The fragility of reproductive rights in the United States has never been so clear. From the Supreme Court’s recent Dobbs v. Jackson Women’s Health Organization decision, which overturned Roe v. Wade, to a quickly growing number of states passing draconian state laws that drastically limit—and in some states, ban—access to safe and legal abortion care, reproductive freedom is under siege at every turn. This difficult reality has elevated the importance of reproductive rights to the forefront of many people’s consciousness. At the same time, the discourse concerning reproductive rights has been narrowly focused and has failed to recognize the scope of reproductive decisionmaking beyond abortion. In addition, the reproductive rights movement has traditionally overlooked the myriad other ways in which marginalized populations, including people with disabilities, experience reproductive oppression.

This Article responds to the contemporary besiege on reproductive freedom and the persistent reproductive oppression experienced by people with disabilities by proposing a vision to help activists, legal professionals, scholars, and policymakers conceive of and articulate the basic contours of a paradigm shift that supports the coalescence of the disability justice and reproductive justice movements. To do so, first the Article examines the origins of weaponizing sexuality and reproduction to subjugate disabled people in the United States. Drawing on legal scholarship and social science research, it then elucidates the scope of the problem by describing the social context and institutions that propagate the sexual and reproductive oppression of people with disabilities and highlights contemporary examples of such injustices. Thereafter, the Article introduces and explores the tenets of two complementary frameworks for analyzing and confronting the reproductive oppression of people with
disabilities: disability justice and reproductive justice. Finally, guided by the tenets of disability justice and reproductive justice, it further develops a jurisprudential and legislative framework for achieving and delivering reproductive justice for people with disabilities.

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INTRODUCTION

The future of reproductive rights in the United States is bleak. From the Supreme Court’s recent *Dobbs v. Jackson Women’s Health Organization* decision,¹ which overturned *Roe v. Wade* and the nearly fifty years of legal precedent that the watershed decision established,² to a precipitously growing

¹ 142 S. Ct. 2228 (2022).
² See *Roe v. Wade*, 410 U.S. 113, 153 (1973) (finding that the U.S. Constitution protects the right to privacy, which “is broad enough to encompass a woman’s decision whether or not to terminate her pregnancy”); *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 874-879 (1992) (affirming *Roe’s* holding that the U.S. Constitution protects the right to terminate a pregnancy, and establishing the “undue burden” framework to determine when that right could be regulated); *Whole Woman’s Health v. Hellerstedt*, 579 U.S. 582, 624 (2016) (finding that a surgical-center requirement and an
number of states enacting draconian state laws that significantly limit—and in some states, ban—access to safe and legal abortion, reproductive freedom is under siege at every turn. This harsh truth has elevated the importance of reproductive rights to the forefront of many people’s consciousness. At the same time, the discourse concerning reproductive rights has been narrowly focused and has failed to recognize the scope of reproductive decisionmaking beyond abortion. Further, it has overlooked the myriad other ways in which marginalized populations, including people with disabilities, experience reproductive oppression.

Recent revelations about Britney Spears’s battle to end her conservatorship illustrate a common way that reproductive autonomy is legally denied to many people with disabilities and reinforces why we must take a more comprehensive approach to fighting for reproductive freedom moving forward. Britney Spears was initially placed under conservatorship in admitting-privileges requirement in Texas law constituted an “undue burden” on the constitutional right to have an abortion).


6 See infra Section III.B (contextualizing the reproductive rights movement and its narrow focus on abortion rights and disregard of the reproductive oppression experienced by marginalized populations).

2008 after experiencing a mental health crisis.\textsuperscript{8} For the next thirteen years, Britney Spears’s conservators exercised complete dominion over her life, such as deciding who she could see and how she could spend her money.\textsuperscript{9} In June 2021, Britney Spears stunned the world when she delivered a heartbreaking statement pleading for an end to her thirteen-year conservatorship and presenting a lengthy list of abuses she had allegedly suffered, including forced medication, surveillance, confinement, and grueling labor demands.\textsuperscript{10} Among the countless injustices that she endured, one was especially egregious: Britney Spears wanted to get married and have more children but was unable to do so because her conservators would not authorize the removal of her intrauterine device (IUD).\textsuperscript{11} Specifically, she stated,

I want to be able to get married and have a baby . . . . I wanted to take the (IUD) out so I could start trying to have another baby. But this so-called team won’t let me go to the doctor to take it out because they don’t want me to have children — any more children.\textsuperscript{12}

Fortunately, because of her tenacity and significant public outcry, Britney Spears’s conservatorship was terminated in November 2021.\textsuperscript{13} Yet, this positive outcome does not negate the fact that for over a decade, Britney Spears was denied her reproductive autonomy because of her disability. Moreover, most people subjected to conservatorships lack Britney Spears’s platform and resources, making overcoming these incredibly restrictive legal arrangements often insurmountable.\textsuperscript{14}

Although Britney Spears’s deplorable experiences with conservatorship may not, at first glance, seem like a reproductive rights issue, what happened to her is neither unique nor uncommon. Indeed, that people with actual or
perceived disabilities—including physical, intellectual, sensory, and psychiatric disabilities—should be denied reproductive autonomy remains a persistent, unrelenting belief plaguing our nation. Each day, sexuality and reproduction is weaponized to subjugate disabled people through forced sterilization, coerced abortion, inadequate access to sexual and reproductive health services and information, surveillance and regulation of disabled parents, and loss of child custody. For people of color with disabilities and LGBTQ+ people with disabilities, these reproductive injustices are even more pronounced. The reproductive oppression experienced by people with disabilities is woven into our laws, policies, and collective conscience. Accordingly, to transform our society into one that respects and supports reproductive freedom for disabled people, systems that propagate these injustices must be wholly dismantled and we must create a society where all people are afforded their fundamental right to decide “whether to bear or beget a child.”

This is undeniably an austere time for reproductive freedom in the United States. It is also one of immense possibility. Now is the time to shift attention away from the courts and onto policymaking, organizing, and the electorate. More importantly, we must reframe the fight for reproductive freedom from one that only focuses on abortion to one that centers reproductive justice. To that end, we must incorporate not only the right to not have a child but also the right to have a child and the right to parent that child safely and with dignity.

15 See infra Part I, II (describing the origins and reproductive oppression and explaining how people with disabilities continue to experience reproductive oppression today).
18 Rachel Rebouché, Reproducing Rights: The Intersection of Reproductive Justice and Human Rights, 7 U.C. IRVINE L. REV. 579, 604 (2017) (“The challenge of access cannot be addressed necessarily by a robust set of rights; the problem is one of politics—how communities and countries decide to allocate social goods and social assistance. Reproductive justice’s reliance on community and grassroots mobilization engages these political considerations.”).
19 See Reproductive Justice, SISTERSONG, https://www.sistersong.net/reproductive-justice [https://perma.cc/A85X-ENAN] (“SisterSong 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.”); see also infra Section III.B (expanding on the concept of reproductive justice).
20 Id.
inclusive of all people, with an intentional focus on marginalized populations, such as people with disabilities, whom have the most to lose and whom have been traditionally disregarded from these efforts.

This Article responds to the contemporary besiege on reproductive freedom and the persistent reproductive oppression experienced by people with disabilities by proposing a vision to help activists, legal professionals, scholars, and policymakers conceive of and articulate the basic contours of a paradigm shift that supports the coalescence of the disability justice and reproductive justice movements. Part I examines the origins of weaponizing sexuality and reproduction to subjugate disabled people in the United States. Part II further considers the social context and institutions that propagate the sexual and reproductive oppression of people with disabilities by exploring contemporary examples of such injustices. Part III introduces and explores the tenets of two complementary frameworks for analyzing and confronting the reproductive oppression of people with disabilities: disability justice and reproductive justice. Finally, guided by the tenets of disability justice and reproductive justice, Part IV further develops a jurisprudential and legislative framework for achieving and delivering reproductive justice for people with disabilities.

I. THE ORIGINS OF REPRODUCTIVE OPPRESSION

People with disabilities endure a complex web of oppression that connects history to contemporary treatment in American culture, medicine, and law. Indeed, the United States has a dreadful history of preventing disabled people from controlling their destinies, including implementing laws, policies, and practices that constrained their reproductive decisionmaking. Therefore, any examination of current reproductive injustices experienced by disabled people must be rooted in an understanding of the unique history and cultural stereotypes that have shaped their experiences. This Part lays the foundation for this examination by describing eugenics-era laws, policies, and practices that restricted reproduction by disabled people and other marginalized populations.

Prior to the late nineteenth and early twentieth centuries, most people with disabilities resided at home, where their families were responsible for

21 Importantly, while reproduction is typically framed as being central to women's lives, transgender, nonbinary, and gender-nonconforming people also need comprehensive reproductive health services and information. I do not intend to further marginalize the reproductive experiences of people who do not identify as women. Accordingly, the Article uses gender-neutral language whenever possible; however, this Article does use the term "women" in some instances, where that terminology is in the research or a cited source.

22 I previously proposed a version of this framework. See Powell, supra note 11, at 261-270.
their care. At that time, disabled people typically did not marry or have children and instead “were often hidden from the public eye and kept in social isolation, fostering and reflecting a common understanding of disabled people as dependent and incapable of filling adult roles of intimacy, sexuality and parenthood.”

However, the late nineteenth and twentieth centuries brought the establishment (and later, proliferation) of institutions for disabled people, where they were isolated from their communities. Institutions functioned as an apparatus of “social control and coercion.” During this time, eugenicists endorsed policies that encouraged procreation among favored groups of people while restricting procreation, including compulsory sterilization, segregation of institutionalized individuals by sex, and prohibition of marriage of those deemed to have “hereditary defects.” According to Adam Cohen, eugenicists’ “greatest target was the ‘feebleminded,’ a loose designation that included people who were mentally [disabled], women considered to be excessively interested in sex, and various other categories of individuals who offended the middle-class sensibilities of judges and social workers.” Hence, the eugenics movement focused on stopping people whom society believed unfit for parenthood from reproducing, grounded in the belief that their offspring would be dangerous and burdensome to society.

23 See David L. Braddock & Susan L. Parish, An Institutional History of Disability, in HANDBOOK OF DISABILITY STUDIES 23 (Gary L. Albrecht, Katherine D. Seelman & Michael Bury eds., 2001) (recounting how families and local communities had the primary responsibility of caring for disabled people).
25 Id. at 467-68; see also Braddock & Parish, supra note 23, at 31-43 (reviewing the history of the first mental hospitals and residential facilities for disabled people in the United States).
26 Braddock & Parish, supra note 23, at 34.
27 ADAM COHEN, IMBECILES: THE SUPREME COURT, AMERICAN EUGENICS, AND THE STERILIZATION OF CARRIE BUCK 5 (2016); see also Bd. of Trs. of the Univ. of Ala. v. Garrett, 531 U.S. 356, 369 n.6 (2001) (“The record does show that some States, adopting the tenets of the eugenics movement of the early part of this century, required extreme measures such as sterilization of persons suffering from hereditary mental disease.”).
28 COHEN, supra note 27, at 6.
29 See Eric M. Jaegers, Modern Judicial Treatment of Procreative Rights of Developmentally Disabled Persons: Equal Rights to Procreation and Sterilization, 31 U. LOUISVILLE J. FAM. L. 947, 948 (1992) (explaining that the purpose of eugenics was to prevent “reproduction by those deemed socially or mentally inferior”).
30 See generally Robyn M. Powell, Confronting Eugenics Means Finally Confronting Its Ableist Roots, 27 WM. & MARY J. RACE, GENDER, & SOC. JUST. 607 (2021) (examining the country’s history of eugenics); see also Powell, supra note 11, at 250-252 (discussing involuntary sterilization laws that were based on the belief that disabled people were “socially inadequate” and therefore should not be permitted to have children); Michael G. Silver, Note, Eugenics and Compulsory Sterilization Laws: Providing Redress for the Victims of a Shameful Era in United States History, 72 GEO. WASH. L. REV.
The Supreme Court adopted this line of reasoning in the 1927 Buck v. Bell decision. At seventeen years old, Carrie Buck, who was deemed “feeble minded,” became pregnant after apparently being sexually assaulted by her foster parents’ relative. To presumably conceal the sexual violence, Carrie was committed to the Virginia State Colony for Epileptics and Feebleminded, where her mother was also institutionalized. After giving birth, Carrie’s daughter, Vivian, was adopted by her foster family, and Carrie never saw her daughter again. Subsequently, the institution sought to sterilize Carrie in accordance with the state’s compulsory sterilization law. After a sequence of appeals, the Court upheld Virginia’s law authorizing state institutions to condition release upon sterilization was upheld as constitutional, in part, on the grounds that it served “the best interests of the patients and of society.” Tellingly, Virginia’s statute was premised on the idea that “many defective persons . . . would likely become by the propagation of their kind a menace to society.” Justice Holmes, writing for the majority, found that “[i]t would be strange if [the State] could not call upon those who already sap the strength of the State for these lesser sacrifices . . . in order to prevent our being swamped with incompetence.” Concluding this historical decision, Justice Holmes declared that “[t]hree generations of imbeciles are enough.” Throughout the twentieth century, more than thirty states passed compulsory sterilization laws like Virginia’s. By 1970, nearly 70,000 Americans—most of whom were disabled, poor, or people of color—were

