Disability-Selective Abortion: Reasons for its Prevalence and Consideration by Indian Women
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“Planning to start a family? Take genetic tests to know what health problems your child can have.” This is the title of one of the first results I encountered on The Economic Times website, a popular newspaper in India. The rest of the article goes on to describe the many benefits of prenatal testing opportunities available so that parents can avoid the future of having a child with a disability. The tone, diction, and focus of the article all summarize the negative attitude toward disability and the valorization of the practice of genetic testing that is prevalent in India.

The advent and wide spread of the prenatal screening process and abortion procedures in India make it possible to abort babies with disabilities or illnesses by identifying the existent conditions of the baby in the mother’s womb. Certain state amendments uphold the legality of the practice, paving the way for its proliferation. The current trend of bio-medicalized childbearing and its effects actively promote a potent message couched in negative stigma for people with disabilities. It also influences women in decision making about their own pregnancies, and reinforces stereotypes about disability already accepted by the general public.

I hope to highlight the major reasons behind the prevalence of disability-selective abortion and explore why women choose to undergo the process, knowing they will have a child with a disability. In doing so, I examine how middle and upper class women in heterosexual relationships negotiate and balance their roles in the family structure and larger social structure. Women are also influenced by the ideas of freedom and choice that have been developed and circulated in neoliberal, urban India. This paper focuses on the structure and practice of disability-selective abortion, the embodied experiences of women, expectation of reproduction and disability, as well as the simultaneously localized and globalized
intersectional discourse on health, duty, family, responsibility, and gender that frames discussions regarding disability-selective abortion.

**Situating Disability-Selective Abortion**

Ableist preference, an underlying reason for undertaking disability-selective abortion, is prevalent in classes, races, religious affinities, and ethnicities around India, although there is less documentary evidence for certain groups (Singh, 2016). Differences in social, religious, and professional positions does result in a stratification reproduction and diversity of women’s experiences and influences (Rapp, 1999). Because of this wide gamut, I will be focusing on middle and upper class, urban women in this research paper. I chose to narrow my research to this sect of the population because of a higher probability of these women facing the conditions and choices I describe when they undergo pregnancy. Due to the high costs of prenatal screening and the abortion process, middle and upper class women are more likely to seriously consider those options. Additionally, they are more likely to have more similar experience with factors such as the affordability and accessibility of prenatal tests and abortions, the role of doctors as genetic counselors, and the expected role of women in the family. I specified urban women to look more closely into how capitalistic notions of freedom and choice influence women’s decision-making processes because growth due to globalization and its effects are more prevalent in urban areas. Although, I do concede the possibility of women who do not identify in the specified social groups and do experience the conditions I describe. I also concede the possibility of women who identify in this social groups and do not experience the conditions I describe.

When considering the decision-making process that women and their families engage in through their moral dilemmas, medical options, and the unidentified forces they perceive, I will be considering the ethnographic findings and observations of other studies that have focused on family making, disability, reproduction, and individual choice in India. I will use their data in the context of my own topic with a critical gaze. I
will take into consideration the population the other researchers interacted with and the similarities and differences that could be possible due to that.

Because I am not able to do ethnographic research and speak to studied individuals myself, I will not be able to consider how factors of class, caste, and religion and interdependency between them influence the particular form of disability-selective abortion. Another limitation, due to the nature of my research, is the broad group I am focusing on. Due to the many differences within urban, middle- and upper- class women, my attempts to talk about the group at large will lead to generalizations. Despite potential variation among my target populations, many urban middle- and upper- class women share cultural logics of political systems, social structures, and personal values that unite their embodied experiences.

The Legal Foundation

The prevalence of disability-selective abortion can be linked to the legality of the procedure. Two main laws govern the legal nature of disability-selective abortion. They are the Medical Termination of Pregnancy Act of 1971 (MTP Act) and the The Pre-Natal Diagnostic Techniques (Regulation and Prevention of Misuse) Act of 1994 (PNDT Act). The MTP act provides that a medical practitioner may terminate a pregnancy up to the twelfth week with the consent of the pregnant woman on one of two grounds: (1) that the continuance of the pregnancy would involve risk of life or health to the woman; or (2) that there is a substantial risk that the child, if born, would be born disabled. The PNDT Act prohibits sex selection through the strict regulation of prenatal diagnosis techniques. However, the Act allows prenatal techniques to be used for the detection of genetic or metabolic disorders, chromosomal abnormalities, certain congenital malformations, or sex-linked disorders. Together, the MTP Act and the PNDT Act provide a legal framework that allows the use of prenatal tests to first detect ‘abnormalities’ of the fetus and then to
terminate it (Ramaswamy, 2018).

