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Access to Obstetric and Gynecologic Care for Patients With Disabilities

This Committee Statement was developed by the American College of Obstetricians and Gynecologists' Committee on Advancing Equity in Obstetric and Gynecologic Health Care in collaboration with Beth Cronin, MD.

Although the Americans with Disabilities Act has been the law for more than 30 years, individuals with disabilities still face substantial barriers to health care and are at higher risk of receiving inadequate care than those without disabilities. It is important that obstetrician–gynecologists are aware of best practices for caring for their patients with disabilities, as well as how to adjust their offices, workflows, and practice patterns to be inclusive of all patients. Obstetrician–gynecologists and other reproductive health care professionals should understand the barriers that prevent disabled people from accessing reproductive health care. This is critical in identifying inequities and informing patient-centered approaches to services. Patients with disabilities should have access to the same health care as all patients, including all age-appropriate screening tests. It is important that health care teams acknowledge their inherent biases and offer and facilitate access to appropriate care, including recommended screening tests. Increasing training and exposure to individuals with different disabilities during medical training programs will not only help improve the lack of experience, but also help challenge the implicit and explicit biases that currently exist in health care.

The disability community is a large, diverse group of individuals with varied thoughts and feelings on the use of specific language. Some individuals prefer the use of person-first language (eg, "patients with disabilities" vs "disabled patients"). Others prefer identity-first language, which includes disability as a core component of one's identity, much like race and gender (eg, "autistic person" instead of "person with autism"). This document uses both identity-first and person-first language throughout and recognizes that different language choices will be favored by different individuals. The National Institutes of Health provides additional information on the nuances of respectful language for individuals with disabilities (1). As a health care professional, it is important to ask about and use the language patients themselves prefer and use. If a patient's preference is not known, it is best practice to use person-first language.

SUMMARY OF RECOMMENDATIONS AND CONCLUSIONS

Under the Americans with Disabilities Act (ADA), individuals are considered to have a disability if they have a

physical or mental impairment that substantially limits one or more major life activities, a history or record of such an impairment, or are perceived by others as having such an impairment (2). Additionally, the World Health Organization identifies three dimensions of disability: 1) impairment in a person's body structure or function or mental functioning (eg, loss of a limb, loss of vision, or memory loss), 2) activity limitation (eg, difficulty seeing, hearing, walking, or problem solving), and 3) restrictions in participating in typical daily activities (eg, working, engaging in social and recreational activities, and obtaining health care and preventive services) (3). Not all individuals may easily fit into categories of disability, and people's experience of disability may fluctuate. Based on the principles outlined in this Committee Statement, the American College of Obstetricians and Gynecologists (ACOG) makes the following recommendations and conclusions:

- **Obstetrician–gynecologists and other reproductive health care professionals should understand the barriers that prevent disabled people from accessing reproductive health care. This is critical in identifying inequities and informing patient-centered approaches to services.**

- **Obstetrician–gynecologists and other reproductive health care professionals should assume that patients have the capacity to consent for themselves, unless proven otherwise. They should recognize that capacity can change and should support patients' agency to exercise consent.**

- **Patients with disabilities should have access to the same health care as all patients, including all age-appropriate screening tests. It is important that health care teams acknowledge their inherent biases and offer and facilitate access to appropriate care, including recommended screening tests.**

- **Patients with disabilities should be provided access to the full range of reproductive health services, including comprehensive contraceptive counseling and prenatal and abortion care. This care should be offered in a safe and welcoming manner.**

BACKGROUND

Disability is part of human diversity. Although there are medical–legal definitions, the social model of disability frames disability in an environmental context in which individual limitations are not the cause of the problem, but instead, society fails to provide appropriate services and adequately ensure that the needs of disabled people are considered in societal organization (4). According to the Centers for Disease and Prevention's 2022 Behavioral Risk Factor Surveillance System data, more than 70 million adults in the United States, or more than one in four individuals, report having a cognitive, hearing, mobility, vision, self-care, or independent-living disability (5). That report also found that cognitive disability (13.9%) is the most prevalent disability type, followed by mobility (12.2%). Although the ADA has been the law for more than 30 years, there are still substantial barriers to health care for individuals with disabilities (6). A 2018 study found that, out of 500 obstetrician–gynecologists (ob-gyns), only 17.2% had received any information or training on providing health care to women with disabilities (7). Additionally, patients report feeling marginalized by other administrative and medical staff, who likely experience similar educational gaps as physicians. It is important that ob-gyns be aware of best practices for caring for their patients with disabilities, as well as how to adjust their offices, workflows, and practice patterns to be inclusive of all patients. Additionally, work needs to be done to expand the representation of disabled individuals across health care fields, areas that generally have centered able-bodied and neurotypical individuals. With reasonable accommodations, many more patients can be cared for by health care professionals with shared lived experiences.

