



Access, Autonomy, and Dignity: Contraception for People with Disabilities



Introduction

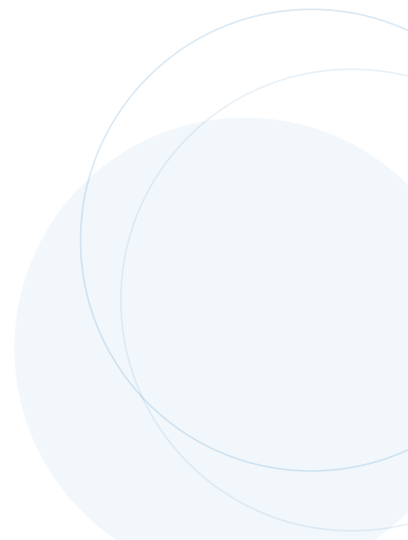
The reproductive health, rights, and justice movement and the disability justice movement have much in common. Both movements strive for bodily autonomy and the right of each person to make their own health care decisions, and share an understanding that these are deeply connected to dignity and equality. However, the reproductive health, rights, and justice movement has not always emphasized the specific needs or challenges of people with disabilities, or sufficiently considered how their histories and experiences add nuance and complexity to the issues of reproductive health and choice.

Health equity, disability justice, and reproductive justice frameworks call on us to understand how these issues intersect in people's lives, how access to reproductive health care is shaped by disability status, and how policy solutions must center the needs of those with the greatest barriers. People with disabilities will not truly have access to reproductive health and rights until we can eradicate ableist notions of if, when, and how people with disabilities can have or not have children, as well as parent them safely, free from coercion, discrimination, and violence.

The issue briefs in this series explore four important areas of reproductive health, rights, and justice for people with disabilities: the right to parent, access to healthy sexuality and sex education, access to abortion, and access to contraception. This particular brief focuses on access to contraception and barriers for people with disabilities, and includes policy recommendations to ensure that contraception is truly accessible for all people.

We have a long way to go. Join us in fighting for bodily autonomy and justice for everyone.

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Reproductive Justice

Reproductive justice is a term that was coined in the early 1990s by a group of Black women who sought to create a movement that was inclusive of and explicitly centered people with marginalized identities, including people of color, LGBTQ people, and people with disabilities. SisterSong, a leading Reproductive justice organization, defines reproductive justice as “the human right to maintain personal bodily autonomy, have children, not have children, and parent the children we have in safe and sustainable communities.”¹

Reproductive Justice reframes the conversation from “choice” to “access,” because a legal right to abortion is meaningless if people cannot realistically access this care. Unfortunately, millions of people do not actually have access, making choice unattainable.² Reproductive justice includes much more than just abortion, which by itself is not enough to ensure that people subject to discrimination and structural oppression have the power and resources necessary to protect their health, safety, economic security, and equity. Reproductive justice understands that these communities also face barriers to accessing contraception, comprehensive sex education, prenatal care, living wages to support their families, supportive workplace policies, intimate partner violence assistance, and much more. The reproductive justice framework recognizes that people do not live single-issue lives.

This framework also incorporates the concept of “intersectionality,” a term coined by legal scholar Kimberlé Crenshaw. Drawing on Black feminist and critical legal theory, intersectionality refers to the multiple social forces and identities through which power and disadvantage are expressed and legitimized. Intersectionality helps explain the realities of people who have multiple identities in which they experience oppression, and how they not only contend with the harms of each of those separate identities (for example, being Black and being a person with a disability), but also experience compounded and unique harms at the particular intersection of those identities (for example, being a Black person with a disability).³

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Why Is Access to Contraception Important?

Access to contraception is a matter of bodily autonomy and dignity.