862, 865 (2004) (discussing the evolution and increased popularity of the eugenics movement leading to widespread acceptance of sterilization laws directed at disabled populations); Paul A. Lombardo, Medicine, Eugenics, and the Supreme Court: From Coercive Sterilization to Reproductive Freedom, 13 J. CONTEMP. HEALTH L. & POL’Y 1, 2 (1996) (“Physicians . . . lobbied for laws that reflected eugenic theory and . . . adopted the rhetorically powerful language of public health law and characterized unchecked procreation among the ‘socially inadequate’ as an epidemic force.”).
involuntarily sterilized.\textsuperscript{41} Notably, \textit{Buck} has never been overturned, meaning that it remains good law.\textsuperscript{42}

As previously mentioned, state statutes barring disabled people from marrying or sanctioning marriages only after the age of forty-five were another hallmark of the eugenics era.\textsuperscript{43} For example, a Connecticut law banned “epileptics, imbeciles, and feebleminded persons from marrying or having extramarital relations before age forty-five.”\textsuperscript{44} By 1912, several states had eugenic marriage laws,\textsuperscript{45} and a 1974 study found that these statutes still existed in nearly forty states.\textsuperscript{46} Remarkably, these laws remain in some states.\textsuperscript{47}

Succinctly, disabled people have experienced an enduring legacy of reproductive oppression. Throughout the eugenics era, states regulated the sexuality and reproductive lives of people with disabilities through the implementation of laws, policies, and practices that were justified by protecting disabled people, their potential children, and society.\textsuperscript{48} As described in the following Part, the same eugenics-based ideologies that once led to institutionalization, forced sterilization, and marriage restriction laws, today manifest in laws, policies, and practices that continue to weaponize sexuality and reproduction to subjugate disabled people.

\textsuperscript{41} \textit{The Supreme Court Ruling that Led to 70,000 Forced Sterilizations}, NPR (Mar. 17, 2016, 1:22 PM), https://www.npr.org/sections/health-shots/2016/03/07/469478098/the-supreme-court-ruling-that-led-to-70-000-forced-sterilizations [https://perma.cc/CE8G-95P3].

\textsuperscript{42} Fifteen years after \textit{Buck} was decided, the Supreme Court struck down an Oklahoma law requiring that people with two or more convictions for felonious offenses be sterilized. \textit{Skinner v. Oklahoma}, 316 U.S. 535, 541 (1942). Although both \textit{Skinner} and \textit{Buck} concern involuntary sterilization statutes, \textit{Skinner}'s analysis took a narrower focus, relating only to the punitive sterilization of criminals, thereby avoiding addressing the forced sterilization of people with disabilities. \textit{Id.} at 544.


\textsuperscript{45} Braddock & Parish, supra note 23, at 35.

\textsuperscript{46} Pietrzak, supra note 43, at 2.

\textsuperscript{47} See id. (describing the most recent systematic investigation of these statutes undertaken in 1997 that found that thirty-three states still had laws restricting people with intellectual or psychiatric disabilities from marrying); see also Michael E. Waterstone, \textit{Disability Constitutional Law}, 63 EMORY L.J. 527, 548–49 (2014) (describing current state laws that restrict people with disabilities from marrying). Moreover, government policies that reduce or terminate disability benefits if people with disabilities get married result in continuing marriage restrictions for many. \textit{Id.} at 549 n.132.

\textsuperscript{48} See, e.g., Pietrzak, supra note 43, at 35 (describing these justifications in the context of marriage restrictions).
II. CONTEMPORARY REPRODUCTIVE OPPRESSION

"History is not the past. It is the present."49

Nearly 100 years after the infamous Buck v. Bell decision, people with disabilities continue to endure reproductive oppression. Today, despite the substantial—and increasing—size of the disability community, “the sexual and reproductive health needs of this population largely have been ignored.”50 Moreover, attitudes and presumptions about people with disabilities’ sexuality and reproduction has been “reified in laws, social policies, and public spaces that deny the fact that people with disabilities are sexual beings.”51

Analysis and advocacy based on reproductive justice necessitates fully understanding the myriad ways sexuality and reproduction is weaponized to subjugate people with disabilities. To that end, this Part limns the contemporary reproductive experiences of disabled people. It begins by describing the panoply of sexual and reproductive health disparities experienced by people with disabilities and the structural roots of these inequities. Next, it details the lack of sexual education provided to people with disabilities and its detrimental effects. It then explains the ways that disabled people are restricted from reproductive decisionmaking, especially because of guardianship. Thereafter, this Part explores barriers to contraception and abortion faced by people with disabilities, focusing on the role of laws and policies that serve as an impediment. Next, it discusses ways that people with disabilities are denied opportunities to express their sexuality. Finally, it concludes by explaining ever-present threats to parenthood experienced by disabled people at the hands of the child welfare system.

51 Margaret Campbell, Disabilities and Sexual Expression: A Review of the Literature, SOCIOLOGY COMPASS, July 2017, at 8.
A. Sexual and Reproductive Health Disparities

Extensive research demonstrates that people with disabilities experience a range of health care disparities. Specifically, disabled people contend with attitudinal, communication, physical, policy, programmatic, social, and transportation barriers that impede access to health care services and information and lead to deleterious health outcomes. Indeed, despite legal protections, including Section 504 of the Rehabilitation Act of 1973 (Section 504), the Americans with Disabilities Act of 1990 (ADA), and the Patient Protection and Affordable Care Act (ACA), disabled people encounter “persistent inequalities” accessing health care. Predictably, these disparities extend to sexual and reproductive health services. According to the World Health Organization and the World Bank, people with disabilities experience a range of unmet sexual and reproductive health needs, including limited access to sexual education and contraception, inadequate reproductive health screening, and insufficient health care provider knowledge about the intersection of disability, sexuality, and reproduction. Thus, “many women with disabilities express particular difficulties accessing comprehensive, high-quality reproductive health care.”

Tellingly, research suggests that people with disabilities are less likely to receive adequate preventive sexual and reproductive health services than people without disabilities. For example, studies have found that people with intellectual disabilities are less likely than others to receive regular Pap tests, often because caregivers or health care providers arbitrarily deem them

52 Gloria L. Krahn, Deborah Kelin Walker & Rosaly Correa-De-Araujo, Persons with Disabilities as an Unrecognized Health Disparity Population, 105 AM. J. PUB. HEALTH S198, S201 (2015). Research consistently shows that people with disabilities experience barriers to accessing health care and have adverse health outcomes. See id. (showing population differences in health care access, health behaviors, and various health outcomes).
59 Caroline Signore, Reproductive and Sexual Health for Women with Disabilities, in ELIMINATING INEQUITIES FOR WOMEN WITH DISABILITIES: AN AGENDA FOR HEALTH AND WELLNESS 93, 93 (Shari E. Miles-Cohen & Caroline Signore eds., 2016).
unnecessary. Further, research shows that people with disabilities are more likely than people without disabilities to become infected with sexually transmitted infections, which underscores the importance of preventive sexual and reproductive health services. People with intellectual disabilities are also less likely than others to be screened for breast or cervical cancer.

Inaccessible or inadequate perinatal care is a significant issue facing many disabled people. A burgeoning body of scholarship has examined the experiences of disabled women from preconception to postpartum and has found that as people with disabilities continue to enjoy increased opportunities for community participation and advances in technology, disabled women are increasingly choosing to become pregnant. Today, women with and without disabilities now have comparable pregnancy rates. Nevertheless, extensive research reveals that women with disabilities experience higher risks of complications and poorer outcomes than nondisabled women. In particular, studies have found that disabled women may be at higher risk than other women for pregnancy, delivery, and postpartum complications, such as gestational diabetes, preeclampsia, cesarean delivery, preterm birth, low-birth-weight infants, and stillbirth. A

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60 See Robyn M. Powell, Susan L. Parish & Eliana Rosenthal, Role of Family Caregivers Regarding Sexual and Reproductive Health for Women and Girls with Intellectual Disability: A Scoping Review, 64 J. INTELL. DISABILITY RSCH. 131, 149-150 (2020) (citing studies which indicate that people with intellectual disabilities who live at home with family caregivers are less likely to receive Pap tests).


62 See Powell et al., supra note 60, at 132 (synthesizing findings from research about reduced breast cancer and cervical cancer screening among women with intellectual disabilities).


65 Id.; Mitra et al., supra note 63, at 499 (citing studies).

recent study found that Black women with intellectual and developmental disabilities are more likely to give birth to preterm infants than white women with intellectual and developmental disabilities, likely due to health disparities stemming from the multiplicative effect of ableism and racism.\textsuperscript{67}

People with disabilities experience a wide range of barriers that impede their access to perinatal care. Specifically, physical, communication, programmatic, and attitudinal barriers can influence maternal (e.g., maternal health, functioning, cesarean delivery) and infant outcomes (e.g., low birth weight, preterm birth, NICU admissions, clinical complications).\textsuperscript{68}

“Numerous studies indicate that women with disabilities encounter barriers accessing and navigating perinatal care[.]”\textsuperscript{69} For example, a study found that forty-four percent of gynecology practices were inaccessible to women with disabilities.\textsuperscript{70} Indeed, many disabled women report encountering physical access barriers in clinical offices, such as a lack of height-adjustable examination tables and accessible weight scales.\textsuperscript{71} Additionally, after giving birth, women with disabilities are often placed in hospital rooms that lack accessibility features, such as inaccessible beds, restrooms, bassinets, and changing tables.\textsuperscript{72}

Women with disabilities often report that their biggest barriers to accessing perinatal care are healthcare providers who are unknowledgeable about pregnancy among disabled people and healthcare providers who are
unsupportive of their pregnancy desires. Some researchers have found that interactions with health care providers, especially negative encounters, can influence pregnancy decisions among disabled women. Strikingly, qualitative interviews with fourteen obstetric clinicians who treat women with physical disabilities reported that they had not received any education or training about treating pregnant women with disabilities. A study of 1,000 obstetrician-gynecologists about practice accessibility, training, attitudes, and perspectives concerning treating women with disabilities also revealed substantial barriers. Specifically, this study found that only seventeen percent of obstetrician-gynecologists had received information or training on providing health care to disabled women. Moreover, only nineteen percent of obstetrician-gynecologists felt “definitely” adequately prepared to care for pregnant disabled women. In addition, more than half of obstetrician-gynecologists reported difficulty communicating with women with sensory or intellectual disabilities.

Furthermore, studies indicate that disabled women often encounter health care providers who explicitly and implicitly question “their ability to become pregnant, carry the baby to term, deliver safely, and/or care for the newborn.” Disabled women also encounter negative attitudes concerning pregnancy and parenting from other sources, including family members and the general public. “This negativity can have wide-ranging effects, including increased stress (with the associated pregnancy health risk) and a hesitancy

74 See Tracey A. LaPierre, Mary K. Zimmerman & Jean P. Hall, “Paying the Price to Get There”: Motherhood and the Dynamics of Pregnancy Deliberations Among Women with Disabilities, 10 DISABILITY & HEALTH J. 419, 422 (2017) (“Healthcare providers significantly influenced the pregnancy decisions of these women by shaping perceptions of feasibility (and risk) related to their current and future health . . . . Participants reported conversations with medical professionals who they perceived as judgmental or unsupportive.”).
75 See Suzanne C. Smeltzer, Monika Mitra, Linda Long-Bellil, Lisa I. Iezzoni & Lauren D. Smith, Obstetric Clinicians’ Experiences and Educational Preparation for Caring for Pregnant Women with Physical Disabilities: A Qualitative Study, 11 DISABILITY & HEALTH J. 8, 10 (2018) (“None of the 14 clinicians received training about caring for women with disabilities when they were students, residents, or fellows. All clinicians learned on the job, including those whose specialty was maternal-fetal medicine . . . .”).
77 Id. at 209.
78 Id. at 212.
79 Id. at 210.
80 Signore et al., supra note 50, at 148 (citing studies about perinatal care for disabled women).
81 Id.
to seek care.” In fact, many disabled women delay or forgo perinatal care because of these negative attitudes.

**B. Scarcity of Comprehensive and Accessible Sexual Education**

Undeniably, comprehensive sexual education is an important aspect of reproductive justice. Without such information, there is no way that young people—especially young people who are already marginalized—can make decisions about birth control; know the signs of an abusive relationship; decide if, when and how to become a parent; understand consent; or even enjoy a pleasurable sexual experience if they’re not provided with the medically accurate and shame-free sex education they need.