Health care professionals must be aware of *ableism*, defined by disability justice activist Talia Lewis as, "A system of assigning value to people's bodies and minds based on societally constructed ideas of normalcy, productivity, desirability, intelligence, excellence, and fitness" (8). These notions of disability and ableism have been conflated with eugenics, anti-Blackness, and capitalism as a way to oppress populations. For example, in the U.S eugenics movement, in addition to those considered cognitively and behaviorally disabled, coerced sterilization was inflicted on Black and poor people—all conceived of as undesirable, unintelligent, and unfit to reproduce or parent. Contemporary examples of ableism in reproductive health care settings include not offering contraceptive counseling, sexually transmitted infection (STI) screening, or pregnancy testing to patients with cognitive or physical disabilities. These practices are ableist, because a health care professional is assuming who may or may not be sexually active. See Table 1 for a list of strategies to dismantle ableism. Additionally, health care professionals may engage in *diagnostic overshadowing*—"…the attribution of symptoms to an existing diagnosis rather than a potential co-morbid condition," causing missed or late treatment for conditions incorrectly assumed to be associated with a patient's disability (9).

Table 1. Strategies to Dismantle Ableism*		
Factor	**Ways the Current System Devalues Individuals with Disabilities**	**Ways to Communicate Value and Interrogate Biases**
Patient and practitioner level	Use of ableist language: "*Even simple exercises like walking and yoga can offer health benefits. The best part? Anyone can do these exercises—no equipment needed.*"	Review how healthy choices are suggested, including in patient-education materials, to ensure accessibility for all.
	Speaking to a patient's caregiver or support person rather than the patient	Center the patient in all conversations, including nonverbal or Deaf individuals. Learn how to appropriately utilize sign language interpreters and augmentative and alternative communication.†
	Ignoring requested accommodations because they seem too difficult to enact	Implement an office policy to meet all requested accommodations.Combine procedures (eg, sedation for IUD insertion when already having anesthesia for another procedure). If sedation or anesthesia services are needed, an anesthesia consultation before the procedure may be beneficial.Collaborate with other health care professionals to streamline health care visits.
Health care system level	Inequitable access to office care	Ensure the office has accessible scheduling processes, a variety of contact options, and options to schedule additional time so that a patient is not rushed.Use welcoming language and other ways of communicating with patients.
System level	Inaccessible physical design (eg, built environment does not allow patient to access the office or parking lot; counter height is too high; doors do not allow for wheelchair users to access without assistance)	Follow ADA requirements‡ (at a minimum) and then examine more deeply how to best ensure a welcoming office visit for all patients. Create a timeline for making needed changes.
	Inaccessible website (not using plain language, use of images without descriptions, lack of compatibility with screen readers for those with low vision)	Prioritize the needs of patients with disabilities (eg, visual, cognitive) when designing websites (eg, ensuring that visuals contain descriptions).§

IUD, intrauterine device; ADA, Americans with Disabilities Act.

*Ableism is a system of assigning value to people's bodies and minds based on societally constructed ideas of normalcy, productivity, desirability, intelligence, excellence, and fitness. See https://www.talilalewis.com/blog/working-definition-of-ableism-january-2022-update for more information.

†Resources: Washington, DC Office of Disability Rights. Guide to using sign language interpreters. Accessed March 12, 2025. https://odr.dc.gov/page/guide-using-sign-language-interpreters; ADA National Network. ADA quick tips—sign language interpreters. ADA National Network; 2017. Accessed December 19, 2024. https://adata.org/factsheet/sign-language-interpreters#; *and* American Speech-Language-Hearing Association. Augmentative and Alternative Communication (AAC). Accessed December 19, 2024. https://www.asha.org/public/speech/disorders/AAc.