Every person should have the right to determine what happens – or does not happen – to their own body. It is one of our most basic human rights, one that is foundational to both reproductive and disability rights and justice. Deciding whether or when to have a child is fundamentally about asserting autonomy over our own bodies. Access to contraception helps to make this right a reality by giving people control over their own reproductive futures. Contraception access is also intrinsically tied to dignity because it allows us to maintain a level of respect for our own bodies and our own decisions about whether and how to expand our families – and encourages society to respect our decisions as well. Importantly, while contraception is typically framed as being central to women’s lives, transgender, nonbinary, and gender-nonconforming people also use contraception and should have access to all reproductive health care that is affirming of their dignity and is free of discrimination and stigma.*

People with disabilities understand all too well how society, the medical establishment, other systems, and even other individuals feel ownership over their own bodies. People with disabilities are frequently told how to live, whether they can or should have children, whether they can or should have sex, what interventions they “need” for their bodies or minds, among other intrusions. As just one example, Karin Willison, a blogger who lives with cerebral palsy, detailed having to negotiate with her mother about cutting her hair because keeping it short would be “easier for [her] and other people to take care of.”⁴ She also described an experience with a former caregiver who expressed repulsion that Karin menstruated, saying, “Most people like you do something about it.”⁵ These anecdotes convey an all-too-common experience for people with disabilities: other people making decisions small and large about their bodies based not on what is best for that individual but instead on what is easy, convenient, or comfortable for others. These beliefs are also shared by the courts, which have failed repeatedly to acknowledge the bodily autonomy of people with

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* In recognition of this fact, this paper uses gender-neutral language wherever possible; however, this paper does use the term “women” in some instances, especially where that terminology is in the research or cited source.

disabilities. For example, Supreme Court Justice Kavanaugh – when he was a D.C. Circuit Court judge – wrote in an opinion about the right to self-determination of people with disabilities, “Accepting the wishes of patients who lack (and have always lacked) the mental capacity to make medical decisions does not make logical sense.”⁶

Bodily autonomy is particularly vital for Black, Indigenous, and other people of color (BIPOC) communities who have faced racism, discrimination, violence, and trauma throughout history and into the present. One of the most salient perpetrators has been – and continues to be – the medical establishment, through reproductive coercion, forced sterilization, unethical experimentation, and ongoing discrimination and bias. For example, the practices of gynecology and obstetrics in the United States were built on abusive and inhumane experimentation on enslaved Black women, including developing cesarean and other surgical procedures on women without anesthesia.⁷ And the first birth control pill – heralded as a tool for the liberation of middle-class white women – was tested on women in Puerto Rico, often without their knowledge or consent.⁸ BIPOC people and people with disabilities have also disproportionately been subject to forced sterilization laws[†] – and remain so to this day.⁹

The ability to control our own reproductive lives helps enable us to participate fully in society. Not having the power to make decisions about our own bodies and reproduction strips us of our agency, undermines our efforts to participate fully in our own lives and communities, and defeats our self-determination. People with disabilities need and deserve access to culturally competent contraceptive counseling and the full range of contraceptive methods to exercise full autonomy over their own bodies and lives on their own terms.

Access to contraception is critical for people’s mental and physical health.

Access to contraception is a basic and essential part of health care. There are 61 million women in the United States of reproductive age (15 to 44 years old), and 60 percent of them are currently using a contraceptive method of some kind.¹⁰ Contraception is also a necessary aspect of some individuals’ health more broadly, including

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[†] Learn more about the history of people with disabilities and forced sterilization in the Right to Parent brief that is part of this series at nationalpartnership.org/ReproandDisabilityParenting.

for people who are transgender, non-binary, or gender-nonconforming. For instance, contraception can help regulate irregular menstrual cycles and hormonal imbalances, make periods less painful, prevent hormonal acne, reduce risks of developing uterine cancer and ovarian cysts, and help manage endometriosis.¹¹

For people with disabilities, better and more equitable access to the full range of high-quality health care, including access to contraception, may be especially important. Structural inequities in the health care system cause people with disabilities to experience inequities in access to care and health outcomes. Nearly one in 10 people with disabilities lack health insurance.¹² Even for those who are able to access health insurance, research suggests that having a physical disability increases the likelihood of having unmet health needs and poor health outcomes.¹³ Adults with disabilities are nearly twice as likely as people without disabilities to report unmet health needs because of barriers to care.¹⁴

To have true access to contraception, people must be able to choose between a full range of contraceptive methods. For example, hormonal birth control can cause unwanted or harmful side effects for some people, barrier-based contraception may pose a challenge to people who have difficulty remembering them or who have motor challenges, and others may wish to avoid intrauterine devices (IUDs) due to concerns about bodily autonomy. Specifically, the daily hormonal birth control pill can cause a range of unwanted side effects, including, nausea, headaches, increased spotting between periods in the short term,¹⁵ and increased incidence of depression in the long term.¹⁶ Furthermore, a 2018 study found that two-thirds of Black and Latino women were concerned with using an IUD as it would restrict their personal agency and require a health care provider for removal.¹⁷ This could be even more of a concern for people with disabilities, who are often denied the ability to make their own health care decisions, especially when under a legal guardianship.¹⁸ With these different challenges and considerations inherent with each form of contraception, each person should have access to the type of birth control that is right for them, regardless of what they choose and why they choose it.