Hence, comprehensive and accessible sexual education is an important strategy for preventing sexual violence and ensuring that disabled people can enjoy their right to sexual agency.

Despite its importance, however, extant studies suggest that many people with disabilities do not have access to adequate sexual and reproductive health information, including sexual education. In fact, students with disabilities are frequently denied comprehensive sex education, with some being entirely left out of sex education classes and others feeling “excluded by the omission of relevant disability-related sex information.”

Research has found that most sexual education curricula intended for people with disabilities, and specifically people with intellectual and developmental disabilities, are not evidence-based. Only three states explicitly consider disabled students in their sexual education requirements, and only six states and the District of Columbia provide optional resources for an accessible sexual education.

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82 Id.
83 Id.
86 See Amy Swango-Wilson, *Meaningful Sex Education Programs for Individuals with Intellectual/Developmental Disabilities*, 29 SEXUALITY & DISABILITY 113, 114 (2011) (“Education has the potential to encourage positive sexuality, promote the decisionmaking abilities about that sexuality and empower the individual with [intellectual or developmental disabilities] to act on their decisions.”).
88 See H.J. Graff, R.E. Moyher, J. Bair, C. Foster, M.E. Gordon & J. Clem, *Relationships and Sexuality: How Is a Young Adult with an Intellectual Disability Supposed to Navigate?*, 36 SEXUALITY & DISABILITY 175, 176 (2018) (“[P]ublished curricula currently in use . . . have little empirical support for teaching sexuality to people with significant disabilities.”).
curriculum for students with disabilities. A recent study found that compared to nondisabled women, women with cognitive disabilities were less likely to learn about six formal sex-education topics; namely how to say no to sex, methods of birth control, where to get birth control, how to use a condom, sexually transmitted infections, and preventing HIV/AIDS. In addition, that study found that women who received education on more topics were more likely to use contraception.

Not receiving comprehensive and accessible sexual education can lead to devastating outcomes for disabled people. For example, studies indicate that young people with disabilities are at an increased risk of exposure to HIV/AIDS and other sexually transmitted infections, in part, because they are often denied access to comprehensive and accessible sexual education. Moreover, for people with disabilities, not receiving sexual education may result in higher rates of experiencing sexual violence combined with a limited ability to report that violence because of lack of knowledge. In addition, allowing disabled people “to remain ignorant about their rights and options does [not] allow them to make healthy choices regarding sexual partners and activities.”

The right to comprehensive and accessible sexual education is especially important for LGBTQ+ people with disabilities who often experience the erasure or dismissal of their sexual or gender identities by people who assume they are sexually unwilling or unable. Research suggests that LGBTQ+
people with disabilities often face unique problems in exploring potential opportunities to engage in sexual relationships under the supervision of their caretakers or families. Moreover, when LGBTQ+ people with disabilities receive information about sexual and reproductive health it is often inadequate because it is heteronormative. Thus, without access to comprehensive sexual education that is accessible to and inclusive of varying gender identities and sexual orientations, LGBTQ+ people with disabilities’ reproductive autonomy is thwarted.

C. Denial of Reproductive Decisionmaking

From forced sterilization to compulsory contraception, people with disabilities continue to be denied opportunities to make decisions about their reproductive destinies. As in the case of Britney Spears, guardianship, also known as conservatorship in some states, is the most common legal mechanism for controlling people with disabilities’ sexual and reproductive autonomy. Briefly, guardianship is a “fiduciary relationship between a guardian and a ward or other incapacitated person, whereby the guardian assumes the power to make decisions about the ward’s person or property.” Typically, guardianship is involuntary and imposed on people with intellectual or psychiatric disabilities and older adults with dementia.

According to disability justice advocates,

While the law varies from state to state, guardianship orders routinely authorize third parties to make decisions about the most personal and important decisions in an individual’s life—choices that impact the person’s own body and reproductive health; how and where they receive medical,
psychiatric, and psychological treatment; how the money and resources they work to earn are spent; and even with whom they associate.\textsuperscript{99}

Although compulsory sterilization has waned since its height of popularity during the Eugenics-era, it has never entirely ceased. In fact, most states still permit the sterilization of disabled people with prior judicial authorization.\textsuperscript{100} At the same time, even with ostensible judicial protections, people with disabilities often have their reproductive freedom threatened.\textsuperscript{101} For example, fears about courts undermining the reproductive freedom of disabled people surfaced in 2018 during hearings for Justice Brett Kavanaugh’s confirmation to the Supreme Court.\textsuperscript{102} Specifically, his 2007 opinion in \textit{Doe ex rel. Tarlow v. District of Columbia}\textsuperscript{103} demonstrated an appalling disrespect for people with disabilities. In that case, the D.C. Circuit Court of Appeals held that the District had no constitutional or legal obligation to consider the preferences of people with intellectual disabilities who were in its custody before sanctioning elective surgeries, including abortion.\textsuperscript{104} In an opinion written by then-Judge Kavanaugh, the Court reasoned that “accepting the wishes of patients who lack (and have always lacked) the mental capacity to make medical decisions does not make logical sense and would cause erroneous medical decisions—with harmful or even deadly consequences to intellectually disabled persons.”\textsuperscript{105} Additionally, then-Judge Kavanaugh ruled that no substantive due process claims were involved because “plaintiffs [did] not show[] that consideration of the wishes of a never-competent patient is ‘deeply rooted in this Nation’s history and tradition’ and ‘implicit in the


\textsuperscript{101} See, e.g., \textit{Stump v. Sparkman}, 435 U.S. 349, 360, 364 (1978) (holding a judge immune from liability despite authorizing the sterilization of a woman with an intellectual disability without notice to the woman, without appointing a guardian \textit{ad litem}, and without giving the petition a docket number or placing it on file in the clerk’s office, as required by statute).


\textsuperscript{103} 489 F.3d 376 (D.C. Cir. 2007).

\textsuperscript{104} Id. at 378-81.

\textsuperscript{105} Id. at 382.
disability reproductive justice

concept of ordered liberty . . . "106 Notably, scholars have portrayed then-Judge Kavanaugh’s opinion as “implicitly reaffirming Buck v. Bell.”107

A 2012 case involving Mary Moe,108 a thirty-two-year-old pregnant woman with a psychiatric disability similarly demonstrates how courts and guardians deny disabled people their reproductive autonomy.109 In that case, Mary’s parents petitioned a Massachusetts family court for guardianship over her daughter so that they could force Mary to have an abortion.110 While Mary fervently opposed abortion, the court appointed her parents as co-guardians and sanctioned that Mary be “coaxed, bribed, or even enticed . . . by ruse” into a hospital for an abortion.111 Additionally, the judge ordered that Mary be sterilized “to avoid this painful situation from recurring in the future.”112 Ultimately, the decision was reversed on appeal, with the appellate court noting specifically in regard to the sterilization order that “[n]o party requested this measure, none of the attendant procedural requirements ha[ve] been met, and the judge appears to have simply produced the requirement out of thin air.”113 Although Mary’s case had a positive outcome consistent with her articulated wishes, her case reveals how people with disabilities experience threats to their reproductive freedom even with supposed judicial protections.

Indeed, compulsory sterilization or contraception is often depicted by courts and guardians as a protective measure in the “best interest” of people with disabilities, or necessary for their safety.114 Recent studies have found

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106 Id. at 383. Tellingly, following Judge Kavanaugh’s remand, the district court eventually found that the District of Columbia’s consent for the unwanted abortions on two of the women was unconstitutional and constituted battery. Doe v. District of Columbia, 206 F. Supp. 3d 583, 632 (D.D.C. 2016).
107 Mary Ann Case, Abortion, the Disabilities of Pregnancy, and the Dignity of Risk, in DISABILITY, HEALTH, LAW, AND BIOETHICS 51, 58 (I. Glenn Cohen, Carmel Shachar, Anita Silvers & Michael Ashley Stein eds., 2020); see also Samuel R. Bagenstos, Disability and Reproductive Justice, 14 HARV. L. & POL’Y REV. 273, 287 (2020) (contending that the practices upheld by then-Judge Kavanaugh in Doe exemplify the eugenic practice of “violently denying the reproductive rights of disabled people”).
110 Id.
111 Id. at 353 (quoting the family court’s decision).
112 Id. (quoting the family court’s decision).
113 Id. at 355.
that women with disabilities, especially those with intellectual disabilities, are significantly more likely than women without disabilities to be sterilized and at younger ages. Today, sterilization of people with disabilities is primarily “driven by parents, guardians, and social service providers who are uneasy . . . [that] they will incur the additional burden of caring for the offspring.”116 Tellingly, in authorizing the sterilization of disabled people, courts often advance analogous presumptions to those put forward in Buck, such as that people with disabilities are “incapable of adequate parenting” and their children will “inevitably be a financial burden on the state.”117 Hence, although the “eugenic rhetoric might have declined,” the “eugenic motivations and eugenic laws did not.”118 While sterilization should indisputably be an option for permanent contraception for people who choose it, in light of the country’s history, it is not difficult to imagine that many of these sterilizations may be forced.

The “Ashley X” case offers another troubling example of how people with disabilities’ reproductive freedom is all too often denied. Ashley was a young girl with intellectual and physical disabilities.119 In 2004, at age six, a Washington hospital, with Ashley’s parents’ consent, performed a series of procedures, including growth attenuation via hormone therapy, a hysterectomy, and bilateral breast bud removal.120 Ashley’s physicians and family defended the permanent alteration of her body by maintaining that the procedures ensured “the best possible quality of life,” by enabling her to

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120 Gunther & Diekema, supra note 119, at 1015.
be more easily cared for by her family, while also allowing her to “retain more
dignity in a body that is healthier, more of a comfort to her, and more suited
to her state of development.”121 In addition, Ashley’s parents claimed, “Ashley
has no need for her uterus since she will not be bearing children,”122 and her
physicians asserted that the hysterectomy helped both Ashley and her family
because it “eliminate[d] the complications of menses.”123 Hence, Ashley’s
“best interest was equated with her parents’ ability to maintain her at home
and being easily able to carry and move her.”124 Appallingly, Ashley’s parents
successfully sought these procedures with just the authorization of an internal
ethics board and not through adjudication.125 A later investigation found that
the hospital had violated state law in this matter.126 Nonetheless, the “Ashley
Treatment” remains accepted globally, with families increasingly seeking to
subject their children to similar procedures.127

Regrettably, the denial of reproductive decisionmaking is a widespread
disability justice issue. Like in the case of Britney Spears, research indicates
that women with disabilities are often denied the opportunity to make
decisions concerning contraception.128 Meanwhile, evidence indicates that
some guardians seek to suppress the sexual desires of their disabled teenage
and adult children through medication.129 Further, sometimes guardians force
people with disabilities to undergo unwanted abortions while others require

121 THE “ASHLEY TREATMENT,” TOWARDS A BETTER QUALITY OF LIFE FOR “PILLOW
ANGELS” 3, 12, http://pillowangel.org/Ashley%20Treatment.pdf [https://perma.cc/TE53-GWUZ]
(Mar. 17, 2012) (noting that the document is authored by “Ashley’s Mom and Dad”).
122 Id. at 10.
123 Gunther & Diekema, supra note 119, at 1015.
124 Rioux & Patton, supra note 119, at 244-45.
125 Id. at 244 (“Ashley’s case was not adjudicated.”).
http://www.cnn.com/2007/HEALTH/05/08/ashley.ruling/index.html [https://perma.cc/G6CE-
4HJQ] (“Children’s Hospital, in acknowledging its error, said that beyond implementing changes to
ensure that sterilization of disabled children doesn’t happen again without a court order, it will seek
court approval for other procedures involved in the controversial growth attenuation therapy.”).
127 Ed Pilkington & Karen McVeigh, Ashley Treatment’ on the Rise Amid Concerns From Disability
Rights Groups, THE GUARDIAN (Mar. 15, 2012, 10:51 AM),
http://www.guardian.co.uk/society/2012/mar/15/ashley-treatment-rise-amid-concerns
[https://perma.cc/S49M-CRTS] (“A controversial procedure to limit the growth of severely disabled
children . . . has begun to spread among families in America, Europe and beyond.”).
128 An Nguyen, Challenges for Women with Disabilities Accessing Reproductive Health Care Around
the World: A Scoping Review, 38 SEXUALITY & DISABILITY 371, 378 (2020) (citing several studies in
which participants reported that they were not provided with the right to decide to use
contraception, with health care providers or family members instead making the decision for them).
129 Loyal Coshway, Julia Broussard, Kruti Acharya, Karen Fried, Michael E. Msall, John D.
Lantos & Leena Nahata, Medical Therapy for Inappropriate Sexual Behaviors in a Teen with Autism
disabled people to continue pregnancies they did not want.\textsuperscript{130} Although most guardians who deprive people with disabilities of these choices are presumably doing so out of genuine concern for the person in their care, sometimes “these decisions are informed by harmful stereotypes and false beliefs, and can be contrary to the wishes of the person with disabilities.”\textsuperscript{131}

D. Barriers to Contraception and Abortion

Conversations about access to contraception and abortion for people with disabilities “invoke[] a complicated history in disability communities because [they] bring[] into focus a deep and enduring social assumption that many individuals with disabilities do not belong in reproductive conversations; they are rarely seen as sexual beings or as potential parents.”\textsuperscript{132} Undeniably, the tensions concerning access to contraception and abortion are persistent and deeply problematic. Consequently, people with disabilities’ access to contraception and abortion is often impeded.