‡U.S. Department of Justice, Civil Rights Division. Americans with Disabilities Act of 1990, as amended. Accessed December 19, 2024. https://www.ada.gov/law-and-regs/ada/; *and* Centers for Medicare & Medicaid Services. Nondiscrimination in health programs and activities. Fed Regist 2024;89:37522–703.

§Resources: U.S. Department of Justice, Civil Rights Division. Guidance on web accessibility and the ADA. Accessed December 19, 2024. https://www.ada.gov/resources/web-guidance/.

Individuals with disabilities still face substantial barriers to health care and are at higher risk of receiving inadequate care than those without disabilities (10). Much of the still-limited research on disabilities is focused on mobility or physical disability; fewer data are available on cognitive and other disabilities, an area of much-needed research. Barriers to adequate health care for patients with mobility impairments include, but are not limited to, inaccessible facilities with lack of options for and lack of training on transferring patients from their

mobility device to an examination table, inadequate appointment length, and inappropriate support for patients. The lack of training ob-gyns receive on the provision of health care to patients with disabilities results in deficits in knowledge and clinical skills, along with biased approaches in caring for this population (7).

Although disability alone does not constitute poor health, due to disparities in access and other barriers, people with disabilities are more likely than those without disabilities to have poor health. A cross-sectional study demonstrated that disabled individuals are less likely to receive gynecologic cancer screenings and less likely to receive timely and consistent prenatal care, even though they are similarly likely to get pregnant as patients without disabilities (11). Notably, like everyone, disabled people hold overlapping and multiple identities that shape their experiences (eg, race, ethnicity, culture, class, gender, gender identity). The concept of intersectionality, coined by feminist scholar Kimberle Crenshaw, acknowledges, "…the multiple identities of an individual and how these result in various experiences of disadvantage or advantage" (12). How an individual experiences disability may differ depending on these multiple identities and whether the additional identities confer privilege or compound disadvantage.

Physicians cannot legally discriminate against a patient because of disability (13), and law mandates that health care professionals accommodate all patients. Despite that, basic care remains inaccessible for some disabled patients. Many opportunities exist to improve the reproductive care currently provided to patients. It is imperative that ob-gyns commit to making their care as accessible as possible to ensure that all patients receive adequate and complete reproductive health care.

RECOMMENDATIONS AND CONCLUSIONS

Pre-visit Considerations

Obstetrician–gynecologists and other reproductive health care professionals should understand the barriers that prevent disabled people from accessing reproductive health care. This is critical in identifying inequities and informing patient-centered approaches to services.

The stated goal of the ADA is, "…to assure equality of opportunity, full participation, independent living, and economic self-sufficiency…" for people with disabilities in the context of "the continuing existence of unfair and unnecessary discrimination and prejudice…" against people with disabilities (14). Examples of discrimination under the ADA, section 504 or 1557, include the following: requiring a patient to wait longer for an examination because there is only one accessible examination room, requiring a person to bring a support person to a clinician's office to assist with lifting or communicating (unless this is the patient's own choice), refusing to examine a person because it may take longer due to the patient's disability, refusing to provide effective communication assistance or charging an extra fee to provide sign language interpretation for Deaf or hard of hearing patients, providing limited appointment dates or times due to a patient's disability, and refusing to provide a requested treatment based on subjective quality-of-life assumptions (eg, a doctor refusing to provide cervical cancer screening for a patient with a severe intellectual disability based on a personal belief that the patient has a low quality of life) (15). See Box 1 for barriers to care to be identified in a practice.

The degree of difficulty accessing care varies by patient. Where possible, practices should consider universal design. The intent of universal design is to simplify life for everyone by making products, communications, and the physical environment more usable by as many people as possible at little or no extra cost (16). Universal design benefits people of all ages and abilities, although it does not replace the need for accommodations for all people with disabilities. When required, health care professionals must provide individualized accommodations based on a patient's individual needs. Additionally, ACOG encourages adoption of hiring practices at health care institutions and practices that provide for a diverse staff, including individuals with disabilities.