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Access to contraception helps maintain one's economic security.

Access to contraception is important for people's ability to time, space, and/or prevent pregnancies. This ability is an economic justice issue because both pregnancy and raising children alter the economic realities of families and single people who become pregnant. Expanded contraception access is linked to greater economic security. For instance, the ability of women to plan out their pregnancies through birth control is linked to greater educational and professional opportunities and increased lifetime earnings.¹⁹ Studies have also linked an increase in women's wages to the availability of birth control.²⁰ Specifically, women who had access to contraception by age 20 had reduced probability of living in poverty.²¹ Further, women living in states with strong reproductive health care access have higher earnings and face less occupational segregation compared with women living in states that have more limited reproductive health care access.²²

Attaining economic security is particularly challenging for people with disabilities, who are disproportionately low-income. This is due in large part to systemic discrimination; a broken, expensive health care system; and being disproportionately excluded from the workforce. Only one in four people with disabilities is employed, compared to more than two-thirds of people without disabilities, almost triple the rate (274 percent).²³ Furthermore, in 2019 – the latest year for which data are available – the gap in median income for people with disabilities compared to people without disabilities was nearly \$12,000, meaning people with disabilities make approximately 66 cents for every dollar earned by people without disabilities. Consequently, people with disabilities are twice as likely to live in poverty as are people without disabilities.²⁴ These issues are further compounded for BIPOC people with disabilities. Compared to white people with disabilities, Black people with disabilities are almost 55 percent more likely to live in poverty.²⁵ In addition, Black and Latino people with disabilities have unemployment rates that are approximately 50 percent higher than white people with disabilities.²⁶

Having a disability can impose additional costs on people and their families, such as medical bills, transportation, home modifications,

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The Legal Right to Contraception in the U.S. Constitution

Several Supreme Court cases recognize the right to contraception. First, in *Griswold v. Connecticut* (1965), the Supreme Court struck down prohibitions against the prescribing and sale of contraception, even to married couples.²⁷ The Court held that the Constitution guarantees a “right to privacy” when individuals make decisions about intimate, personal matters such as childbearing.”²⁸ Then, in *Eisenstadt v. Baird* (1972), the Supreme Court struck down a Massachusetts law limiting the distribution of contraceptives to married couples whose physicians had prescribed them.²⁹ This decision established the right of unmarried individuals to obtain contraception.³⁰ In *Carey v. Population Services International* (1977), the Court held that it was unconstitutional to prohibit anyone other than a licensed physician to distribute non-prescription contraceptives to individuals over age 16, and to prohibit anyone to advertise or display contraception.³¹

Nevertheless, it is not enough for people to have a right to contraception on paper; people need real access in order to achieve true reproductive freedom. For too many, including many people with disabilities, access falls drastically short.

and personal assistants.³² People with disabilities who rely on Medicaid-funded long-term services and supports in order to live in the community, and/or who rely on Supplemental Security Income, are typically subject to draconian income and asset limits that make it difficult or impossible to escape from poverty.³³ Furthermore, independent living supports that are available to people with disabilities are often not available to assist with parenting-related tasks.³⁴ All of these factors together mean that people with disabilities – and especially BIPOC people with disabilities – face systemic challenges to achieving economic security. Therefore, they make decisions about whether or when to become a parent or grow their families within that context.

Although access to contraception is not enough on its own to ensure economic security for people with disabilities, it is a necessary component to creating a more equitable and just society, where everyone has the power and ability to make the best decisions for themselves and their families.

Access to contraception helps maintain one's healthy and enjoyable sex life.

The ability to engage in consensual sex, if someone so desires, is central to personal autonomy. For people who have the ability to get pregnant, contraception is a way to enjoy sex while also being able to make informed decisions about, and have control over, their reproductive future. Access to whichever contraceptive method best fits one's preferences and lifestyle is critically important to sexual autonomy and freedom. This can be especially true for people with disabilities, whose autonomy is often eroded.

