

ACCESS FOR EVERYBODY

• DISABILITY INCLUSION IN ABORTION AND CONTRACEPTIVE CARE •



OVERVIEW

INTRODUCTION

Healthy sexuality, reproductive freedom and bodily autonomy are important indicators of health and well-being for everybody regardless of gender, age, class, economic status, ethnicity, religion, sexual orientation, ability or other social factors. This is also true for people with disabilities, who represent 15% of the world's population—and 80% of whom live in low-resource settings (World Health Organization [WHO], 2011). Despite being a considerable percentage of the population, people with disabilities¹ are grossly underserved and neglected by sexual and reproductive health services (Addlakha, Price, & Heidari, 2017), particularly those focused on safe abortion and contraceptive care. While donors, sexual and reproductive health (SRH) program implementers, universities and activists are beginning to examine the needs and rights of people with disabilities, considerable gaps persist in the specific areas of safe abortion and contraceptive care.

Ipas conducted a literature review and key informant interviews² to begin to address these evidence gaps. This process yielded significant insights for understanding and meeting the abortion and contraceptive needs of people with disabilities:

- Abortion and contraceptive needs for people with disabilities are diverse, largely invisible, underserved and unskillfully handled.
- Unsafe abortion itself can be the cause of disabilities.

¹ This brief specifically addresses abortion, contraception and sexual and reproductive health needs regarding *informed and consenting* people with disabilities. It is important to not conflate this group with those who are coerced into unwanted reproductive health choices or those who are unable to provide informed consent.

² Key informant interviews were conducted with 18 individuals from disabled people's organizations, disability rights organizations and activists, Ipas, Marie Stopes International (MSI) and academics, representing a total of seven countries in Africa, Asia and Latin America in addition to the United States and United Kingdom. A literature search included reviews of peer-reviewed and published materials, grey literature, Internet articles and blogs.

- Due to compounded and intersecting stigmas, people with disabilities may face unique and extensive barriers to abortion care.
- Sexual and gender-based violence is experienced by women with disabilities at extraordinary rates,³ which can drive high levels of unwanted pregnancies and subsequent desire for an abortion.
- A “twin-track” approach, which promotes interventions that specifically target the sexual and reproductive health needs of people with disabilities while concurrently mainstreaming disability inclusion into general sexual and reproductive health service delivery practices, is critical for meaningful and sustainable disability inclusion.
- Governments’ and other actors’ compliance with the Convention on the Rights of Persons with Disabilities (CRPD) is imperative to respect and recognize the human rights of people with disabilities.

This brief explains the programmatic importance of disability inclusion in abortion and contraceptive care and provides resources to support the design and implementation of interventions to address unmet need for this care. This includes an outline of common barriers that people with disabilities face, a description of global frameworks that can guide programmatic approaches to disability inclusion, and a select list of promising practices and lessons learned from the field. The accompanying *Guide for Disability Inclusion* provides actionable steps to operationalize disability inclusion in **policy, service delivery** and **community engagement strategies** and thus ensure access to life-saving health care for everybody, including people with disabilities.

WHY ACCESS FOR EVERYBODY

The WHO defines disability as “impairments, activity limitations and participation restrictions, referring to the negative aspects of the interaction between an individual (with a health condition) and that individual’s contextual factors” (WHO, 2011). Disabilities can be broadly categorized as affecting an individual’s vision, movement, cognitive abilities, communication, hearing, mental health and relationships with others (Centers for Disease Control and Prevention [CDC], 2017). Despite representing a significant portion of the global population, people with disabilities do not have their needs and preferences considered or prioritized in most safe abortion and contraceptive care. To access this care, people with disabilities must therefore navigate additional challenges such as physical, communication or stigma-related barriers.

³ Women with disabilities are 10 times more likely to experience sexual violence than women without disabilities (United Nations Fund for Population Activities [UNFPA], 2016).

Averting preventable disability and mental health issues

Around 25 million unsafe abortions occur yearly with an estimated 8.5 million individuals in need of treatment for complications of unsafe abortion, otherwise known as postabortion care (WHO, 2008). Despite those numbers, only about five million individuals in need of postabortion care are admitted to hospitals annually, leaving 3.5 million people without services (WHO, 2008). Infertility due to unsafe abortion and maternal sepsis is the eighth most prevalent disability worldwide, affecting 33.4 million individuals—almost all in low-resource settings (WHO, 2011). Injuries and complications due to unsafe abortion result in over two million disability-adjusted life years (DALYs), representing 15% of all DALYs for maternal health conditions (Shah & Ahman, 2014).