For example, disabled people encounter a range of barriers to contraception. On the one hand, research indicates that disabled women have less contraception knowledge and lower contraception use than nondisabled women.\textsuperscript{133} Research consistently shows that women with disabilities’ “contraceptive needs are frequently overlooked . . .”\textsuperscript{134} Consequently, compared to nondisabled women, disabled women have decreased knowledge about contraception, are less likely to receive family planning services, and are less likely to use contraception.\textsuperscript{135} These disparities are most pronounced in women who are unemployed, have lower incomes, or have lower


\textsuperscript{131} ABORTION CARE, supra note 130, at 13.

\textsuperscript{132} MICHELLE JARMAN, DISABILITY RIGHTS THROUGH REPRODUCTIVE JUSTICE, in THE ROUTLEDGE HANDBOOK OF DISABILITY AND SEXUALITY 138 (Russell Shuttleworth & Linda R. Mona eds., 2020).

\textsuperscript{133} Powell et al., supra note 60, at 132 (citing several studies that conclude contraception knowledge and use among women with intellectual disabilities is lower than knowledge and use among women without disabilities).

\textsuperscript{134} Signore, supra note 59, at 100.

\textsuperscript{135} Willi Horner-Johnson, Mekhala Dissanayake, Justine P. Wu, Aaron B. Caughey & Blair G. Darney, Pregnancy Intendedness by Maternal Disability Status and Type in the United States, PERSPS. ON SEXUAL AND REPROD. HEALTH, Mar. 2020, at 31-32 (finding that women with disabilities are less likely to receive timely prenatal care or constructive sex education).
educational attainment. Research has also revealed that women with disabilities are significantly less likely to receive contraception or contraception counseling than nondisabled women. Further, studies have found that women with disabilities have higher rates of unintended pregnancies than women without disabilities, underscoring the importance of contraception for disabled people. On the other hand, like Britney Spears, some women with disabilities are forced by guardians to use contraception out of fear that the disabled person will become pregnant. In these instances, disabled people are effectively sterilized because they are unable to reproduce due to forced contraception.

Similarly, disabled people, like other marginalized populations, experience numerous barriers to safe and legal abortion care. People with disabilities experience high rates of poverty, which makes it more difficult to pay for abortion care. In addition, some people with disabilities are unable to travel to an abortion provider, especially in areas with limited to no providers. The cost and transportation barriers are especially notable because abortion providers are becoming increasingly scarce as states continue to impose laws significantly restricting abortion rights. For example, a 2018 study revealed that twenty-seven cities in the United States are “abortion deserts”—cities in which people must travel at least one-hundred miles to reach an abortion provider. According to the New York Times, over eleven million women of reproductive age nationwide live more than a one

137 Id.
138 Horner-Johnson et al., supra note 135, at 33 (finding a higher proportion of unintended pregnancies among women with disabilities as compared to women without disabilities); see also Alhusen et al., supra note 136, at 1-2.
139 Powell et al., supra note 60, at 132 (citing several studies that conclude contraception knowledge and use among women with intellectual disabilities is lower than knowledge and use among women without disabilities).
141 ABORTION CARE, supra note 130, at 9-10.
An hour drive from an abortion provider. Further, according to the Guttmacher Institute, as of 2017, eighty-nine percent of counties in the United States have no known abortion providers. Abortion deserts greatly harm marginalized populations, including disabled people. Critically, access to abortion care will become even more difficult as states increasingly move to restrict or ban abortions following the Dobbs decision. Moreover, health care facilities that do not have accessibility features, such as ramps and height-adjustable examination tables, further hinder disabled people’s access to abortion care.

In recent years, states have enacted laws, commonly known as “reason bans,” that prohibit abortions based on fetal disability diagnosis. Anti-choice activists and legislators often claim that these laws have a false pretense “stopping discrimination against people with disabilities, while in actuality doing nothing to address—and potentially even increasing—the structural discrimination that people with disabilities face.” As the National Partnership for Women & Families and the Autistic Self Advocacy Network explain, abortion bans based on a fetal diagnosis do not address the discrimination people with disabilities face or misinformation directed at prospective parents of people with disabilities, nor do they respond to the needs of people with disabilities, such as access to health care, economic security, housing, or other social supports. In fact, reason bans “land[] heavily on disabled people’s body autonomy.” In particular, reason bans “may have a chilling effect on patients who wish to obtain relevant medical information about a pregnancy and discuss that

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146 ABORTION CARE, supra note 130, at 10 (arguing that factors such as lack of accessible transportation and other logistics serve as barriers to abortion care for people with disabilities).

147 Id. at 11.

148 Id.

149 Id.

150 SINS INVALID, SKIN, TOOTH, AND BONE: THE BASIS OF MOVEMENT IS OUR PEOPLE 59 (2d ed. 2019) [hereinafter SINS INVALID].
information openly with their doctor”, especially people with heritable disabilities.151

Realities concerning sexual violence as well as disability-related needs underscore the importance of abortion access for people with disabilities. Specifically, access to safe and legal abortion is especially significant for people with disabilities, as people with disabilities are uniquely vulnerable to sexual violence.152 In fact, research shows that people with disabilities are at least three-and-a-half times more likely than people without disabilities to experience sexual violence.153 Moreover, “[t]he intersection of access to abortion care and maternal health is particularly important to some people with disabilities who are at a heightened risk of pregnancy-related health complications, or who may rely on medications that are contraindicated during pregnancy.”154 This is “all the more pressing” for disabled people of color who experience even higher rates of pregnancy complications.155

E. Restrictions on Sexuality

Reproductive justice recognizes that people have a right to express their sexuality.156 Similarly, disability justice necessitates “the right to sexual pleasure and choice and desire for all types of disabled people.”157 Undeniably, “[t]he expression of sexuality, including how individuals form and maintain intimate relationships, is a fundamental part of being human.”158 Thus, sexual autonomy must be freely enjoyed by all people, including people with disabilities.

151 ABORTION CARE, supra note 130, at 11.
152 See, e.g., In re Guardianship of J.D.S., 864 So. 2d 534, 536 (Fla. Dist. Ct. App. 2004) (involving the sexual battery of a twenty two year old woman with “severe” intellectual disabilities who was residing in a group home); Deborah W. Denno, Sexuality, Rape and Mental Retardation, 1997 U. ILL. L. REV. 315, 320-21 (discussing the particular challenge of determining consent in cases of rape involving people with intellectual disabilities).
154 ABORTION CARE, supra note 130, at 6.
155 Id.
157 SINS INVALID, supra note 150, at 118.
Despite its importance, however, “[g]aining sexual autonomy has long been a struggle for people with disabilities.”159 According to Sins Invalid, a disability justice performance project, “[o]ne of the ways that disabled people are oppressed is through the negation of our sexualities as a means of denying the viability of our bodies, including our potential reproductive viability.”160 In particular, “[d]isabled people face structural and attitudinal barriers when seeking sexual and reproductive autonomy.”161 Much of the attempt to suppress people with disabilities’ sexual expression is entrenched in Eugenics-era ideologies.162

Harmful misconceptions about people with disabilities and their sexuality persists. Rooted in prejudiced constructs of sexuality,163 some people with disabilities are perceived as sexually unwilling or unable.164 Other disabled people—especially people with intellectual or psychiatric disabilities—are assumed to be hypersexual and incapable of having appropriate (i.e., non-promiscuous) sexual relationships.165 People with intellectual disabilities are often perceived as childlike, and thus unable or uninterested in engaging in sexual expression.166 Further, sexual expression by people with disabilities is sometimes viewed as dangerous and something that must be suppressed.167

Presumptions about people with disabilities and sexual expression often lead to substantial oppression. For example, in situations where disabled people are presumed “eternal children”, “ableist infantilisation results in these individuals being regarded as a people who are indeed never able to develop

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160 SINS INVALID, supra note 150, at 116.
161 Bethany Stevens, Structural Barriers to Sexual Autonomy for Disabled People, GPSOLO, Spring 2011, at 14.
162 Emily M. Lund, Anjali J. Forber-Pratt & Erin E. Andrews, Combating Old Ideas and Building Identity: Sexual Identity Development in People with Disabilities, in THE ROUTLEDE HANDBOOK OF DISABILITY AND SEXUALITY 98 (Russell Shuttleworth & Linda R. Mona eds., 2020) (“The idea that sexual behaviour in people with disabilities should be suppressed has its roots largely in eugenicist policies and ideals, and disabled people have been historically subject to involuntary sterilisation.”).
163 See generally Tom Shakespeare, Disabled Sexuality: Toward Rights and Recognition, 18 SEXUALITY AND DISABILITY 159, 161-62 (2000) (discussing the prejudices people with disabilities face in the context of sexuality, such as societal exclusion of people with disabilities, diminishing their self-esteem).
165 Ann Craft, Mental Handicap and Sexuality: Issues for Individuals with a Mental Handicap, Their Parents and Professionals, in MENTAL HANDICAP AND SEXUALITY: ISSUES AND PERSPECTIVES 13-14 (1987); Renu Addlakha, Janet Price & Shirin Heidari, Disability and Sexuality: Claiming Sexual and Reproductive Rights, 25 REPRO. HEALTH MATTERS 4, 4 (2017) (“People with disabilities are . . . held to be asexual (or in some cases, hypersexual).”).
166 Lund et al., supra note 162, at 97.
167 Id.
a sexual identity, much less a healthy or fulfilling one.”168 Based on beliefs
about the ability of people with intellectual disabilities to consent to sexual
activity, caregivers often deny people with intellectual disabilities the right to
engage in sexual and romantic relationships.169 For example, research
indicates that some family caregivers discourage their disabled relatives from
engaging in sexual relationships.170 Some caregivers even try to prevent
disabled people from masturbating.171 Moreover, some disabled adults who
live in group homes are outright denied opportunities to engage in sexual
relationships while others are significantly restricted.172 According to Natalie
Chin, “[g]roup homes deny their residents opportunities related to gaining
knowledge and information about sex, intimate relationships, marriage, and
starting a family.”173 Moreover, bans on sexual expression are “harmful when
the message to people with disabilities becomes one where sexual behaviour
for pleasure and sexual expression is something to be ashamed of.”174 In
addition, unfounded beliefs often lead to disabled people not receiving
adequate sexual and reproductive health care services and information.175
They can also result in forced sterilization because of guardians’ concerns
about pregnancy.176

For LGBTQ+ disabled people, these issues are amplified. For example,
research reveals that LGBTQ+ disabled people often contend with
“numerous barriers to expressing their sexuality and establishing and
maintaining romantic and sexual relationships because of discrimination and
stigma as well as a lack of awareness and education on the part of health care
providers and society at large.”177 Moreover, interviews with LGBTQ+ people
with intellectual disabilities found that “in the context of virtual prohibition
of their sexual activity within their homes, and a dearth of accessible
alternatives, LGBTQ+ youth labeled with intellectual disabilities resort to
uncomfortable and risky physical and social spaces for romantic and sexual
Further, research suggests that support staff often lack confidence and skills about how to discuss matters relating to sexual orientation with people with intellectual disabilities, which likely affects their ability to support people with intellectual disabilities who are LGBTQ+. Thus, LGBTQ+ disabled people are often denied opportunities to engage in sexual relationships because of fallacies about both their sexual orientation and their disabilities.

F. Threats to Parenthood

The Supreme Court has repeatedly affirmed that the right to raise a family is a fundamental right protected by the Fourteenth Amendment of the Constitution. Nonetheless, that right is still not afforded to people with disabilities. In particular, prejudice and speculation about the competencies of parents with disabilities—emulating those raised during the Eugenics movement—have led to contemporary discriminatory child welfare laws, policies, and practices that assume parental unfitness.