People with disabilities deserve the right to be seen as sexual beings, but often they are not. Little has been done to end the persistent discriminatory attitudes towards the sexuality of people with disabilities. There is a long history of treating their sexuality as “deviant” and something that should be suppressed, rather than a natural human desire. According to Tom Shakespeare, a leading disability rights scholar, people with disabilities are only seen on two ends of a spectrum: completely asexual or “perverse” and hypersexual.³⁵ A portrayal of a diverse group of people as only on one or the other end of a spectrum of sexuality minimizes the breadth of their experiences and perpetuates stereotypes. For example, there are some people with disabilities who may enjoy having a lot of sex, some who only have sex occasionally, and some who are asexual. For LGBTQ and BIPOC people with disabilities, this can be further compounded by stereotypes and stigma rooted in racist and heterosexist conceptions of sexuality and sexual expression. While having greater access to contraception would not curtail these harmful stereotypes, it would allow people with disabilities greater control and autonomy in expressing their sexuality.⁵

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Accessing Contraception

While the Constitution grants the right to use contraception, for many people, meaningful access is far from guaranteed in real life. While important laws and policies have strengthened access to contraception for millions of people, access can still vary considerably

⁵ Learn more about the barriers people with disabilities face in expressing their sexuality and accessing sex education in the Access to Sex Ed brief that is a part of this series [LINK](#).

based on a number of factors, including where you live, your income, whether you have health insurance, and if so, what kind of coverage you have.

One of the most significant steps forward in improving access has been the Affordable Care Act's birth control benefit. This benefit guarantees coverage for all FDA-approved methods prescribed by a doctor.³⁶ The benefit provides meaningful cost savings for people, as well: Women saved, on average, \$254.91 per year on birth control pills after the law's mandate went into effect.³⁷ Before the Affordable Care Act (ACA), even co-pays as low as \$6 prevented some women from obtaining birth control; furthermore, one in three Latina women and two in five Black women of reproductive age say they could not afford to pay more than \$10 for contraception.³⁸ Before the benefit, women were also more likely to forego more expensive, more effective birth control forms such as IUDs.³⁹ Thus, the ACA significantly improved people's ability to afford – or access at no cost – a range of birth control options. For instance, the mandate has increased insurance claims for short-term contraceptive methods (the pill, patch, ring, shot, diaphragms/cervical caps, and prescription emergency contraception) and also increased initiation of long-term methods (IUDs, implant, or sterilization).⁴⁰

However, despite the promise of the ACA birth control benefit in increasing contraception access, court cases since the ACA's initial passage have eroded the right to coverage through expanding employers' religious objections to providing contraception. Most significantly, in *Little Sisters of the Poor v. Pennsylvania* (2020), the Supreme Court upheld the Trump administration's regulations that extended sweeping religious and moral exemptions to the ACA's contraception coverage guarantee,⁴¹ meaning that employers can refuse to provide contraceptive coverage as part of their health insurance if the employer has a personal religious or moral opposition to contraception use. As a result, many employees across the country are left without access unless they can afford to pay for it out of pocket.⁴²

Many people with disabilities are insured not through the ACA but through Medicaid or Medicare – 38 percent and 27 percent of people with disabilities respectively in 2016.⁴³ All Medicaid programs are

1 IN 3
LATINA
WOMEN



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2 IN 5
BLACK
WOMEN

required to cover family planning services and supplies without cost-sharing, but the actual range of contraceptive products and services that are covered can vary by state and differ depending on how a person qualifies for Medicaid.⁴⁴ Conversely, there is no federal requirement for Medicare to cover contraceptive services and supplies, posing significant access to challenges for people with disabilities who are insured through this program.⁴⁵

Moreover, far too many people, including some people with disabilities, do not have insurance coverage at all, a number that has risen over the past few years,⁴⁶ and therefore must pay the full cost of contraception themselves. Some methods of contraception can be incredibly cost-prohibitive. For example, IUDs can cost more than \$1,000 and birth control pills can range from \$20 to \$50 for each monthly pack.⁴⁷ And these costs do not include the cost of a contraceptive counseling appointment with a health provider who can prescribe them.⁴⁸