Denying abortion care to individuals in need has been linked to lower educational attainment, lower socio-economic status and negative effects on mental health (Ipas, 2008). Conversely, the ability to make personal decisions about one's health, family and future is associated with feelings of empowerment (Ipas, 2008).

BARRIERS TO ACCESS

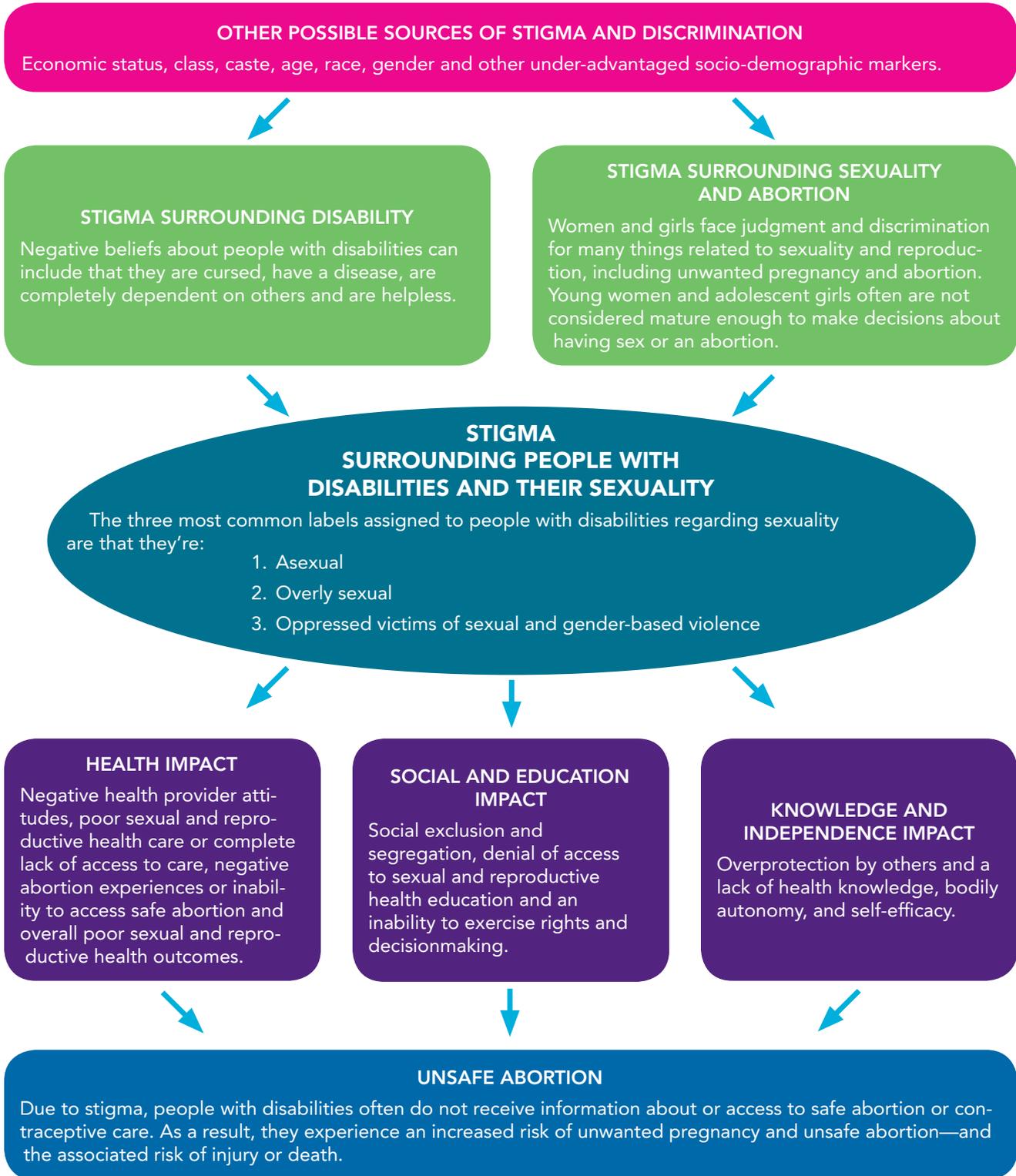
To promote non-discrimination and ensure that people with disabilities can actively and meaningfully access abortion and contraceptive care on an equal basis with others, it is critical to understand the additional barriers that people with disabilities encounter at the **policy, service delivery, community** and **family** levels.