Scheduling

Having a space on referral forms for the inclusion of specific accommodations may reduce the stress a first-time patient experiences when presenting to a new office, where the availability of necessary accommodations is unknown. It also is critical that a health care office ask about a patient's needs and that the necessary accommodations are provided. Incorporating accommodations into the registration or prebook process is another way to decrease stress for both the patient and the health care team. Office websites should be accessible to persons with disabilities, including those with limitations in vision. All forms or electronic tablets used for check-in at health care institutions and practices should be accessible to persons with disabilities, and staff should be available to assist if necessary. If a patient requires additional time for transfer or for an examination, that should be built into the schedule (17). Deferring an examination if a patient requires more time is not appropriate, and a health care professional's lack of time does not mean a patient should be referred to another institution. Telehealth with appropriate accommodations made for patients with visual or hearing disabilities can be a valuable approach in providing accessible care for patients, particularly for those visits that do not require a physical examination. Ongoing access to telehealth is important in creating and maintaining equitable

Box 1. The Axes of Access

Physical access

Definition: The health care environment, including care settings, is free of physical barriers to care.

Strategies

Parking is accessible.

The building can be entered.

The elevator is functional.

Doors and hallways are kept clear.

Bathrooms are accessible, including toilet, sink, and grab bars.

Equipment is accessible.

Examination tables are height-adjustable.

Specialized accessible equipment is available (eg, diagnostic imaging, ophthalmic equipment, dental equipment).

Policies and procedures are optimized to ensure that physical access is maintained.

Policy and procedural access

Definition: Policies and procedures promote accessibility of scheduling, staffing, and administrative resources.

Strategies

Policies and procedures should be reviewed and include the following:

Patients are asked about needs for accommodation at the time of the first interaction with a health care provider.

Any special needs are flagged in the scheduling system and electronic record.

When patients are expected for an appointment, accessible equipment and staff are reserved.

Service animals that are qualified under ADA provisions are allowed.

Staff are correctly trained in disability etiquette (eg, a wheelchair is part of the patient's personal space) and methods of transfer.

Communication policies are reviewed.

Communication access

Definition: Provider and system factors do not limit a patient's ability to make an appointment, arrange for follow-up, understand goals of care, or adhere to prescribed therapy.

Strategies

Printed forms are available in large font and in modified versions that accommodate patients who have low literacy.

American Sign Language interpreters are available free of charge.

Amplification devices for patients with impaired hearing are accommodated.

E-mail or text messaging is allowed to make appointments and communicate with providers.

Work is done to change systematic problems (eg, hard-to-read prescription labels).

ADA, the Americans with Disabilities Act.

access to reproductive health care for individuals with disabilities.

Visit Considerations

Consent

Obstetrician–gynecologists and other reproductive health care professionals should assume that patients have the capacity to consent for themselves, unless proven otherwise. They should recognize that capacity can change and should support patients' agency to exercise consent.

Intellectual disability is characterized by significant limitations in intellectual functioning (generally measured as an IQ of 70–75 or lower) and in adaptive behavior, including conceptual, social, and practical skills, which originates before the age of 18 years (18). Elements of medical decision-making capacity include understanding, appreciation, reasoning, and communication (19). Adult patients are presumed to have decision-making capacity unless formally determined otherwise, and health care professionals generally can determine a patient's capacity to make informed decisions through typical patient–physician interactions. A structured approach also may be used to assess a patient's capacity (19, 20). An adult patient with decision-making capacity has the right to refuse treatment, including during pregnancy, labor, and delivery and when treatment is necessary for the patient's health or survival, that of the patient's fetus, or both (21). Clinicians should communicate clearly and directly with a patient. If the patient does not understand the questions or instructions, the clinician can repeat what has been said, use other words, or find another way to provide the information.

As detailed by the National Council on Disability and the Center for American Progress, guardianship has major civil rights implications for disabled individuals, especially regarding reproductive health care decisions (22, 23). Guardianship is the legal authority to make decisions for an individual who is deemed to be "incapacitated"; it generally is divided into two categories: 1) guardianship over an individual's personal affairs (eg, health care and living arrangements) and 2) guardianship (or conservatorship) focused on property and financial matters (24). Concerns about the guardianship system, including the lack of due process for those whose rights are being considered and the potential for exploitation and abuse once within the guardship system, have been detailed elsewhere (23).

Support People

Patients' caregivers, family members, or other support people should be integrated into the visit if the patient desires. At the beginning of the visit, the health care professional should determine the role of the caregiver (eg, is the support person a medical decision maker or someone who provides physical support?). Support people, as opposed to guardians, are not legally appointed and do not make decisions for the patient. A discussion should take place to clarify whom to discuss care plans with and how the patient wants that information communicated. Because many patients may not be forthcoming with reproductive health concerns if a family member is present in the room, patients should have the opportunity to discuss health issues with a health care professional one-on-one to ensure that their questions are addressed and their needs are met. It is important that family members or friends are not relied on for assisting in transferring or moving a patient for examinations or for sign language interpretation, unless requested by the patient.