For people who are low-income or without adequate insurance coverage, the Title X Family Planning Program provides critical access to contraceptive counseling and care.⁴⁹ Despite the importance of this program in the lives of many, in 2019, the Trump Administration promulgated a rule that forbid any provider that referred patients for abortion care from receiving Title X funding.⁵⁰ This was devastating for reproductive health care access, forcing almost a quarter of Title X providers – about 1,000 health centers – out of the program and cutting the network’s capacity nearly in half.⁵¹ As a result, at least 1.5 million people lost access to Title X-funded services, including contraceptive counseling and care.⁵² The Biden administration has since moved to reverse this Title X gag rule, but has not yet finalized the regulations necessary to do so. As a result, access to contraception remains out of reach for too many.⁵³

Even without this decimation of the Title X network, many people live in what are known as “contraception deserts,” meaning they lack reasonable access in their county to a health center that offers the full range of contraceptive methods.⁵⁴ More than 19 million women of reproductive age living in the United States are in need of publicly funded contraception and live in contraceptive deserts,⁵⁵ and approximately 1.5 million of these women live in a county without a single health center offering the full range of methods.⁵⁶ For all of

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these people, getting contraception means having to do more than showing up to an appointment.⁵⁷ They, as well as those who are not in a contraception desert, must find child care, take time off work, or travel long distances to access their preferred birth control method.⁵⁸

This difficulty in access is compounded for BIPOC people. When people of color experience discrimination from a health care provider, they are less likely to access contraception care or to use a more effective method.⁵⁹ Furthermore, although young Black women tend to live closer to pharmacies than their white counterparts, they tend to be independent pharmacies that are open fewer hours per week and have fewer female pharmacists, fewer patient brochures on contraception, more difficult access to condoms, and fewer self-checkout options.⁶⁰ They may also be less accessible for people with disabilities. Given that women of color are more likely to lack insurance coverage than are white women – with Hispanic and Alaska Native and American Indian women nearly three times as likely to be uninsured⁶¹ – and therefore get contraception from a Title X provider,⁶² when access to birth control is attacked or lessened, the harms of this disproportionately fall on people of color.

For people with disabilities, other factors might be barriers to accessing contraception. These can be logistical barriers, such as a lack of accessible transportation, difficulty scheduling appointments around transportation constraints, and lack of understanding from insurance companies and providers about their specific needs.⁶³ They can also be barriers related to intersecting identities and personal characteristics, such as immigration status, sexual orientation, or gender identity. At a minimum, the clinic or medical office must comply with the Americans with Disabilities Act (ADA). But beyond that, it must be actually accessible for people with a range of disabilities and needs. Furthermore, people with disabilities who also live at the intersection of another marginalized identity face compounded barriers to accessing care, ranging from lack of language access, to not having their symptoms taken seriously, to having their expressed health goals ignored.⁶⁴ The intersections of systemic racism and ableism in particular can put care entirely out of reach.

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Specific Concerns around Contraception Access for People with Disabilities

In addition to general access concerns, people with disabilities often face additional, particular barriers to contraceptive care and counseling.

Provider discrimination and lack of competent, trustworthy health care providers

People with disabilities are generally underserved by health care providers for a variety of reasons. These include a lack of provider competency on the needs of people with disabilities, lack of accommodations in the facility, lack of transportation accessibility, and centuries of abuse and ill treatment by the medical establishment that has undermined trust.⁶⁵ People with disabilities also face frequent discrimination from providers who are ignorant of the specific challenges they face – and from providers who assume that their health care needs in some areas are nonexistent. This is particularly prevalent in the context of reproductive health care, as providers often do not ask people with disabilities about contraception or abortion needs because they assume they are asexual, infertile, or simply incapable of having or consenting to sex.⁶⁶ Providers therefore routinely fail to offer people with disabilities with culturally competent, comprehensive, and non-coercive contraceptive counseling and care. Providers too often share insufficient and incomplete information about the birth control options that are available, or may minimize or deny a request for contraception from a person with disabilities.⁶⁷ Conversely, some providers assume that people with disabilities are hypersexual and thus may coerce them into using contraception they may not have wanted or that does not meet their needs.⁶⁸ Many providers also do not consider factors that may be unique to an individual person and their disability, such as their comfort level with different types of contraceptive methods, ease of use, or interactions with other characteristics of their disability, adaptive technologies, or medications they may take.⁶⁹ This lack of fully informed, culturally competent counseling and care puts people’s physical and mental health at risk and denies them full access to contraception.