181 Dave Shade, Empowerment for the Pursuit of Happiness: Parents with Disabilities and the Americans with Disabilities Act, 16 L. & INEQ. 153, 153-54 (1998) (“Although persons with disabilities have made significant gains in recent years in overcoming the invidious discrimination with which they have long been burdened, the legal rights of parents with disabilities remain in question.”).
The child welfare system, more accurately termed the family policing system,183 pathologizes, controls, and punishes marginalized communities, including disabled parents and their children.184 Parents with disabilities are more likely than parents without disabilities to be referred to the family policing system.185 Disabled parents, especially parents with intellectual or psychiatric disabilities, also endure strikingly high rates of termination of parental rights.186 Further, children of parents with intellectual or psychiatric disabilities are more likely than other children to be removed from their homes and placed in foster care.187

Once involved with the family policing system, disabled parents and their children experience a range of injustices. For example, they are often denied adequate family preservation or reunification services and supports.188 They also encounter pervasive biases and misconceptions that they are unable to care for their children, which can lead the family policing system and courts to presume that disabled parents will not be able to benefit from services and that separation is in the child’s best interest.189

Tellingly, nineteen percent of all children in foster care have parents with disabilities,190 while children of parents with disabilities comprise only approximately nine percent of the country’s youth.191 The National Council on Disability (NCD), an independent federal agency that advises the President and Congress on disability policy, described the family policing system’s bias against disabled parents as “persistent, systemic, and pervasive[.]”192 Other federal agencies are in agreement, with the U.S. Departments of Justice (DOJ) and Health and Human Services (HHS)

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183 This Article recognizes the importance of language through the use of the phrase “family policing system” when referring to the multi-agency system historically referred to as the “child welfare” or “child protection” system. See Dorothy Roberts, Abolish Family Policing, Too, DISSENT MAG., https://www.dissentmagazine.org/article/abolish-family-policing-too [https://perma.cc/UQD7-4XM4]. Accordingly, this Article utilizes the term “family policing system,” except when directly quoting others.


186 Id. at 531.

187 Id.

188 Id.

189 Id. (citing studies).

190 Elizabeth Lightfoot & Sharyn DeZelar, The Experiences and Outcomes of Children in Foster Care Who Were Removed Because of a Parental Disability, 62 CHILD. & YOUTH SERVS. REV. 22, 26 (2016).

191 ROCKING THE CRADLE, supra note 182, at 44.

192 Id. at 15, 51.
Positing that the family policing system’s prejudicial policies and practices toward parents with disabilities are “long-standing and widespread.”

While the family policing system is seemingly instituted to protect children, it is often the source of considerable and enduring harm for both children and their parents. Compared to other children, children in foster care experience increased rates of mental health conditions, lower post-secondary educational attainment, increased rates of poverty and homelessness, and lower rates of health insurance. Accordingly, children often fare better when they remain at home with their families. Further, extant research has shown that children of disabled parents often live in fear that they could be separated from their parents, temporarily or permanently, because their parents are deemed incapable of caring for them. Interestingly, a study of adult children of parents with intellectual disabilities discovered that children removed by the family policing system had subsequently reestablished and maintained contact with their parents. Surely, this finding underpins the significance of family bonds. In addition, disabled parents often report “living in constant fear that they [will] eventually be reported [to the family policing system] because of their disability.” Parents with disabilities often are afraid to ask for help because they worry that someone may view them as unable to adequately care for their children and refer them to the family policing system. Some disabled parents are even frightened to be in public with their children because they fear that a stranger will needlessly report them to the family policing system.

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195 See Powell, supra note 184, at 50 (citing studies that demonstrate that children tend to have better outcomes when they are not placed in foster care and instead remain at home).


197 TIM BOOTH & WENDY BOOTH, GROWING UP WITH PARENTS WHO HAVE LEARNING DIFFICULTIES 58-59 (1998).

198 ROCKING THE CRADLE, supra note 182, at 82.

199 Id. at 82-84.

200 Id. at 82.
Parents with disabilities who are also people of color are likely to face compounded discrimination.\textsuperscript{201} Extensive research shows that Black mothers are “especially likely to be monitored, regulated, and punished by the child welfare system[,]” and to lose custody of their children—often permanently—at disproportionately high rates.\textsuperscript{202} Indigenous parents are also especially vulnerable to being separated from their children by the state.\textsuperscript{203} Thus, for disabled people of color, the threats to parenthood are heightened.

III. GUIDING TENETS TO A FRAMEWORK FOR ACHIEVING REPRODUCTIVE FREEDOM

Each day, sexuality and reproduction are weaponized to subjugate marginalized populations, including people with disabilities. The oppression of disabled people’s reproductive freedom is often the result of deeply entrenched ableist laws and policies. Accordingly, as activists, legal professionals, scholars, and policymakers respond to the increasing threats to reproductive freedom in the United States, their advocacy and analysis must consider people with disabilities. The jurisprudential and legislative framework proposed in Part IV, \textit{infra}, is guided by the tenets of two complementary frameworks: disability justice and reproductive justice. Both disability justice and reproductive justice are intersectional social movements, theories, and praxes that provide important lenses for analyzing and responding to the ongoing weaponization of sexuality and reproduction to subjugate people with disabilities. This Part briefly describes each framework.

A. Disability Justice

Disability justice is an essential lens for dismantling the reproductive oppression of marginalized populations, including people with disabilities. Significantly “[r]eproductive [j]ustice is [d]isability [j]ustice.”\textsuperscript{204} Undoubtedly, ableism remains a deeply-rooted cause of the reproductive injustice experienced by disabled people. Disability justice offers an important framework for examining ableism as it relates to other forms of oppression and identity, including reproductive oppression.


\textsuperscript{202} Id. at 12.

\textsuperscript{203} Id. (citing studies focusing on the treatment of indigenous parents by the family policing system).

\textsuperscript{204} SINS INVALID, supra note 150, at 59.
Broadly, ableism is a system of prejudice and discrimination that devalues and excludes people with disabilities. Accordingly, ableism results in disabled people being perceived as inferior compared to nondisabled people. Ableist views embrace the notion that disability is “something that needs to be ameliorated, corrected or erased in order to come closer to the ideal able-bodied state.” “As a social process, ableism involves labeling—or pathologizing—bodies and minds as deviant, abnormal, incapable, incompetent, dependent, or impaired.” Like other systems of oppression, ableism operates at multiple levels and is therefore “a complex system of cultural, political, economic, and social practices that facilitate, construct, or reinforce the subordination of people with disabilities in a given society.”

Disability justice is an intersectional social movement, theory, and praxis originally conceived in 2005 by the Disability Justice Collaborative, a group of queer, trans, and/or racialized disabled people. Disability justice encompasses ten fundamental principles needed to achieve a truly inclusive and just society:


Disability justice recognizes that “[a]ll bodies are unique and essential” and, simultaneously, that “[a]ll bodies are confined by ability, race, gender, sexuality, class, nation state, religion, and more, and we cannot separate them.” Notably, this Article contributes to emergent legal scholarship that actively engages the tenets of disability justice.

205 Fiona Kumari Campbell, Ableism as Transformative Practice, in RETHINKING ANTI-DISCRIMINATORY & ANTI-OPPRESSIVE THEORIES FOR SOCIAL WORK PRACTICE 79-80 (Christine Cocker & Trish Hafford-Letchfield eds., 2014).
208 Id. at 980.
210 SINS INVALID, supra note 150, at 22-26.
211 Id. at 19.
212 See, e.g., Katie Eyer, Claiming Disability, 101 B.U. L. REV. 547, 584 (2021) (using disability justice as a lens for understanding disability identity); Jasmine E. Harris, Reckoning with Race and Disability, 130 YALE L.J.F. 916, 931-35 (2021) (considering how disability justice has informed intersectional scholarship on people with disabilities); Powell, supra note 30, at 629-30 (applying a disability justice lens for disrupting eugenics); Morgan, supra note 207, at 989 (employing disability
Essential to disability justice is the understanding that universalist and individualist approaches to inequities are inevitably limited and inadequate. Indeed, the law has limits to achieving equality for people with disabilities. As attorney and organizer Talila A. Lewis aptly said, “Litigation can’t save us. The systems that abuse us can’t save us.” Disability justice was established in response to the disability rights movement and emphasizes that addressing problems of disability-based discrimination requires attending to disparities created by race, immigration status, gender identity, sexual orientation, class, and other systems of oppression. Specifically, in response to the disability rights movement, which has been overwhelmingly white, disability justice activists and scholars emphasize the need to shift activism beyond traditional legislative efforts. As Mia Mingus writes, “I want us to tap into the transformative powers of disability, instead of only gaining access to the current system . . . . We don’t simply want to join the ranks of the privileged, we want to challenge and dismantle those ranks and question why some people are consistently at the bottom.” Consequently, while “[t]he disability rights movement has been crucial to the liberation of people with disabilities[,]” disability justice activists and scholars understand the importance of thinking beyond “gaining access to the current system,” and instead working to dismantle structural oppression. Therefore, “[w]here disability rights seeks to change social conditions for some disabled people via law and policy, disability justice moves beyond law and policy: It seeks to radically transform social conditions and norms in order to affirm and support all people’s inherent right to live and thrive.”

justice as a framework for developing multidimensional consciousness); Powell, supra note 184, at 58 (proposing a framework for abolishing the child welfare system guided by disability justice).


214 SINS INVALID, supra note 150, at 15-16; see also PIEPZNA-SAMARASINHA, supra note 209, at 15.


216 Nomy Lamm, This is Disability Justice, THE BODY IS NOT AN APOLOLOGY (Sept. 2, 2019), https://thebodyisnotanapology.com/magazine/this-is-disability-justice [https://perma.cc/gFC2-BXFS].

217 Mingus, supra note 215, at 3.

218 Lamm, supra note 216, at 3.

Disability justice is rooted in intersectionality\textsuperscript{220} and was established as a “movement-building framework that would center the lives, needs, and organizing strategies of disabled queer and trans and/or Black and brown people marginalized from mainstream disability rights organizing’s white-dominated, single-issue focus.”\textsuperscript{221} Accordingly, “disability justice values an intersectional analysis which requires us to consider the complexities of reproductive justice in the context of ableism.”\textsuperscript{222} Thus, disability justice is an important lens for analyzing and responding to the reproductive oppression experienced by disabled people, especially disabled people of color and LGBTQ+ people with disabilities for whom subjugation is magnified.

Disability justice also supports dismantling systems that oppress people with disabilities and addressing reproductive health disparities. To that end, disability justice recognizes that “[a]ccess to information, quality healthcare, and autonomy in decision-making are essential for the well-being of all.”\textsuperscript{223} In other words, to ensure that disabled people are afforded true choice, they must have access to comprehensive and accessible sexual and reproductive health services and information. Moreover, they must be provided opportunities to make decisions about their bodies. Above all, disability justice is essential because existing laws and policies are undeniably ineffective at ensuring reproductive freedom for disabled people.

B. Reproductive Justice

Reproductive justice is complementary to disability justice and provides an equally important lens for dislocating reproductive oppression. Reproductive justice is based on the international human rights framework and draws from reproductive rights and social justice. Reproductive justice was first “conceived in 1994 by feminists of color to conceptualize reproductive rights struggles embedded in social justice organizing that

\textsuperscript{220} In 1989, Kimberlé Crenshaw coined the term “intersectionality” to help explain the oppression of African-American women. See Kimberlé Crenshaw, Demarginalizing the Intersection of Race and Sex: A Black Feminist Critique of Antidiscrimination Doctrine, Feminist Theory & Antiracist Politics, 1 U. CHI. LEGAL F. 139, 140 (1989) (stating that an analysis that does not take intersectionality into account will necessarily obscure the particular nature of oppression Black women face). Since then, intersectionality has been used to examine how people with multiple marginalized identities or statuses, including multiply-marginalized people with disabilities, experience subordination. See, e.g., Beth Ribet, Surfacing Disability Through a Critical Race Theoretical Paradigm, 2 GEO. J.L. & MOD. CRITICAL RACE PERSPS. 209, 211-22 (2011) (applying intersectionality to the study of disability).

\textsuperscript{221} PIEPZNA-SAMARASINHA, supra note 209, at 11.

\textsuperscript{222} SINS INVALID, supra note 150, at 61-62.

\textsuperscript{223} Id. at 61.
simultaneously challenged racism and classism, among other oppressions."

According to Loretta Ross, co-founder of the SisterSong Women of Color Reproductive Justice Collective, “[t]he Reproductive Justice framework analyzes how the ability of any woman to determine her own reproductive destiny is linked directly to the conditions in her community—and these conditions are not just a matter of individual choice and access.”

Like disability justice, reproductive justice is rooted in intersectionality. Thus, reproductive justice is “based on the understanding that the impacts of race, class, gender, and sexual identity oppressions are not additive but integrative” and understands that only a holistic lens can adequately respond to them. In other words, the reproductive justice movement recognizes that reproductive choice “does not occur in a vacuum, but in the context of all other facets of a [person]’s life, including barriers that stem from poverty, racism, immigration status, sexual orientation and disability.”