Stigmatizing attitudes about disability by community influencers, politicians and religious leaders can lead to population-level and community-wide exclusion of people with disabilities and other underserved groups. *Figure 1: Stigma cycle* illustrates how people with disabilities must navigate compounded and intersecting obstacles due to negative attitudes, superstitions and misconceptions about their sexuality—particularly pervasive beliefs of asexuality or sexual deviance. These misconceptions are further exacerbated by negative attitudes about unwanted pregnancy and abortion.

Figure 1

STIGMA CYCLE

AFFECTING PEOPLE WITH DISABILITIES REGARDING THEIR SEXUALITY AND SEXUAL AND REPRODUCTIVE HEALTH



Policy-level barriers

Lack of understanding and de-prioritization of disability inclusion by policymakers and decisionmakers at national and international levels creates barriers for people with disabilities that block their access to abortion and contraceptive services. The absence of targeted content on disability inclusion and sexual and reproductive health and rights in law schools and policy institutes can perpetuate negative attitudes and pervasive stigma toward people with disabilities (see *Figure 1*). Additionally, the general **lack of understanding and compliance** at local and national levels to the [Convention on the Rights of Persons with Disabilities](#) and [CESCR General Comment No. 14: the Right to the Highest Attainable Standard of Health \(Art. 12\)](#)⁴ undermines intentions to meet the needs of people with disabilities.

Such an environment encourages **lower rates of registering children with disability at birth**. Without registration, people with disabilities are unable to obtain a national identification card and are subsequently excluded from census and other societal-level data sets. The result is scarce data collected or disaggregated about people with disabilities, reinforcing their invisibility and making advocacy efforts more challenging (Handicap International, 2012).

Service delivery-level barriers

Barriers to accessing abortion and contraceptive care at the service delivery level exist within health facilities and with health-care providers.

Facilities

Limited **time and funding** to modify equipment and eliminate **physical and communication/information barriers** within health facilities are fundamental barriers. Many public health systems are **under-resourced** with limited supplies, equipment, functional infrastructure and trained staff. The rights and needs of people with disabilities are **not recognized or prioritized**; therefore, addressing these needs can be perceived as a financial burden. **Distance and inadequate transportation** to abortion and contraceptive services are additional obstacles that are intensified in rural areas.

People with disabilities **require more time** from health professionals for counseling, procedures and follow-up care. Additional obstacles include long lines and wait times at health centers. Since people with disabilities are often isolated or not connected with disabled people's organizations⁵, many have limited access to interpreters or other referral networks, inhibiting them from accessing the health facility or receiving quality services upon arrival.

Not being able to hear or comprehend what someone is saying is the most common barrier for people with hearing, communication, or psychosocial/mental disabilities. This can happen at several points throughout service delivery where there are no clear directions for signing in, knowing if your name is called or understanding the pharmacist's directions for taking medicine. Likewise, the **inability to communicate** in response to questions from a provider or other health facility staff could fail to address

4 Developed by the United Nations' Committee on Economic, Social, and Cultural Rights, General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12) states that health is a fundamental human right necessary for the ability to exercise all other human rights.

5 Disabled people's organizations or disabled persons' organizations are organizations composed of and advocating for people with disabilities. These terms can be used interchangeably though we have chosen to use the former for consistency.

needs and concerns. **Difficult-to-read or complicated forms** and other **information materials** can make it more challenging to get abortion or contraceptive services or referrals—especially for people with visual impairments or psycho-social and intellectual disabilities.