These two acts effectively legitimize the selection and discrimination against disabled bodies as a form of acceptable health intervention, reinforcing the completely unwanted nature of disability perpetuated by the state. They imply that the birth of people with a particular set of characteristics should be prevented. The contextualization of disability in the law is intertwined with the medical perception in which any form of disability is treated as a disease and unfavorable. Together, they reinforce negative stigma toward disability that already exists as a general consensus amongst people.

Prenatal testing essentially creates a division among human beings by creating two classes: desirable and undesirable. The undesirable is seen as ‘unredeemable difference’ solved by technology (Kafer, 2012). Technological advancements are so powerful that society internalized such categorizing and provides legal permission to execute this division (Nizar, 2016). This shows how the state plays an active role in the removal of what it considers difference to create a ‘utopia,’ an imagined community that possesses highly desirable qualities for its citizens. The Indian state does this by defining disability and acting on these definitions through laws, resources, funding, and bureaucracy to further its own version of ‘utopia’ (Kafer, 2012).

**Bio-Medicalization in India**

The dramatic growth in disability-selective abortion in India in the past two decades has contributed significantly to the increasing availability and easy access to the fetal ultrasound scan. The more routine use of the scan in India has emerged only in the last decade and is connected with its local manufacture and related low cost (Unnithan-Kumar, 2010). The use of the scan is associated with modernity and progress, resulting in the bestowment of modern status to clinics that utilize it. Despite strict restrictions and regulations placed on such practices by the Pre-Natal Diagnostic Testing Act, these practices are difficult to enforce or monitor.
in the private sector because the technology is inexpensive and highly manufactured. This makes the technology obtainable and operable by a range of medical practitioners, particularly local practitioners.

The increased circulation and consumption of prenatal scanning machines has led to a diffusion of medical authority, related to this technology, away from hospitals to private practitioners, who also assume the role of genetics counseling. There is an “underlying ethic of social service that frames the way in which doctors think about their work,” including the provision of disability-selective abortion services (Unnithan-Kumar 2010). This leads to local private doctors offering their advice and guidance during the pregnancy process. This advice and guidance are often reflective of the general negative outlook toward disability.

Without greater awareness and a stream of information fed from their personal doctor, women face “imposed self-determination” (Samerski 2009). They are put in positions where decisions about medical tests and treatments are left solely to the patient. Prenatal genetic counseling causes women to be in positions that assess chances and risks associated with each test and their results and are forced to make a decision based on the information and experiences they have perceived.

This also exemplifies the concept of emergent epidemiologies, the concept that women are not faced with choices, rather they are forced to make decisions influenced by larger structural forces at play (Samerskia, 2009). When women are subjected and commodified through bio-medical processes, their bodies are embedded in structures based on larger systems because techno-scientific intervention has already been shaped by social and cultural commitments (Rapp 1999). These women’s decisions are merely a reflection of larger structural forces and hierarchies, such as the ones highlighted in this paper, that exist and govern the medical world.
Embodyment of Responsibility by Indian Women

Influenced by negative stigma surrounding disability perpetuated by the media, law, and public views, women are further influenced by their embodied roles in the family and society. These women embody idealized notions of Indian womanhood and wifehood subjectivity in which they identify as women who are responsible for completing reproduction considered successful. Disability-selective abortion needs to be understood in terms of changing social institutions, such as marriage, and the attendant social anxieties (regarding status, inheritance, securing the future) (Unnithan-Kumar 2010). Marriage plays a central role in the structuring of quality of life for women and within the marriage. Women are proscribed the responsibility of securing an appropriate reproductive future for the family (Unnithan-Kumar 2010). According to analysis of values prevalent amongst Indian urban classes, the quality of the woman is determined through the quality of the offspring, a requirement not fulfilled through the birth of a child with a disability.

The use of biomedical technologies enables a simultaneous focus on women's bodies as sources of both reproductive power and value, and away from their bodies as exclusively vessels for the vansh, or creators of aulad (respect) for their in-laws (Singh 2014). The link between fertility and a woman's status matters beyond the individual level, with implications that are also connected to the extended family. Women's bodies, and particularly women's reproductive potential, have been put into service of their marital families (in-laws) in India to uphold the respect and lineage of the family to production of healthy, viable offspring (Singh 2014). These prenatal services advance the commodification of reproductive potential, as are used as objects used to fulfill purposes set by other standards.

Women also perceive the offered suffering of other women, who may not have reproduced in the ideal way, through stories and news that are shared in social circles. Women live in the midst of lore about the fates of infertile women—that they died, disappeared, or were divorced, abandoned, attacked, and/or murdered by their husbands or other relatives.
Surrounded by stories with underlying tones of threat and warning, these women internalize the importance of reproducing in a manner deemed successful and the social, widespread knowledge of their reproductive natures. This knowledge that women gain as they experience life contributes to their social fund of knowledge. Rapp writes about the social fund of knowledge as collectively produced and individually accessed. Subjective at an individual level, their accessibility to the social fund of knowledge about contraception and disability affect how women in India perceive systems of support as collective knowledge from lived experiences, inevitably impacting their perception of having a child with a disability and their consideration of medical decisions.

