosis always introduced new questions and new complications. At the same time, these questions pushed prospective mothers to have conversations that they might not have pursued in a pregnancy with no “complications.” Piepmeier narrates one story in particular where the prenatal diagnosis precipitated a profound familial conversation. A prospective single mother, Aasha, was having a difficult time making a decision after receiving a prenatal diagnosis, but when one member of her extended family told her to have the baby, the rest of the family pledged their support. Her family’s voiced investment in her child’s future provided crucial emotional support for her to make the decision and commit to mothering her child (179).

Ultimately, the rhetoric of choice overly individualizes the process of making reproductive decisions. And in line with Roberts's (2011) work, Piepmeier stresses a point that we are all witnessing: if women make choices that cause extra resources to be needed, they are likely to be seen as not having made the right decision (177)—and these judgments often come from mainstream progressive feminists. In contrast, Piepmeier rightly points out that reproductive justice and feminist disability frameworks move more radically toward the “we”—acknowledging that reproduction has to take place within communities, even if a woman is making a decision to be a single parent. All mothers, both with partners and without, need the support and care of others to create a sustaining environment. For a woman who decides to carry a pregnancy to term after a prenatal diagnosis, kinship relations, as well as the relationships that her wider community has with disability, will shape her ability to provide for, and what she can provide to, her future child. On the other side, however, women who opt to terminate a pregnancy due to prenatal diagnosis should be supported and their decisions contextualized within wider sociopolitical realities. As disability activists push toward greater political engagement with disability, including a more nuanced understanding of the potentially rich lived experience of disability and the dangers of selective abortion, feminist disability scholars can also partner with reproductive justice scholars to support the complex relational-decision-making processes for all women.

Ultimately, we must infuse our politics of reproductive justice with a more crip lens, one that pays careful attention to the dangers of figuring disability as a central defense of either life or abortion. Notably, using disability strategically to defend abortion glosses over and renders invisible the unique political and familial demands and potentials of disability. Such arguments do not simply dehumanize disabled people and devalue the complexity of their lives; they also play into the expanded privatization of women's health and the decreasing social supports that marginalized groups, including children and adults with disabilities, often experience. Frameworks of disability access that focus on relations and sustaining environments support a more radical and inclusive politics of reproduction. If we remain mindful, in Titchkosky's (2011, 3) words, of “how we are enmeshed in making people and places meaningful to one another,” discussions of reproductive justice and access will reflect the concerns of women from diverse communities and hopefully enliven and enrich the collective imaginings of disability.

Acknowledgments

I am extremely grateful to Alison Kafer for reading earlier drafts of this article and her generous, insightful comments and suggestions. I also want to thank Alison Piepmeier for her interest, advice, and support, and the anonymous reviewers for providing detailed, extremely useful ideas.

Michelle Jarman is an associate professor of disability studies at the University of Wyoming, where she directs the undergraduate minor in disability studies through the Wyoming Institute for Disabilities. She earned her doctorate in English from the University of Illinois at Chicago. Broadly, her research explores the tensions and productive connections among disability studies, race studies, and gender theory in twentieth- and twenty-first-century literary and cultural representations of disability. Her essays have appeared in such journals as MELUS (Multi-Ethnic Literature of the United States), Review of Disability Studies, Journal of Literary and Cultural Disability Studies, Feminist Formations, Disability Studies Quarterly, and several literary and disability studies anthologies. She can be reached at mjarman@uwyo.edu.

Notes

1. Reducing the potential future of a fetus to a trait of disability could also be linked to abortions based on sex/gender. Both practices depend on the assumption that a child's future is primarily determined by one trait.

2. In making this argument I echo many feminist disability studies scholars who have stressed their support for access to abortion and nonbiased information on disability. As mentioned, Marsha Saxton, Ruth Hubbard, Adrienne Asch, and Alison Kafer all highlight this position. Other scholars, such as Kim Q. Hall (2011), Eva Feder Kittay (2005), Alison Piepmeier (2013a, 2013b), and Faye Ginsburg and Rayna Rapp (2013) stress the importance of reproductive options and disability advocacy—some connecting selective abortion to discussions of euthanasia. Disability scholars like Annette Patterson and Martha Satz (2002) have also tied these dual perspectives specifically to genetic counseling.