Health-care providers

Health-care providers may **lack a general understanding** of the needs of people with disabilities, such as the need for health professionals to learn their preferred communication method, to schedule additional time to ask and answer questions, and to have adjustable equipment. The absence of disability in **content and curricula** in university- and facility-based clinical training on abortion and contraception perpetuates negative attitudes and pervasive stigma toward people with disabilities (see *Figure 2*, page 7). Additionally, the lack of disability content in standard operating procedures and clinical guidelines inhibits the ability of health administrators to **prioritize and fund** services for people with disabilities, which in turn results in poor-quality care, denial of care and no resourcing for modifications of equipment, information materials, and infrastructure. The lack of provider training on **informed consent** for abortion and contraceptive care could also result in providers referring people with disabilities elsewhere or not offering services due to fear or lack of knowledge.

Community-level barriers

Gender and power dynamics, negative attitudes, and socio-cultural norms contribute to stigma against people with disabilities. This stigmatization often results in their exclusion from community participation and inhibits connection with disabled people's organizations, which can assist with broader social support, educational opportunities, and employment prospects. Differential treatment by community members and a lack of compliance to the principles of universal design⁶ and the [Convention on the Rights of Persons with Disabilities](#) accessibility guidelines⁷ in public spaces—such as places of worship, recreation and shopping areas and education and employment locations—inhibits active and meaningful participation for people with disabilities.

Family-level barriers

For people with disabilities, exclusion from abortion, contraception, and other sexual and reproductive health services and educational resources results in a lack of knowledge and self-efficacy that reinforces the stigmatizing idea that they are incapable and undeserving of equal treatment. A significant barrier is reliance on family for financial support, physical assistance, or communication in accessing abortion and contraceptive care. *Figure 2: Support within the family* demonstrates how stigma against people with disabilities manifests most powerfully at the family level, where they are often neglected, violated, dehumanized, confined to the house and lack bodily autonomy.

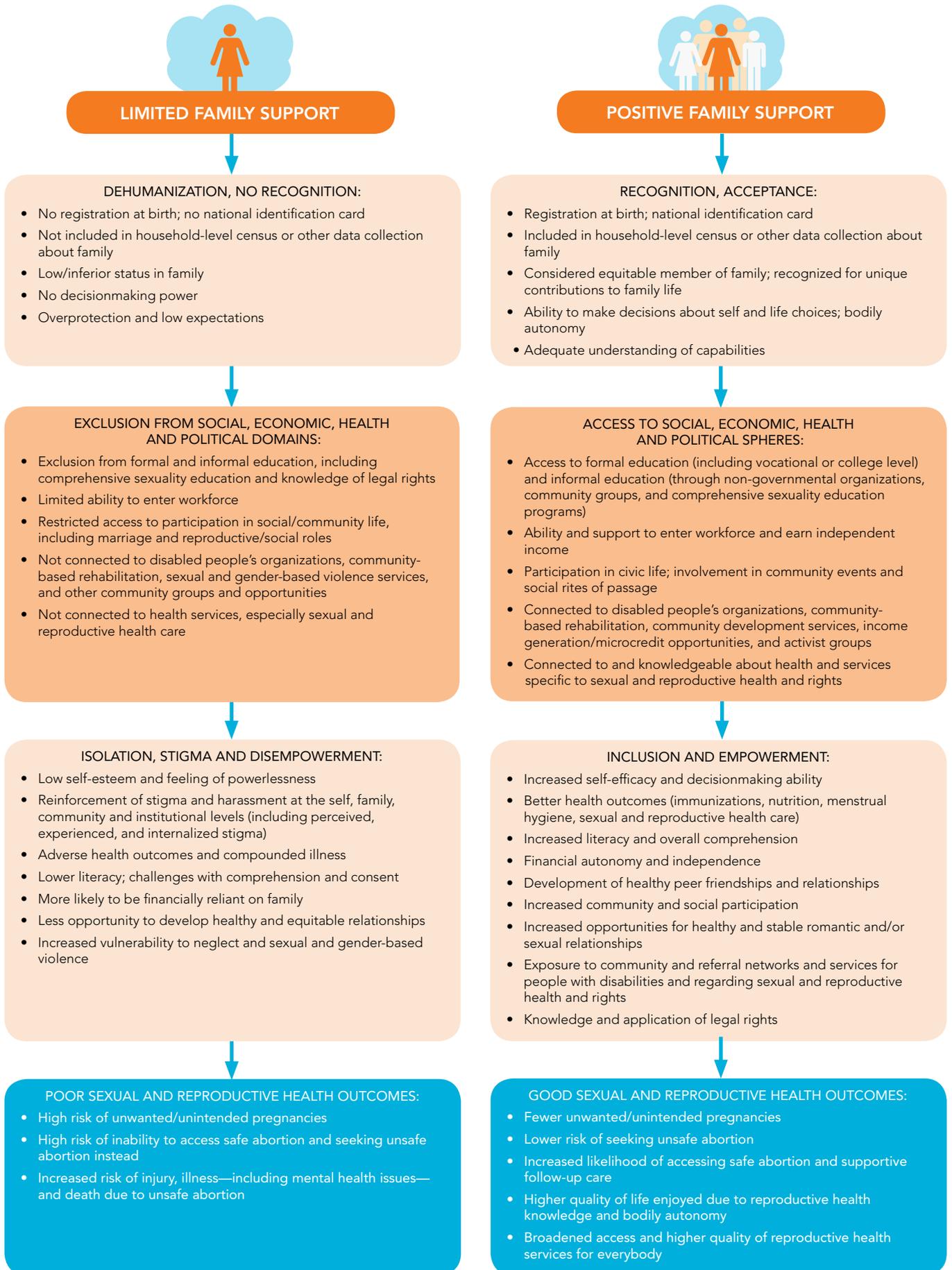
6 [Universal design](#) is a design concept with the goal of making the built environment, products and services more accessible for all people, particularly those with disabilities, the elderly, pregnant people, children and those with temporary illnesses (Australian Agency for International Development [AusAID], 2013).