Positive Opinion of Abortion Amongst Indian Women

Ethnographic studies of contraceptive behavior in India have documented the preference for pregnancy termination over the use of contraception as a means through which women exercise birth control (Anand, 2005). In a study done of urban lower-class women in the state of Rajasthan, it was found that abortion was considered favorable in terms of pregnancy control and desirable technology. It remains a popular choice among these women because abortion allows women to completely terminate a specific pregnancy. Many factors play into the preference for abortions such as the shame associated in talking about sex, men’s (and often women’s) taken-for-granted attitude about women’s lack of sexual rights and sexual needs, and the women’s ‘naturalized’ connection to constant childbearing (Unnithan-Kumar 2010). These conditions make induced abortion a means by which women can show wifely compliance through availability for sexual intercourse as well as provide temporary relief from constant childbearing (Unnithan-Kumar 2010). Abortion is also referred to as ‘safai’, meaning ‘cleaning,’ amongst these women. This is a reference to the removal of bad blood through abortion, resulting in a cleaner, more fertile body.

Abortion is also seen positively amongst urban women in In-
dia because it represents higher degrees of freedom, choice, and bodily autonomy. Urban women experience the repercussions and effects of the development of a neoliberal, globalized Indian economy. Neoliberalism has resulted in a shift in Indian cultural ethos. Socio-centric perceptions that value the larger society are being rapidly replaced with a highly individualized notion of selfhood (Addlakha 2010). The choice of abortion is a manifestation of increased agency and democratic citizenship that is being constantly being championed and furthered. Therefore, women may have a positive outlook on abortion due to these notions of freedom and choice attributed to it.

The Implications of the Disability-Selective Abortion

The prevalence of disability-selective abortion and the general acceptance of the practice is supported by the understanding that prenatal screening and selective abortion successfully reduces occurrences of disease and disability in the population, and thus is good. However, this assumption is embedded in many socialized views: that the enjoyment of life for disabled people is necessarily less than for non-disabled people; that raising a child with a disability is wholly undesirable; that selective abortion will save mothers and families from the burdens of raising a disabled child; and that we, as a society, have the means to decide who is better off not being born.

These practices and assumptions have major implications toward the value ascribed to the lives of people with disabilities. Prenatal testing and disability-selective abortion unfold the ‘prejudicing’ aspect of science (Nizar, 1016). They are mainly performed to identify fetuses with conditions that are considered undesirable by parents, practitioners, or society in general causing them to be discriminatory in nature. Notions of biological difference play a key role in legitimizing bodies and their capabilities in ableist hierarchies upon which quality of life is based, which are further legitimized through the portrayal of disability in the media, law, and medicine. These resources and technology are used not to empower the
lives of persons with disabilities, but to diminish their value by denying them the right to live (Nizar 2016). Additionally, this logic operates on the assumption that disability is the lack of an individual, not an effect of the broader interaction between larger political and social structures and individuals.

Disability-selective abortions are seen as necessary steps for creating a better society consisting of only ‘perfect bodies and minds.’ This results in a dehumanizing ideology that is harmful and marginalizing to people who live their lives with disability. This acceptance and proliferation of the belief communicates to people with disabilities that their human life should be prevented and is not worth living.

Justifications of disability-selective abortion as demonstrations of free choice are also not as ‘free’ as they seem. Individual decision-making is a situated process that is dependent of context and subjectivity and is influenced by webs of social relations and structural forces (Nizar 1999). ‘Free choice’ is framed by ethnicity, class, profession, race, religion, forms of privilege, and communities. Therefore, any process of ‘selectiveness’ is driven by prejudiced social forces, funds of social knowledge, support systems, opportunities available, stratified reproduction, and not by simply the women’s choices.

**Conclusion**

Disability-selective abortion is prevalent in India due to many factors and forces that enable the practice to exist in the first place and influence women to choose when they learn their child is going to have a disability through prenatal testing. Intricate connections between legal amendments, developments in medical technology, and neoliberal values have led to development of disability-selective abortion as an accepted practice. They also reinforce negative stereotypes and stigmas surrounding disability, as they select against specific bodies and label them undesirable. These factors also generate a different notion of personhood in the Indian context. As women perceive their role in the family, the positive
aspects of abortion, social delineations of disability, responsibilities of re-
production, and increasing individualism, their decision-making process is impacted. Therefore, there are many forces that affect women when they decide to undergo a disability-selective abortion, and these forces range from the specificities of the state of pregnancy that Indian women face particular to their families to the generalities of new choice and freedom enabled by the neoliberal growth in urban India.
References

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