Physical Space

There are many steps to be taken to ensure that the needs of all patients are met. The initial steps include physical space (Table 2):

- Are front doors equipped with automatic openers? A heavy, inaccessible door to the office often is the first barrier patients face. Even a doorbell can be helpful and more welcoming.
- Is there adequate space for patients with physical disabilities to maneuver a wheelchair through the front doors, to comfortably interact with front desk staff, and to access the examination rooms and bathrooms?
- Are there examination tables that accommodate all people? Do they reach low enough to the ground and have adequate space to the side to ease transfer?
- Are there accommodations for patients with sensory disabilities, such as deafness, blindness, or limited dexterity?
- Does the office policy ensure that patients can easily attend appointments accompanied by their service animals (25, 26)?

If the office space cannot be modified (beyond what is required by federal law), staff should explain the limitations to the patient ahead of time and develop a plan to accommodate the needs for that visit. It is important to identify areas for improvement to ensure that all patients can safely and comfortably access the office space and receive necessary health care.

Screening Considerations

Patients with disabilities should have access to the same health care as all patients, including all age-appropriate screening tests. It is important that health care teams acknowledge their inherent biases and offer and facilitate access to appropriate care, including recommended screening tests.

Table 2. Steps to Improve Office Physical Accessibility	
Facility Area	**Considerations and Improvements**
Patient check-in	• Have a space for wheelchairs and open space close to the front desk with adequate floor space to move around. • Make technology such as touch screens adjustable by height or have stations for wheelchair users or others who sit. • Make sure screens are accessible—or provide another option for people with limited dexterity or who cannot see a touch screen. Privacy should still be prioritized. • Note that accommodations can take different forms, such as visual notifications for people who are Deaf and oral notifications for those who are visually impaired. For example, a vibrating pager can give a visible or tactile signal to a patient who is Deaf or hard of hearing when the clinician is ready to see them.
Bathrooms*	• Clear entrances wide enough for a wheelchair or other assistive device. • Accessible signage. • Raised toilet seats with appropriately placed grab bars. • Sufficient turning radius within the toilet stall for wheelchairs. • Wide toilet stalls with doors that open outward. • Mirrors, sinks, soap, sanitizer, specimen collection, and towel dispensers located where people can use them either standing or seated.
Examination rooms	Examine the accessibility of all patient spaces, including for example radiology, mammography, and dental: • Examination rooms and related medical equipment. • An entry door that is accessible, sufficiently wide, and with adequate clearance, including no boxes or equipment blocking access. • Examination tables that can be adjusted to different heights, with transfer supports and supports for head and back. • Scale that accommodates wheelchairs. • Lift equipment to move patient onto examination table. • Floor space next to the examination table that is clear of equipment (including trash cans) and access to the table by side transfer. • Space between the examination table and the wall for staff to help move and position patients from both sides.
Adapted from Centers for Medicare & Medicaid Services. Modernizing health care to improve physical accessibility. A primer for providers. Accessed December 19, 2024. https://www.cms.gov/files/document/cmsmodernizinghealthcare.pdf *Required by the Americans with Disabilities Act.	

Breast and Cervical Cancer Screening

Like all patients, individuals with disabilities require preventive services. However, there are consistent disparities in rates of breast and cervical cancer screening for disabled patients when compared with the general population. A 2021 review of National Health Interview Survey data determined that patients with self-reported disabilities, including those with movement difficulties and complex activity limitations, had a higher likelihood of breast and cervical cancer diagnoses compared with the general population (27). Data from the 2020 Behavioral Risk Factor Surveillance System and the 2021 National Health Interview Survey showed that women with any disability were less likely to have received a mammogram in the previous 2 years and less likely to be up to date on cervical cancer screening than women without disabilities (28). A 2024 systematic review reported multiple barriers to breast and cervical cancer screening for individuals with disabilities, including at the clinician level (lack of awareness of current guidelines, lack of communication skills to accommodate disability, lack of knowledge about disability and providing care for disabled patients, negative attitudes toward patient or ableism, failing to listen patients with disabilities), system level (clinician time constraints), and facility level (inaccessible facilities and equipment) (28).