These issues are further compounded for BIPOC and LGBTQ people with disabilities, who also face numerous additional barriers to health care, including a history and current practice of abuse, systemic racism, and bias in health care that also undermines trust in

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providers.⁷⁰ If people with disabilities struggle to access basic health care, accessing contraception – which is further pushed out of reach and sometimes stigmatized – can be nearly impossible.

Guardianship and the recognition as competent to decide

People with disabilities, particularly people with intellectual disabilities, may not be viewed as competent to decide the course of their own health care, including whether to use contraception, and if so, which method. Many people with disabilities are forced into guardianship – a legal arrangement that strips the person of some or even all of their rights, from deciding where they live to whether they will receive medical care and what kind. Instead, legally appointed guardians are given the power of “substituted decision-making,” in other words the ability to make decisions for – instead of with – people with disabilities.⁷¹ Sometimes, these decisions are informed by harmful stereotypes and false beliefs, and can be contrary to the wishes of the person with disabilities. In the context of accessing contraception, this means people with disabilities could be forced into receiving unwanted contraception, blocked from accessing the care they desire, or deprived of privacy with respect to their contraceptive choices. Although many states have enacted laws protecting against compulsory sterilization by court-appointed guardians, these laws often do not address coercion or denial of access to contraceptives.⁷² Court-appointed guardians may include parents, siblings, spouses, or even strangers who act as professional guardians; as a result, people under guardianship may have serious concerns discussing or disclosing their need for contraception to a guardian and may even decline to discuss contraception with doctors for fear of their privacy being violated. In some circumstances, guardians who become aware that a person under guardianship is sexually active have pushed for long-acting contraceptives or sterilization in order to prevent pregnancy – thus violating people’s right to decide both when to begin or stop using contraception and creating additional disincentives to have open conversations about sexual activity with one’s health provider.⁷³ This leaves critical health care decisions out of the hands of those who are seeking access to contraception and leaves people with disabilities vulnerable to shame, stigma, and even coercion from their guardians and caretakers. Even when they are not legally empowered to make contraceptive decisions on behalf of a person

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with disabilities, a caregiver can still act coercively. For example, if a person with a disability uses a method like birth control pills and needs assistance with medication, that puts the caregiver in a position to more readily interfere with or deny them their contraception.

Religious refusals

While the right to religious liberty is protected from governmental intrusion by law, politicians have been expanding this right to create blatantly discriminatory laws and policies.⁷⁴ On their face, these laws allow health care and other service providers to refuse to engage in certain activities if doing so would violate their religious or moral beliefs. In practice, laws and policies that carve out religious exemptions or refusals have been weaponized to enable discrimination against vulnerable communities, from openly discriminating against LGBTQ people in foster care and adoption, to denying access to health care based on the service someone is receiving or their sexual orientation or gender identity.⁷⁵

People with disabilities are among those particularly vulnerable to the harms caused by religious refusal laws. For example, people with disabilities may be residents of group homes or other institutional settings, many of which are run by religious organizations that seek to impose on others their own beliefs about abortion, contraception, and premarital sex. Alternatively, they may be served in their own homes by caregivers or in-home aides from religiously affiliated staffing agencies. Because some people with disabilities need assistance from their facility, transportation provider, and/or aide to access medical care, they may be directly prevented from accessing contraception by that institution or person claiming a religious “exemption” from their duty to care for people with disabilities. This could include refusals to help a person with disabilities take an oral contraceptive, refusal to arrange medical appointments, or refusal to transport someone to receive care. As of 2015, one in 10 nonprofits (generally, not just medical centers) with 5,000 or more employees had elected for an accommodation against providing contraception coverage to employees without challenging the requirement.⁷⁶ Importantly, this is on top of the religious refusals people with disabilities may encounter in the health care system itself – whether from providers who generally refuse to provide access to contraception, or who may refuse to provide such care specifically to people with disabilities.

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Proposals to Protect and Enhance Contraception Access for People with Disabilities

Ensure that health care is accessible for people with disabilities.