Therefore, reproductive justice understands how intersecting factors, such as race and disability, constrain the reproductive freedom of marginalized populations.

Reproductive justice emerged as a movement because women of color and members of other marginalized populations felt that the reproductive rights movement overlooked their needs and experiences. Reproductive justice, thus, goes beyond our traditional understanding of reproductive rights in two notable ways. First, reproductive justice acknowledges the importance of choice while also recognizing the broader social, legal, and institutional structures that affect people’s reproductive decisionmaking. Second, and relatedly, reproductive justice applies to all aspects of reproductive freedom rather than only abortion rights.

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226 ROSS & SOLINGER, supra note 156, at 73-74.

227 Id. at 74.


229 Id. at 75.

230 REPRODUCTIVE JUSTICE BRIEFING BOOK, supra note 225, at 4 (“Moving beyond a demand for privacy and respect for individual decision making to include the social supports necessary for our individual decisions to be optimally realized, this framework also includes obligations so . . . [o]ur options for making choices [are] safe, affordable and accessible, three minimal cornerstones of government support for all individual life decisions.”).

231 See id. (“Instead of focusing on the means—a divisive debate on abortion and birth control that neglects the real-life experiences of women and girls—the Reproductive Justice analysis focuses on the ends: better lives for women, healthier families, and sustainable communities.”).
Reproductive justice “includes not only a woman’s right not to have a child, but also the right to have children and to raise them with dignity in safe, healthy, and supportive environments.”232 Notably, reproductive justice views each of these rights as equally important for achieving reproductive freedom.233 Central to reproductive justice is the recognition that “all fertile persons and persons who reproduce and become parents require a safe and dignified context for these most fundamental human experiences.”234 “By moving beyond the traditional pro-choice narrative and into the reality of lived experiences within the women’s communities, the reproductive justice movement focuses on the inequality among groups of women that inhibits access to these rights for some more than others.”235 Hence, reproductive justice reframes the discourse from “choice” to “access,” recognizing that a legal right to abortion is meaningless if people cannot access this care.

Similar to disability justice, reproductive justice moves beyond a focus solely on achieving rights. Reproductive justice demands “an integrated approach that draws on constitutional protections and movement-based policy strategies.”236 In addition, reproductive justice recognizes that “many kinds of laws shape the conditions in which women conceive and bear children.”237 Reproductive justice supports an affirmative government role “in ensuring that all women have the social, political, and economic power and resources to make the best decisions for themselves and their families.”238 To that end, reproductive justice necessitates both positive and negative rights, including states providing resources and supports that enable a person to exercise their right to have a child, to not have a child, and to parent one’s child.239 Furthermore, instead of relying solely on litigation and attorneys, reproductive justice also engages in grassroots and community organizing.240

233 See Luna & Luker, supra note 224, at 343 (“[R]eproductive justice is equally about the right to not have children, the right to have children, the right to parent with dignity, and the means to achieve these rights.”); see also id. at 328 (“[Reproductive justice] encompassed the right to not have a child but also moved beyond that to include the right to have a child and the right to parent any children one has.”).
234 ROSS & SOLINGER, supra note 156, at 9.
239 ROSS & SOLINGER, supra note 156, at 169.
240 See London, supra note 228, at 71-72 (describing the aims of reproductive justice).
IV. A Way Forward: Disability Reproductive Justice

As described throughout this Article, a large and growing segment of the United States—approximately sixty-one million people, or twenty-six percent of the population—endures the ongoing weaponization of their sexuality and reproduction as a mechanism for subjugating them. Undeniably, this reproductive oppression is entrenched in our laws, policies, and collective conscience. Reckoning with the nation’s current besiegement on reproductive freedom requires the inclusion of marginalized populations, especially people with disabilities. To that end, we must swiftly reframe the fight for reproductive freedom from one that only focuses on abortion to one that centers reproductive freedom broadly.

Below, I further develop a jurisprudential and legislative framework for disrupting the longstanding systems that oppress disabled people’s reproductive freedom. The proposed framework is guided by the tenets of disability justice and reproductive justice. It encompasses five principles I believe are necessary to finally achieving reproductive justice for people with disabilities. First, to achieve reproductive justice, legal and policy solutions must be aimed at disrupting the intersecting oppressions experienced by multiply-marginalized people with disabilities. Second, activists, scholars, legal professionals, and policymakers must actively engage people with disabilities in establishing legal and policy responses. Third, legal and policy responses must be developed and implemented to guarantee that disabled people’s rights to autonomy and self-determination are protected. Fourth, sexual and reproductive health services and information must be accessible and available to people with disabilities. Finally, disabled people must be ensured rights, justice, and wellness for themselves and their families.

The principles of disability reproductive justice are grounded in the existing legal and social science scholarship and are foundational elements of legal and policy solutions for addressing the reproductive oppression of disabled people. Importantly, the reproductive oppression experienced by disabled people is complex and requires an interdisciplinary and interprofessional response that engages all fields of expertise, including law, medicine, public health, social work, and organizing, among others. Thus, achieving reproductive freedom will necessitate a multifaceted approach. The need for such efforts could not be more timely or clear.


242 I proposed an earlier version of this framework in an Essay published in the Virginia Law Review Online. See Powell, supra note 11, at 261-70.
A. Disrupt Intersecting Oppressions

Audre Lorde famously said, “[t]here is no such thing as a single-issue struggle because we do not live single-issue lives.” Audre Lorde famously said, “[t]here is no such thing as a single-issue struggle because we do not live single-issue lives.”243 Although the community is often seen as monolithic, with white cisgender people front and center, the community is far more diverse than is often recognized.244 Indeed, the disability community is hugely diverse in race, ethnicity, religion, gender identity, sexual orientation, and other demographics. People with disabilities, therefore, often experience multiple oppressions relating to their sexuality and reproduction, and we can only achieve true reproductive freedom by addressing how these multiple oppressions impact one another.

While all disabled people experience a range of threats to their reproductive freedom, these injustices are amplified for disabled people of color and LGBTQ+ people with disabilities. For example, research shows that people of color with disabilities as well as LGBTQ+ people with disabilities face significant and persistent barriers to sexual and reproductive health services and information, often leading to deleterious outcomes.245 Multiply-marginalized people with disabilities often receive minimal—if any—sexual education, and when they do, it is often not accessible or inclusive.246 Moreover, disabled people of color and LGBTQ+ people with disabilities also experience significant barriers to accessing contraception and safe and legal abortion, an issue that is only increasing as states and the judiciary continue to chip away at reproductive rights.247 LGBTQ+ people with disabilities are often denied opportunities to express their sexuality and gender identities because of entrenched ableism, heterosexism, and transmisia.248 Further, disabled people of color experience staggering threats to their parenthood because of the pervasive ableism and racism that undergird the family policing system.249

244 See Carrie Elizabeth Mulderink, The Emergence, Importance of #DisabilityTooWhite Hashtag, 40 DISABILITY STUD. Q. (2020) (discussing how the hashtag #DisabilityTooWhite was used to draw attention to the focus on whiteness in conversations about disability); see also Sarah Blahovec, Confronting the Whitewashing Of Disability: Interview with #DisabilityTooWhite Creator Vilissa Thompson, HUFFPOST: BLOG (Dec. 6, 2017), https://www.huffpost.com/entry/confronting-the-whitewash_b_10574994 [https://perma.cc/UAE3-EDY9] (providing an interview discussion with founder of the hashtag #DisabilityTooWhite).
245 See supra Section II.A.
246 See supra Section II.B.
247 See supra Section II.D.
248 See supra Section II.E; see also Shain A. M. Neumeier & Lydia X. Z. Brown, Beyond Diversity and Inclusion: Understanding and Addressing Ableism, Heterosexism, and Transmisia in the Legal Profession: Comment on Blanck, Hyseni, and Altunkol Wise’s National Study of the Legal Profession, 47 AM. J. L. & MED. 76, 76 n.2 (2021) (arguing that the terms heterosexism and transmisia should be used rather than homophobia and transphobia because the latter are based on ableist underpinnings).
249 See supra Section II.F.
Therefore, the first principle to achieving disability reproductive justice requires activists, scholars, legal professionals, and policymakers to develop and implement legal and policy responses that are aimed at disrupting intersecting oppressions. Of note, Professor Jasmine Harris recently examined the dearth of legal scholarship studying the intersection of race and disability, noting, “discussions of race and disability do not use a critical-intersectional lens to interrogate inequities or a central subject of legal inquiry.” Disability reproductive justice should be used to begin to address this void.

B. Center People with Disabilities as Leaders

Critical to both reproductive justice and disability justice is the recognition that marginalized populations must be actively engaged as leaders in developing and implementing laws and policies that impact them. Indeed, a foundational aspect of justice-based approaches is “listening to, engaging, and developing affected communities.” According to Sins Invalid, “[b]y centering the leadership of those most impacted, we keep ourselves grounded in real-world problems and find creative strategies for resistance.” Centering people with disabilities as leaders is also aligned with the disability community’s ethos, “nothing about us, without us,” which emphasizes that disabled people should be actively involved in legal and policy efforts that impact them. Undeniably, when the voices of marginalized populations, including disabled people, are centered, solutions that benefit all members of society are conceived.

Cross-movement organizing, an important aspect of centering people with disabilities as leaders, is essential to disrupting the reproductive oppression of people with disabilities. Traditionally, there have been substantial tensions—particularly concerning issues of prenatal genetic testing for markers of disability and abortion on grounds of fetal disability diagnoses—between the disability rights and reproductive rights movements. Nevertheless, these tensions have come at high costs to both the disability rights and reproductive rights movements. As the Center for Reproductive Rights explains, “[t]he cost of ignoring tensions between the

250 Harris, supra note 212, at 926-27.
252 SINS INVALID, supra note 150, at 23.
254 Bagenstos, supra note 107, at 280-81.
disability rights and reproductive rights movements is high.” Recently, in response, the Center for Reproductive Rights deliberately established partnerships with disability rights advocates as a way to begin bridging the gap between the movements. These conversations are an important reminder that the movements must work collectively to confront the subjugation of disabled people’s reproductive freedom and that purposefully including disabled people is essential to developing and implementing legal and policy responses.

Notably, centering disabled people as leaders is also aligned with the critical lawyering movement. In 1991, Professor Louise Trubek coined the term “critical lawyering” to refer to lawyering that seeks “to empower oppressed groups and individuals” and focuses on forging a path to achieve “a more just society.” Professor Trubek opined that critical lawyers must “encourage participation, personalize the issues, be skeptical of bureaucracy, be unbiased in approach to advocacy arenas, organize with other lawyers, and apply feminist and anti-racist analyses.” Critical lawyers’ “approach to social justice requires the participation of empowered communities. These lawyers work with communities by offering their technical expertise to interact with the legal system. The sustainability of these law practices relies heavily on the engagement of the community they are built to support.” Ultimately, critical lawyering necessitates “moves away from the lawyer as the central protagonist to the lawyer as collaborator with the client and community.”

Therefore, the second principle needed for achieving disability reproductive justice requires activists, scholars, legal professionals, and policymakers to actively engage people with disabilities, especially people of color with disabilities and LGBTQ+ people with disabilities, in leading legal and policy responses to disrupt reproductive oppression. Such engagement will require an understanding of and respect for people with disabilities sharing their lived experiences and must involve elevating disabled people,

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256 See id. (“Over a four-year period, the Center sought out partnerships with disability rights groups, educated our staff about disability rights, challenged our own assumptions and biases, and identified areas where our substantive work, and workplace, could incorporate perspectives of people with disabilities.”).


258 Id.


260 Id. at 380.
especially multiply-marginalized disabled people, to leadership positions within both disability rights and disability justice movements. Recognizing that people with disabilities are the experts of their lives will lead to legal and policy responses that are disability-competent and address the actual reproductive needs of disabled people.

As explained previously, centering people with disabilities, especially multiply-marginalized disabled people, as leaders will facilitate cross-movement organizing and a broader effort toward fostering alliances and growing partnerships among the communities impacted most by the ongoing attacks on reproductive freedom. Cross-movement solidarity will create progress toward specific policy goals while also increasing and enhancing the dignity of people who can value one another’s shared humanity. Practically, this means that those involved in the reproductive justice movement must deliberately include disabled people in their work. Likewise, disability rights and justice activists must acknowledge the diversity of the disability community and guarantee that disabled people from marginalized communities hold leadership roles within the movements. To achieve disability reproductive justice, disabled people, especially disabled people of color and LGBTQ+ people with disabilities, must be centered in all legal and policy responses to disrupt reproductive oppression.