As with any screening test, the patient and health care professional should have a discussion about the purpose of the test, potential costs, what the examination involves, and potential benefits and harms. If the examination will be physically or emotionally challenging for the patient, it may be appropriate to offer the patient an anxiolytic. In some circumstances, sedation may be considered, or the procedure may be paired with other needed tests or

examinations, or both. If sedation or anesthesia services are needed, an anesthesia consultation before the procedure may be beneficial.

Screening for Intimate Partner Violence and Sexual Abuse

Having a disability is a known risk factor for intimate partner violence, and individuals with disabilities are at nearly double the lifetime risk of intimate partner violence victimization as those without disabilities (29). Individuals with physical and developmental disabilities may be reliant on their partners or caregivers for help, creating a dangerous dynamic in which abusers may be in a position to physically abuse their victims by withholding medication, preventing use of assistive equipment such as canes or wheelchairs, and sabotaging other personal service needs such as help with bathing, bathroom functions, or eating (30).

Although disability communities are diverse and abuse is experienced differently, the rate of sexual abuse in patients with disabilities, particularly those who need personal caregivers, is high. A 2021 systematic review and meta-analysis of U.S. and international data showed a 31.3% prevalence rate of unwanted sexual activity in women with intellectual disabilities; the rate of abuse was found to increase as the severity of the intellectual disability increased (31). A 2020 study reported that 25% of women with Down syndrome had experienced unwanted sexual advances (32). Although it can be challenging to screen for sexual abuse in patients who present to care with family members or caregivers, it is essential to incorporate these screening practices into routine care to safely identify patients at risk.

Additionally, women with disabilities are at greater risk of physical abuse during pregnancy. A study of the Massachusetts Pregnancy Risk Assessment Monitoring System data found that women with disabilities were three to four times more likely to experience abuse before and during pregnancy than pregnant women without disabilities (33). Nevertheless, in a qualitative study of U.S women with limitations in hearing, vision, cognition, mobility, self-care, and independent living, eight of the nine respondents (89%) reported that no health care professional had ever asked them about violence during their pregnancies (34).

Screening for Sexually Transmitted Infections

All patients should be screened for STIs and offered testing in accordance with Centers for Disease Control and Prevention guidelines (35). Data suggest that health care professionals who care for patients with physical and intellectual disabilities often assume patients are not sexually active, avoid asking questions about sexual history and activity, and fail to provide sexuality education information. Although data on rates of STIs in patients with intellectual disabilities are lacking, the increased risk of abuse and lack of access to sexuality education for many patients makes screening especially important (36). Oftentimes, individuals might not have the ability or feel safe to disclose abuse, putting patients at risk for unidentified STIs. Clinicians should keep in mind that STIs also may be the result of consensual sexual relationships.

Reproductive Health Care Services

Patients with disabilities should be provided access to the full range of reproductive health services, including comprehensive contraceptive counseling and prenatal and abortion care. This care should be offered in a safe and welcoming manner.

Menstrual Hygiene

Anticipatory guidance before menarche can be very useful and may lessen anxiety felt by patients and caregivers (37). Some patients with difficulty managing menstrual blood loss due to physical disability or intellectual disability may be candidates for hormonal suppression of menses. Other individuals may be seeking education on menstrual health. A 2020 study of young women with Down syndrome demonstrated that, although they were less likely to access reproductive health care compared with the general population, more than half of them received medication for menstrual issues (32). For more details on options for and approaches to menstrual suppression, see ACOG Clinical Consensus No.3, *General Approaches to Medical Management of Menstrual Suppression* (37).

Contraceptive Access

Sexuality is a human right, and individuals with disabilities have the same right to sexual expression as their peers without disabilities. Education on reproductive health, expectations for fertility, and discussions about healthy relationships are important for all patients, and ob-gyns should engage their patients with disabilities in these discussions. As noted by the National Partnership for Women and Families, the ability to control one's own reproductive life allows individuals with disabilities to participate fully in society (38). Individuals should be supported in accessing opportunities for consensual sexual expression if they desire to do so (39), even if this conflicts with the wishes of their caregivers. This may require helping patients to navigate getting care without their trusted caregiver for the first time or helping to navigate challenging conversations with the patient and caregiver. With access to and support for sexual expression, many of these patients will require access to contraceptive choice. The American College of Obstetricians and Gynecologists recommends the use of a patient-centered reproductive justice framework and a shared decision-making model in the provision of supportive contraceptive counseling and care to help patients achieve their reproductive goals (40).