References

- Asch, Adrienne. 1999. "Prenatal Diagnosis and Selective Abortion: A Challenge to Practice and Policy." *American Journal of Public Health* 89 (11): 1649–57.
- Boardman, Felicity. 2011. "Negotiating Discourses of Maternal Responsibility, Disability, and Reprogenetics." In *Disability and Mothering: Liminal Spaces of Embodied Knowledge*, edited by Cynthia Lewiecki-Wilson and Jen Cellio, 34–48. Syracuse, NY: Syracuse University Press.
- Boonstra, Heather D. 2008. "The Impact of Government Programs on Reproductive Health Disparities: Three Case Studies." *Guttmacher Policy Review* 11 (3): 6–12.
- Bordo, Susan. (1993). *Unbearable Weight: Feminism, Western Culture, and the Body*. Berkeley: University of California Press.
- Butler, Judith. 2006. *Precarious Life: The Powers of Mourning and Violence*. New York: Verso.
- Carmon, Irin. 2014. "The End of Abortion Access in the South?" MSNBC, April 28. <http://www.msnbc.com/msnbc/abortion-access-the-south-mississippi-law>.
- Cohen, Susan A. 2008. "Abortion and Women of Color: The Bigger Picture." *Guttmacher Policy Review* 11 (3): 2–5, 12.
- Crary, David. 2013. "Abortion Laws in Arkansas, North Dakota Set Stage for Legal

- Battle." *Huffington Post*, March 31. http://www.huffingtonpost.com/2013/03/31/abortion-laws_n_2988932.html.
- Eckholm, Erik. 2013. "Bill in North Dakota Bans Abortion After Heartbeat Is Found." *New York Times*, March 15. http://www.nytimes.com/2013/03/16/us/north-dakota-approves-bill-to-ban-abortions-after-heartbeat-is-found.html?_r=0.
- Ely, Gretchen E., and Catherine N. Dulmus. 2010. "Abortion Policy and Vulnerable Women in the United States: A Call for Social Work Policy Practice." *Journal of Human Behavior in the Social Environment* 20 (5): 658–71.
- Ginsburg, Faye, and Rayna Rapp. 2013. "Disability Worlds." *Annual Review of Anthropology* 42: 53–68.
- Good, Chris. 2014. "Republican National Committee Backs 20-Week Abortion Ban." ABC News, "The Note," May 9. <http://abcnews.go.com/blogs/politics/2014/05/republican-national-committee-backs-20-week-abortion-ban/>.
- Guttmacher Institute. 2013. "Roe at 40: New Infographics Illustrate Key Facts About Abortion in the United States." <http://guttmacher.org/media/inthenews/print/2013/01/08/index.html>.
- . 2014. "State Policies in Brief: An Overview of Abortion Laws." http://www.guttmacher.org/statecenter/spibs/spib_OAL.pdf.
- Hall, Kim Q., ed. 2011. *Feminist Disability Studies*. Bloomington: Indiana University Press.
- Hubbard, Ruth. 2010. "Abortion and Disability: Who Should and Should Not Inhabit the World?" In *The Disability Studies Reader*, 3rd ed., edited by Lennard J. Davis. New York: Routledge, 107–19.
- Jesudason, Sujatha, and Katrina Kimport. 2013. "Decentering the Individual and Centering Community: Using a Reproductive Justice Methodology to Examine the Uses of Reprogenetics." *Frontiers: A Journal of Women Studies* 34 (3): 213–25.
- Jones, Rachel K., and Lawrence B. Finer. 2012. "Who Has Second-Trimester Abortions in the United States?" *Contraception* 85 (6): 544–51.
- , Ushma D. Upadhyay, and Tracy A. Weitz. 2013. "At What Cost? Payment for Abortion Care by U.S. Women." *Women's Health Issues* 23 (3): e173–78.
- Kafer, Alison. 2013. *Feminist, Queer, Crip*. Bloomington: Indiana University Press.
- Kissel, Kelly P. 2014. "Arkansas' 12-Week Abortion Ban Is Struck Down by Federal Judge." *Huffington Post*, March 15. http://www.huffingtonpost.com/2014/03/15/arkansas-abortion-ban_n_4970764.html.
- Kittay, Eva Feder. 2005. "At the Margins of Moral Personhood." *Ethics* 116 (1): 100–131.
- Lalvani, Priya. 2011. "Constructing the (M)other: Dominant and Contested Narratives on Mothering a Child with Down Syndrome." *Narrative Inquiry* 21 (2): 276–93.
- Lee, Susan J., Henry J. Peter Ralston, Eleanor A. Drey, John Colin Partridge, and Mark A. Rosen. 2005. "Fetal Pain: A Systematic Multidisciplinary Review of the Evidence." *JAMA* 294 (8): 947–54.
- MacPherson, James. 2013. "North Dakota Abortion Ban Signed by Governor Jack Darlymple." *Huffington Post*, March 26. http://www.huffingtonpost.com/2013/03/26/north-dakota-abortion-ban_n_2956552.html.
- Manninen, Bertha Alvarez. 2013. "The Value of Choice and the Choice to Value: Expanding the Discussion about Fetal Life within Prochoice Advocacy." *Hypatia* 28 (3): 663–83.
- Marcotte, Amanda. 2013. "The Demographics of Abortion: It's Not What You Think."