C. Protect Autonomy and Self-Determination

As Britney Spears’s tragic ordeal reveals, disabled people, especially people with intellectual or psychiatric disabilities, are often denied bodily autonomy and self-determination, which leads to reproductive oppression.261 Constitutional doctrine concerning abortion was previously entrenched in a principle of autonomy.262 Precisely, constitutional protections of abortion rights were rooted in the guarantee of “liberty” in the Due Process Clause of the Fourteenth Amendment.263 Indeed, the Supreme Court has ruled that the

261 See supra Section II.C.
262 See Pamela S. Karlan & Daniel R. Ortiz, In a Different Voice: Relational Feminism, Abortion Rights, and the Feminist Legal Agenda, 87 NW. U. L. REV. 858, 876 (1993) (“The language of autonomy has provided the central rationale for protecting individual women’s control over the abortion decision.”).
263 However, these guarantees were regularly questioned in the context of abortion, even before the Dobbs decision, as seen in Planned Parenthood of Southeastern Pennsylvania v. Casey, 505 U.S. 833, 844 (1992), which states that

Liberty finds no refuge in a jurisprudence of doubt. Yet 19 years after our holding that the Constitution protects a woman’s right to terminate her pregnancy in its early stages, Roe v. Wade, 410 U.S. 113 (1973), that definition of liberty is still questioned. Joining the respondents as amicus curiae, the United States, as it has done in five other cases in the last decade, again asks us to overrule Roe.
liberty protected by the Constitution comprises freedom in making “the most intimate and personal choices a person may make in a lifetime, choices central to personal dignity and autonomy . . . .”264 Similarly, autonomy is a lynchpin of the disability rights movement.265

People with disabilities have unceasingly fought against paternalism and the belief that other people—specifically, family members and professionals—are best equipped to make decisions for disabled people.266

As explained previously, guardianship, also known as conservatorship in some states, is a draconian and antiquated system that has existed for centuries and robs disabled people of autonomy and self-determination.267 Importantly, guardianship is a notable way that many people with disabilities are deprived of their reproductive autonomy. “This issue of autonomy bleeds into reproductive justice, sexual freedom, and parental rights for disabled women.”268 Reprehensibly, many disabled people under guardianship, such as Britney Spears, are forced to use contraception to prevent pregnancy.269 Forced contraception is akin to involuntary sterilization since it prevents people, against their will, from procreating. According to the National Council on Disability, an estimated 1.3 million people with disabilities presently are under guardianship.270

264 Id. at 851. But see Dobbs v. Jackson Women’s Health Org., 142 S. Ct. 2228, 2301 (2022) (Thomas, J., concurring) (asserting that any right not explicitly enumerated in the Constitution must be "deeply rooted in this Nation’s history and tradition" and "implicit in the concept of ordered liberty" to be protected by the Constitution).

265 See Samuel R. Bagenstos & Margo Schlanger, Hedonic Damages, Hedonic Adaptation, and Disability, 60 VAND. L. REV. 745, 795 (2007) (“[P]aternalism has historically been one of the most significant contributors to the disadvantage people with disabilities experience. Non-disabled parents, teachers, doctors, rehabilitation counselors, employers, and others have arrogated to themselves the prerogative to decide what is best for people with disabilities.”).

266 See CHARLTON, supra note 253, at 3 (“Control has universal appeal for [disability rights movement] activists because the needs of people with disabilities and the potential for meeting these needs are everywhere conditioned by a dependency born of powerlessness, poverty, degradation, and institutionalization. This dependency, saturated with paternalism, begins with the onset of disability and continues until death.”).


270 NAT’L COUNCIL ON DISABILITY, BEYOND GUARDIANSHIP: TOWARD ALTERNATIVES THAT PROMOTE GREATER SELF-DETERMINATION 17 (2018),
To be sure, concerns about capacity are often raised as justification for denying people with disabilities autonomy. Specifically, “[o]ne argument frequently made in opposition to providing autonomy and support for sexual expression is that of capacity. . . .”\(^{271}\) Of course, “[t]here will not be a ‘one size fits all’ approach to determining whether someone has the capacity to understand how to exercise their own sexual autonomy in a safe way.”\(^{272}\) At the same time, current approaches that presume incompetence are “contrary to the established law, and based on perceptions, fears and bias, rather than facts and data.”\(^{273}\)

Thus, the third principle for achieving disability reproductive justice requires the development and implementation of legal and policy responses that ensure people with disabilities’ autonomy and self-determination are protected. Although “[t]he guardianship system is designed as a last resort, applied only when an individual lacks capacity to make decisions,” there is “reason to believe that guardianships are imposed on many individuals without sufficient evidence of their decision-making incapacity and that, in some cases, disability alone appears to be used as a sufficient justification for the imposition of guardianship.”\(^{274}\)

Legislative efforts are presently underway to begin to confront the injustice imposed on disabled people because of guardianship. For example, disability rights advocates across the nation are urging state legislatures to implement supported decision-making as a least restrictive alternative to guardianship.\(^{275}\) Succinctly, supported decision-making allows people with disabilities greater autonomy in their choices while receiving help with decision-making from people whom they prefer and trust.\(^{276}\) Supported decision-making “does not require court involvement and can be coupled with other legal tools, such as powers of attorney and advance health care


\(^{272}\) Id.

\(^{273}\) Id.


\(^{275}\) U.S. Supported Decision-Making Laws, CTR. FOR PUB. REPRESENTATION, https://supporteddecisions.org/resources-on-sdm/state-supported-decision-making-laws-and-court-decisions (listing states that have implemented supported decision-making).

\(^{276}\) About Supported Decision-Making, CTR. FOR PUB. REPRESENTATION, https://supporteddecisions.org/about-supported-decision-making.
directives, that promote self-determination and autonomy.” Further, a bipartisan group of Members of Congress have expressed interest in addressing guardianship abuse. Federal and state legislative responses are long overdue and urgently needed.

In addition, legal and policy responses are needed to thwart the “school-to-guardianship pipeline.” Specifically, although guardianship results in a major deprivation of autonomy, “it is often imposed as a matter of course.” For example, schools and healthcare providers often push parents to seek appointment as guardian upon their children turning eighteen-years-old. Again, although guardianship was intended to be a last resort, there is reason to believe that is in fact often the first resort, which often has devastating and long-lasting effects. Indeed, courts often “approve guardianship petitions without asking many questions. And once a guardianship is created, it can be almost impossible to undo.” Hence, protecting autonomy and self-determination in furtherance of disability reproductive justice requires confronting the school-to-guardianship pipeline.

D. Ensure Sexual and Reproductive Health Services and Information are Accessible and Available to People with Disabilities

As previously explained, disabled people encounter numerous barriers that threaten their access to sexual and reproductive health services and information. While federal disability rights laws, including the ADA, Section 504, and Section 1557 mandate that healthcare providers be accessible and prohibit disability-based discrimination, these statutes have

281 Id.
282 Id.
283 See supra Section II.A.
failed to address the daily indignities and abuses experienced by people with disabilities. From general reproductive healthcare to perinatal care, to abortion care, disabled people encounter numerous and significant barriers that severely restrict their access to necessary sexual and reproductive health services. Additionally, transportation barriers often affect disabled people’s access to sexual and reproductive health services. In fact, studies indicate that transportation is a “key factor influencing a disabled person’s access to health services . . . .” Transportation accessibility transcends physical accessibility but also encompasses “the available routes, the reliability of the service and financial cost.”

Further, people with disabilities are often denied comprehensive and accessible sexual and reproductive health information, such as sexual education. Deprived of such information, people with disabilities are unable to make informed decisions about their reproductive wellbeing. In other words, the scarcity of comprehensive sexual and reproductive health information impacts autonomy and self-determination.

Moreover, policy and programmatic barriers exist that curtail people with disabilities’ access to sexual and reproductive health services and information. For example, because disabled people are more likely to be poor and receive public benefits, policies such as the Hyde Amendment, which bars the use of federal Medicaid funds for abortion care, often inhibit their access to comprehensive sexual and reproductive health services. To illustrate, in 2016, around thirty-eight percent of working-age adults with disabilities were covered by Medicaid, and around twenty-seven percent were covered by Medicare. In other words, disabled people, especially disabled people of

287 Powell, supra note 30, at 625-27 (describing federal disability laws’ application to matters concerning reproductive justice).
288 See supra Section II.A., II.D.
290 Id.
291 Powell & Stein, supra note 114, at 57-58 (explaining the implications of disabled people not receiving sexual education).
293 ROCKING THE CRADLE, supra note 182, at 178 (“Medicaid and Medicare [are] the primary health insurers for people with disabilities . . . .”).
294 Jae Kennedy, Elizabeth Geneva Wood & Lex Frieden, Disparities in Insurance Coverage, Health Services Use, and Access Following Implementation of the Affordable Care Act: A Comparison of
color because they are more likely to receive Medicaid, are disproportionately impacted by the Hyde Amendment. Furthermore, within the past few years, Congress has made several attempts to repeal the ACA, which disabled people successfully fought off. Repealing the ACA would be devastating for people with disabilities as it would likely result in substantial cuts to Medicaid. While Medicaid does not cover abortion care, it does cover other types of sexual and reproductive health services and information, and reducing or eliminating Medicaid benefits would hinder people with disabilities’ access.

As such, the third principle for achieving disability reproductive necessitates ensuring that sexual and reproductive health services and information are accessible and available. Increased compliance with and enforcement of existing legal protections are urgently needed to ensure reproductive freedom for people with disabilities. To that end, the U.S. DOJ and HHS Office for Civil Rights (OCR) must prioritize access to sexual and reproductive health services and information, such as by investigating alleged violations of disability-based discrimination by healthcare providers and enforcing federal disability rights laws as necessary.

People with disabilities also need access to comprehensive and accessible information about sexuality and reproduction. Both the Individuals with Disabilities Education Act and Section 504 require that “students with disabilities have the benefit of receiving access to the general curriculum, including comprehensive sex education when offered by schools.” Nonetheless, people with disabilities are continuously denied access to comprehensive and accessible sexual education, which can lead to increased vulnerability of sexual violence and deleterious outcomes. Accordingly, the U.S. Department of Education should establish standards for sexual education for students with disabilities. Moreover, healthcare providers and

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295 Distribution of the Nonelderly with Medicaid by Race/Ethnicity, KAISER FAM. FOUND., https://www.kff.org/medicaid/state-indicator/medicaid-distribution-nonelderly-by-raceethnicity/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D [https://perma.cc/B36P-QEKQ] (reporting that over fifty percent of the nonelderly receiving Medicaid in 2019 were people of color).


297 Id.


299 See supra Section II.B.
disability services providers must ensure that people with disabilities receive ongoing and comprehensive information about sexuality and reproduction. In addition to teaching about sexual violence, pregnancy prevention, contraception, and sexually transmitted infections, disabled people need information about sexuality and relationships. Importantly, sexual education must encompass diverse sexual orientations and gender identities.

Further, attention to the social determinants of health and their impact on access to sexual and reproductive health services and information is important. Developing and implementing laws and policies that recognize the social determinants of health will allow for addressing factors such as poverty and transportation and how they affect disabled people’s access to sexual and reproductive health services and information. For example, given that a significant number of people with disabilities live in rural areas without access to transportation, the integration of telehealth services can increase opportunities for disabled people to access sexual and reproductive health services. To that end, federal and state governments should enact statutory and regulatory changes, as needed, to expand telehealth sexual and reproductive health services. Congress should also allocate additional Medicaid funding for telehealth sexual and reproductive health services. In other words, legal and policy reforms should be made to the health care delivery system to allow for greater access to sexual and reproductive telehealth services. Ultimately, by addressing the social determinants of health, disabled people will have greater access to those services and information.

300 See generally Benfer, supra note 251 (explaining the social determinants of health and the health justice framework).
301 See Kathryn Wagner, Healthcare Justice for Women with Disabilities: The Need for Integrative Primary Care Services and Education for Medical Providers, 77 SEX ROLES 430, 431 (2017) (stating that 14 percent of women with disabilities live in rural areas); see also George M. Powers, Lex Frieden & Vinh Nguyen, Telemedicine: Access to Health Care for People with Disabilities, 17 HOUS. J. HEALTH L. & POL’Y 7, 12 (2017) (“[T]elemedicine offers a number of advantages that benefit individuals with disabilities to a greater extent than those without disabilities. Telemedicine can bring health care to consumers directly on demand while eliminating physical barriers and eliminating transportation costs.”).
Finally, in light of the Dobbs decision, the increased attempts by states to restrict abortion care, and the Hyde Amendment, Congress must mandate that all health insurers cover abortion care, including Medicaid and Medicare. For example, Congress should swiftly pass the Equal Access to Abortion Coverage in Health Insurance (EACH) Act, which would end the Hyde Amendment and related abortion funding restrictions in government health insurance plans. Additionally, Congress must work with disability rights and justice activists to identify other policy and programmatic barriers to sexual and reproductive health services and information.