There is a long history of forced sterilization of patients with disabilities, resulting in the erosion of trust in the health care system. See ACOG Committee Statement No. 8, *Permanent Contraception: Ethical Issues and Considerations*, for further details on counseling considerations for permanent contraception (41). Patients require full access to information about various contraceptive methods, including adverse effects. As with all patients who seek reproductive health care, ob-gyns should engage individuals with disabilities in patient-centered contraceptive counseling and offer the full spectrum of contraceptive care, from initiation to discontinuation.

Abortion Access

The changes in the national legal landscape of abortion access will further marginalize individuals with disabilities (42). Those who desire abortion care will continue to have increased difficulty accessing the care they need (43). It is critical that health care professionals who provide reproductive health care continue to advocate for equitable access to care for all patients and guard against potential reproductive coercion from partners or caregivers (44).

Pregnancy and Parenting

A 2018 study of National Survey of Family Growth data found that 19.5% of birthing respondents had at least one disability, which is similar to the prevalence of disability among all women of reproductive age in the United States (45). A 2017 study demonstrated that women with disabilities are as likely as their nondisabled peers to desire pregnancy (61% and 60%, respectively), but fewer intend to have a baby in the future (43% and 50%, respectively) (46). More research is needed to further identify factors that affect the desire of an individual with a disability to parent and barriers that could be eliminated.

In addition to negative attitudes from the general public toward the parenting abilities of individuals with disabilities, studies widely document that patients with disabilities have had negative experiences with obstetric care professionals who may doubt a patient's ability to parent, carry a pregnancy, and deliver safely (46). This bias contributes to delays in accessing prenatal care or avoiding it altogether. A 2022 study of National Survey of Family Growth data found that, in comparison with those without disabilities, women with disabilities were more likely to have smoked during pregnancy, delayed entry into prenatal care, given birth prematurely, and have had a neonate with low birth weight (47). Other studies have shown similar increased associations with adverse conditions in the pregnancies of individuals with disabilities, including gestational diabetes, hypertensive disorders, and increased risk of cesarean delivery (48). According to experts, given the risk factors women with disabilities have going into pregnancy, there likely is an increased theoretical risk of maternal mortality (49). All-cause mortality among community-dwelling adults with any disability is increased compared with adults without disabilities (adjusted hazard ratio 1.51, 95% CI, 1.45–1.57), with a greater magnitude of the association between disability and death in young and middle-aged adults (age 18–64 years) (50). Patients should receive evidence-based counseling about their individual risks in pregnancy based on specific medical conditions, avoiding making generalized assumptions about limitations that may be associated with disability. Genetic screening should be discussed and offered according to typical office guidelines for all patients, but consideration should be given that there is a perception of inherent ableism built into genetic screening that can be offensive to some patients.

CONCLUSION

For the more than 70 million adults with disabilities living in the United States, access to health care is limited and the quality of health care provided is inadequate. More work needs to be done to improve the access and quality of health care for individuals with disabilities. Increasing training and exposure to patients with different disabilities during medical training programs will not only help improve the lack of experience, but also help challenge the implicit and explicit biases that currently exist in health care.

Use of Language

The American College of Obstetricians and Gynecologists recognizes and supports the gender diversity of all patients who seek obstetric and gynecologic care. In original portions of this document, authors seek to use gender-inclusive language or gender-neutral language. When describing research findings, this document uses gender terminology reported by investigators. To review ACOG's policy on inclusive language, see https://www.acog.org/clinical-information/policy-and-position-statements/statements-of-policy/2022/inclusive-language.

CONFLICT OF INTEREST STATEMENT

All ACOG committee members and authors have submitted a conflict of interest disclosure statement related to this published product. Any potential conflicts have been considered and managed in accordance with ACOG's Conflict of Interest Disclosure Policy. The ACOG policies can be found on acog.org. For products jointly developed with other organizations, conflict of interest disclosures by representatives of the other organizations are addressed by those organizations. The American College of Obstetricians and Gynecologists has neither solicited nor accepted any commercial involvement in the development of the content of this published product.

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