- American Prospect*, January 22. <http://prospect.org/article/demographics-abortion-its-not-what-you-think>.
- McLeod, Harriet. 2014. "South Carolina House Advances 20-Week Abortion Ban." *Huffington Post*, March 19. http://www.huffingtonpost.com/2014/03/19/south-carolina-abortion-ban_n_4995899.html.
- Nash, Elizabeth, Rachel Benson Gold, Andrea Rowen, Gwendolyn Rathbun, and Yana Vierboom. 2014. "Laws Affecting Reproductive Health and Rights: 2013 State Policy Review." Guttmacher Institute. <http://www.guttmacher.org/statecenter/updates/2013/statetrends42013.html>.
- "North Dakota: Abortion Ban at 6 Weeks Is Overturned." 2014. *New York Times*, April 17: A14.
- Patterson, Annette, and Martha Satz. 2002. "Genetic Counseling and the Disabled: Feminism Examines the Stance of Those Who Stand at the Gate." *Hypatia* 17 (3): 118–42.
- Pettus, Emily Wagster. 2014. "Mississippi Governor Signs 20-Week Abortion Ban." *Huffington Post*, April 23. http://www.huffingtonpost.com/2014/04/23/mississippi-abortion-law_n_5200458.html.
- Pickert, Katie. 2013. "House Passes 20-Week Abortion Ban." *Time*, June 18. <http://swampland.time.com/2013/06/18/house-passes-20-week-abortion-ban>.
- Piepmeyer, Alison. 2013a. "The Inadequacy of 'Choice': Disability and What's Wrong with Feminist Framings of Reproduction." *Feminist Studies* 39 (1): 159–86.
- . 2013b. "Outlawing Abortion Won't Help Children with Down Syndrome." *New York Times*, "Motherlode" (blog), April 1. http://parenting.blogs.nytimes.com/2013/04/01/outlawing-abortion-wont-help-children-with-down-syndrome/?_r=0.
- Pow, Helen. 2014. "Virginia Republican Claims Pregnant Women are Just 'Hosts' in Angry Facebook Rant." *Mail Online*, April 24. <http://www.dailymail.co.uk/news/article-2567033/Virginia-Republican-claims-pregnant-women-just-hosts-angry-facebook-rant.html>.
- Price, Kimala. 2010. "What Is Reproductive Justice? How Women of Color Are Redefining the Pro-Choice Paradigm." *Meridians* 10 (2): 42–65.
- Puar, Jasbir, ed. 2012. "Precarity Talk: A Virtual Roundtable with Lauren Berlant, Judith Butler, Bojana Cvejić, Isabell Lorey, Jasbir Puar, and Ana Vujanović. *TDR: The Drama Review* 56 (4): 163–77.
- Roberts, Dorothy. 2011. *Fatal Invention: How Science, Politics, and Big Business Re-Crete Race in the Twenty-first Century*. New York: New Press.
- Saxton, Marsha. 2010. "Disability Rights and Selective Abortion." In *The Disability Studies Reader*, 3rd ed., edited by Lennard J. Davis, 120–32. New York: Routledge.
- Solinger, Rickie. 2013. *Reproductive Politics: What Everyone Needs to Know*. New York: Oxford University Press.
- Titchkosky, Tanya. 2011. *The Question of Access: Disability, Space, Meaning*. Toronto: University of Toronto Press.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.