- **Medical facilities must consult with the disability community in their area to ensure they are as accessible as possible to everyone they purport to serve.** This includes establishing an accessible location within the community, going beyond minimum ADA requirements to ensure the accessibility of the facility for each person, working with the community to ensure there is accessible transportation, and expanding telehealth[‡] in a way that gives meaningful access to care, and specifically to contraception and reproductive health care.
- **Entities in charge of medical schooling, continuing medical education, and hospital standards, among others, must ensure provider education and training to properly meet the needs of people with disabilities.** Health care providers and staff must receive education and information about the health care needs of people with disabilities so that they can provide care that is medically appropriate in each situation. Furthermore, all providers should understand present-day concerns about eugenics and the historical context so that they can adequately present the comprehensive spectrum of reproductive health care options, including contraception, without shaming, stigmatizing, or stereotyping people with disabilities.
- **Congress must pass the Home and Community Based Services Access Act,** which would ensure that all people with disabilities have access to needed long-term services and supports, including transportation and assistance with scheduling and attending medical appointments. These supports may be necessary in order to access health care.

Build trust and shared commitment to disability justice.

- **Providers and the medical establishment must build trust with the disability community.** It is not enough for facilities to educate providers and ensure physical building compliance, because the medical establishment has done years of lasting damage to the trust between doctors, in particular, and the disability community. This trust is even further eroded for BIPOC people with disabilities. It is the responsibility of the medical community to reach out to and build trust with the disability community, and to demonstrate their commitment to providing culturally appropriate, equitable care, including comprehensive reproductive health care.
- **The reproductive health, rights, and justice movement must build trust with the disability justice movement.** The reproductive health rights and justice movement

[‡] Learn more about telehealth in [Delivering on the Promise of Telehealth: How to Advance Health Care Access and Equity for Women](#)

must demonstrate that it is committed to being inclusive and intersectional, responsive to critiques from allies in the disability justice movement, and ready to be thoughtful partners in ensuring meaningful reproductive autonomy and justice for all people.

Enact laws and policies that support reproductive health care access, as well as equity and justice for people with disabilities.

- **Federal policymakers must pass legislation and enact policies that will protect and expand contraception access, as well as laws and policies that better meet the health care needs of people with disabilities.**
 - ◆ Congress and federal agencies must protect, strengthen, and increase investments in the Title X Family Planning Program.
 - ◆ Congress and federal agencies must protect and strengthen the Affordable Care Act’s birth control benefit.
 - ◆ Congress and federal agencies must ensure that Medicare and Medicaid adequately cover for consumers and reimburse for providers contraceptive care and counseling, including through the Title X network and other high-quality family planning clinics.
 - ◆ Congress and federal agencies must protect and strengthen protections against discrimination on the basis of race, gender, ability, sexual orientation, gender identity, or immigration status in health care and other settings.
 - ◆ Congress and federal agencies must repeal religious refusals laws that enable health care providers and religious organizations who run and staff group homes, nursing homes, or other long-term services and supports to deny access to reproductive health care, including contraception.
 - ◆ Congress and federal agencies must ensure there is more data collection and analysis to disaggregate different communities’ needs and barriers to accessing contraception, including at the intersection of race and disability.
- **Policymakers must support people with disabilities’ decisionmaking.** They must recognize supported decision-making as an alternative to guardianship and other forms of substituted decision-making in the context of all health care, including contraception. States may wish to implement additional safeguards against coercion and abuse, including restrictions on guardians’ authority to either prevent or compel use of contraception.
- **The U.S. Government must ratify the Convention on the Rights of Persons with Disabilities.** The Convention reaffirms that all people with disabilities must have access to all human rights and fundamental freedoms, and identifies areas where protections of the rights of people with disabilities must be reinforced.

Endnotes

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The National Partnership for Women & Families is a nonprofit, nonpartisan advocacy group dedicated to advancing gender and racial equity in the workplace, improving access to affordable, quality health care that authentically meets the needs of all women and families and reduces inequities in health, and promoting reproductive freedom and justice, access to contraception and abortion care, and elimination of the stigma associated with abortion.

Learn more: NationalPartnership.org



The Autistic Self Advocacy Network is a nonprofit organization run by and for autistic people, created to serve as a national grassroots disability rights organization for the autistic community, advocating for systems change and ensuring that the voices of autistic people are heard in policy debates and the halls of power. ASAN works to advance civil rights, support self-advocacy in all its forms, and improve public perceptions of autism.

Learn more: AutisticAdvocacy.org

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