E. Guarantee Rights, Justice, and Wellness for People with Disabilities and Their Families

Finally, it is impossible to effectively respond to the pervasive reproductive oppression experienced by people with disabilities without considering the significant role of law and policy in undermining reproductive justice. Indeed, people with disabilities and their families encounter numerous laws and policies that threaten their rights, justice, and wellness. These threats are widespread and require substantial attention. For disabled people of color and LGBTQ+ people with disabilities, threats to rights, justice, and wellness are magnified.

Poverty is a persistent and substantial barrier to people with disabilities being afforded reproductive freedom. It is also a barrier largely created by laws and policies. For example, disabled people are often prohibited from marrying because they risk losing necessary benefits, such as Supplemental Security Income (SSI) and Medicaid, because of draconian income and asset rules. To illustrate, consider a mother with a disability who is unemployed and receives a mere $841 each month in SSI benefits; she also receives Medicaid benefits, which covers the costs of her personal care assistants, who provide in-home assistance with personal care and household chores. She would like to marry the father of her children but cannot because she will


\[ \text{305 See, e.g., Robert E. Rains, Disability and Family Relationships: Marriage Penalties and Support Anomalies, 22 GA. ST. U. L. REV. 561, 567 (2006) (describing how people with disabilities who marry could experience a reduction in total SSI benefits); Waterstone, supra note 47, at 549 n.132 (explaining governmental policies that reduce or terminate benefits if people with disabilities get married and how these rules result in continuing marriage restrictions for many).} \]

become ineligible for SSI and Medicaid once his income is considered.\textsuperscript{307} She would also like to work, at least part-time, but cannot because she will lose her SSI benefits if she earns more than $1,350.\textsuperscript{308} Since Medicaid eligibility in her state is tied to receipt of SSI benefits,\textsuperscript{309} she will also lose Medicaid and needed in-home personal care assistants. Restrictive and outdated federal and state rules force this mother to live in poverty and prohibit her from getting married.

According to the U.S. Department of Labor’s Bureau of Labor Statistics, in 2020 only eighteen percent of people with disabilities were employed, compared to sixty-two percent of people without disabilities.\textsuperscript{310} While many more people with disabilities, like the mother described above, would like to work, “SSI and reliance on state and federal subsidized health insurance keep most disabled people in a poverty trap.”\textsuperscript{311} As scholar and activist Bethany Stevens aptly wrote, “The political economy of disablement is egregious by keeping disabled people at a living wage that is below the poverty line, and it has a negative impact on their sexual and reproductive autonomy.”\textsuperscript{312} Reproductive freedom should not be contingent on where people live, how much they make, or who they are. And yet, as the above narrative exemplifies, all too often these factors infringe on people with disabilities’ reproductive justice.

Furthermore, people with disabilities, especially disabled people of color and LGBTQ+ people with disabilities, often additionally contend with discriminatory legal and social service systems that separate them from their families.\textsuperscript{313} As previously explained, the family policing system targets people

\begin{footnotes}
\item[307] Bethany Stevens, \textit{Structural Barriers to Sexual Autonomy for Disabled People}, 38 HUM. RTS. 14, 15 (2011) (“Social Security’s Supplemental Security Insurance (SSI) disincentives to marriage continue to place many disabled people in the position of deciding whether to marry or cohabitate and lose benefits; or remain single to retain life-sustaining benefits.”). Although marriage is certainly not required to form families, it should be available to people with disabilities to the same extent that it is for people without disabilities.
\item[309] MaryBeth Musumeci & Kendal Orgera, \textit{Supplemental Security Income for People with Disabilities: Implications for Medicaid}, KAISER FAM. FOUND. (June 23, 2021), https://www.kff.org/medicaid/issue-brief/supplemental-security-income-for-people-with-disabilities-implications-for-medicaid/ [https://perma.cc/454G-RGSH] (“SSI eligibility generally is a pathway for Medicaid eligibility, [and] changes that affect the ability of people with disabilities to obtain or retain SSI also can affect the ability of people with disabilities to access Medicaid.”).
\item[311] Stevens, supra note 307, at 15.
\item[312] Id.
\item[313] See supra Section II.F.
\end{footnotes}
of color and disabled parents using pathology, control, and punishment.\textsuperscript{314} The reasons for this staggering discrimination are many, but ableist laws and policies play a significant role. For example, an estimated two-thirds of state child welfare system laws explicitly include parental disability—usually intellectual or psychiatric disabilities—as grounds for termination of parental rights.\textsuperscript{315} Thus, in many states, disabled people are lawfully denied their right to raise children. Moreover, the Adoption and Safe Families Act (ASFA),\textsuperscript{316} the federal law governing the family policing system, does not reference parents with disabilities, but the statute contains ableist provisions that negatively impact disabled parents and their children.\textsuperscript{317} For example, parents with disabilities often have trouble complying with the strict timelines set forth by ASFA because obtaining adequate services and supports often takes longer than the mandated timelines.\textsuperscript{318} Additionally, ASFA allows family policing agencies to bypass the provision of reasonable efforts and instead terminate parental rights if the child has been “subjected . . . to aggravated circumstances,” which some states have interpreted to include parental disability.\textsuperscript{319} In other words, some states forgo preferring family reunification services simply because the parent is disabled.

\textsuperscript{314} See supra Section II.F.
\textsuperscript{315} ROCKING THE CRADLE, supra note 182, at 16.
\textsuperscript{317} ROCKING THE CRADLE, supra note 182, at 93-96 (detailing ways that ASFA disparately impacts disabled parents).
\textsuperscript{318} Ella Callow, Kelly Buckland & Shannon Jones, Parents with Disabilities in the United States: Prevalence, Perspectives, and a Proposal for Legislative Change to Protect the Right to Family in the Disability Community, 17 TEX. J. C.L. & C.R. 9, 22 (2011); see also Christina Risley-Curtiss, Layne K. Stromwall, Debra Truett Hunt & Jennifer Teska, Identifying and Reducing Barriers to Reunification for Seriously Mentally Ill Parents Involved in Child Welfare Cases, 85 FAM. SOC’Y 107, 112 (2004) (“Most important to parents with a serious mental illness, ASFA affirms and clarifies specific exceptions that permit states to refuse reunification efforts, and requires states to initiate or join termination of parental rights . . . proceedings for children who have been in care 15 of the most recent 22 months.”); Colby Brunt & Leigh Goodmark, Parenting in the Face of Prejudice: The Need for Representation for Parents with Mental Illness, 36 CLEARINGHOUSE REV. 295, 299 (2002) (“These requirements can be especially onerous for mentally ill parents. Judges may view mental illness as lifelong and intractable—and therefore not amenable to resolution in a fifteen-month period.”); Leslie Francis, Maintaining the Legal Status of People with Intellectual Disabilities as Parents: The ADA and the CRPD, 57 FAM. CT. REV. 21, 25 (2019) (“[S]hort time periods for reunification may make it very difficult for people to achieve reunification goals if they require longer time periods for accessing services or learning successfully from them.”); ROCKING THE CRADLE, supra note 182, at 87-88 (detailing the difficulties parents with disabilities experience related to complying with ASFA’s timelines).
\textsuperscript{319} 42 U.S.C. § 671(a)(15)(D)(i)-(iii); see also ROCKING THE CRADLE, supra note 182, at 90-92 (describing how some states have included parental disability among reasons to bypass providing reasonable efforts).
Finally, people with disabilities, especially people of color with disabilities and LGBTQ+ people with disabilities, are deeply affected by the ongoing attacks on abortion care.\textsuperscript{320} Since the Court decided \textit{Roe}, states have enacted more than 1,300 restrictions on abortion.\textsuperscript{321} In 2021 alone, over 500 abortion restrictions have been introduced in forty-seven states, and more than eighty of those bills have been enacted.\textsuperscript{322} The incessant assaults on access to safe and legal abortion care only serve to further oppress marginalized populations, including disabled people. Indeed, with \textit{Roe} now overturned, abortion is expected to soon become illegal in twenty-six states.\textsuperscript{323}

Accordingly, the fifth principle for achieving disability reproductive justice requires people with disabilities be guaranteed rights, justice, and wellness for themselves and their families. To that end, an in-depth analysis of existing laws and policies that affect people with disabilities and reproductive freedom is urgently needed. Such examination must include laws and policies that are ostensibly facially neutral but are applied in ways that reflect societal biases and prejudices and that ultimately operate to the detriment of people with disabilities, such as family policing system laws and policies. While a complete analysis is beyond the scope of this Article, below are some areas that warrant attention. In the end, legal and policy solutions that reflect the fifth principle will need to be comprehensive and transformative.

For example, laws and policies that cause people with disabilities to live in poverty necessitate swift consideration. Amending the income and asset rules that keep people with disabilities in poverty would allow them to have livable incomes and the families they desire.\textsuperscript{324} Elevating disabled people

\textsuperscript{320} See generally, ABORTION CARE, supra note 130 (providing examples of how multiply marginalized disabled people encounter barriers to abortion care).

\textsuperscript{321} Elizabeth Nash & Lauren Cross, 2021 is on Track to Become the Most Devastating Antiabortion State Legislative Session in Decades, GUTTMACHER INST. (June 14, 2021), https://www.guttmacher.org/article/2021/04/2021-track-become-most-devastating-antiabortion-state-legislativetes-decades [https://perma.cc/AXV2-JGR3].

\textsuperscript{322} Id.

\textsuperscript{323} Elizabeth Nash & Lauren Cross, 26 States Are Certain or Likely to Ban Abortion without Roe: Here’s Which Ones and Why, GUTTMACHER INST. (Oct. 28, 2021), https://www.guttmacher.org/article/2021/10/26-states-are-certain-or-likely-ban-abortion-without-roeheres-which-ones-and-why [https://perma.cc/XTyV-EKN5].

with disabilities out of poverty would also allow them greater access to reproductive health services and information.325 To that end, employment opportunities similarly need to be expanded so that people with disabilities can work and earn livable wages. In addition, Section 14(c) of the Fair Labor Standards Act,326 which allows people with disabilities to be paid subminimum wages, must be immediately repealed. Ultimately, all laws and policies that relegate disabled people must be transformed.

Further, disabled parents and their children must be able to live free from fear of unnecessary separation. Accordingly, the family policing system must be entirely dismantled.327 In pursuit of abolishing the family policing system, we must reimagine a world that provides families with adequate and nonpunitive supports and resources. Recognizing that abolition takes time, legal protections must be immediately implemented to safeguard families already ensnared in the system. Specifically, removing parental disabilities as grounds for termination of parental rights from state statutes, providing high-quality legal representation, and increasing enforcement by DOJ and HHS’ OCR of violations of disability rights laws will reduce the number of families subjected to the family policing system, an important step in achieving family policing system abolition.

Lastly, action is urgently needed to thwart the ongoing and increasing attacks on access to safe and legal abortion care. The judiciary may not be the appropriate venue for doing so considering the current composition of the Supreme Court.329 Instead, efforts should focus on legislative solutions. For example, Congress must pass the Women’s Health Protection Act (WHPA),

62/pdf/GAOREPORTS-HEHS-96-62.pdf [https://perma.cc/F4A2-54NY] (noting that the benefit structure provides disincentives to low-wage work and impedes the return to work).

325 Powell, supra note 11, at 269-70 (examining the how poverty impacts disabled people’s reproductive freedom); see also ABORTION CARE, supra note 130, at 7-8 (describing the ways in which economic insecurity impedes access to abortion care).


327 I propose a legal and policy agenda for family policing system abolition in an article published by the Yale Journal of Law and Feminism. See generally Powell, supra note 184. The recommendations described herein are part of that broader agenda.

328 See generally id. (describing the urgent need for these transformative legal and policy solutions).

which would create a national protection against state abortion bans and medically unnecessary restrictions. WHPA would guarantee that the right to abortion care is a reality in every state. Importantly, all efforts to protect the right to safe and legal abortion care must be inclusive of marginalized populations, including disabled people.

**CONCLUSION**

While it is undeniably an austere time for reproductive freedom in the United States, it is also one of immense possibility. Now is the time to shift attention away from the courts and onto policymaking, organizing, and the electorate. More importantly, it is time to reframe the fight for reproductive freedom from one that focuses only on abortion to one that centers reproductive justice. To that end, we must incorporate not only the right to not have a child but also the right to have a child and the right to parent that child safely and with dignity. Above all, future fights for reproductive freedom must be fully inclusive of all people, with an intentional focus on marginalized populations, such as people with disabilities, whom have the most to lose and whom have been traditionally disregarded from these efforts. Guided by the tenets of disability justice and reproductive justice, this Article further develops jurisprudential and legislative framework for achieving and delivering reproductive justice for people with disabilities.

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331 *Id.*