7 [Article 9—Accessibility](#) of the [Convention on the Rights of Persons with Disabilities](#) outlines how states must identify and eliminate barriers to accessibility to allow people with disabilities to live independent, actualized lives (United Nations, 2006).

Figure 2

SUPPORT WITHIN THE FAMILY: CRUCIAL FOR ENSURING SAFE ABORTION ACCESS

Family-level support for children and adults with disabilities varies depending on context, available time and resources, and family and community attitudes and norms.



Compounding factors

Higher rates of sexual and gender-based violence, HIV/AIDS and poverty further complicate the experiences of people with disabilities and their abortion and contraceptive needs.

Sexual and gender-based violence

Due to misconceptions about their sexuality, people with disabilities often do not receive basic information on sexual and reproductive health, and certainly not targeted information or care related to sexual and gender-based violence. However, people with disabilities are more likely to experience sexual acts due to violence or coercion, (Abimanyi-Ochom, Mannan, Groce, & McVeigh, 2017) and women with disabilities are 10 times more likely to experience sexual violence than women without disabilities (UNFPA, 2016). One study indicated people with disabilities are more likely to live unpartnered with their birth family and suffer high rates of family violence—most frequently perpetrated by their mother or father (Vallins & Wilson, 2013). Since most sexual and gender-based violence interventions are geared toward intimate partner conflicts, the violence that people with disabilities endure often goes unrecognized by health providers (Bradbury-Jones et al., 2015). People with disabilities often lack legal knowledge and are less likely to report violence because they depend on their caretakers, thereby further limiting their access to sexual and gender-based violence services and their ability to procure independent living accommodations (Andrae, 2016; Vallins & Wilson, 2013).

HIV/AIDS

Despite being perceived as less likely to be HIV positive, people with disabilities experience a rate of HIV infection three times higher than individuals without disabilities due to sexual coercion and violence and lack of sexual education (Human Rights Watch, 2011). Due to physical, communication, information and attitudinal barriers, people with disabilities are also more likely to delay receiving HIV test results or return for services at all (Abimanyi-Ochom et al., 2017).

Poverty

Financial barriers are particularly burdensome for people with disabilities because it is common for them to financially depend on others for their care. People living in poverty are more likely to suffer from disabilities, and people with disabilities are more likely to live in poverty due to the additional expenses that caring for a disability incurs (Chintende, Sitali, Michelo, & Mweemba, 2017). Discrimination and stigma toward people with disabilities further limits employment opportunities, making it more difficult to escape poverty (AusAID, 2013; Chintende et al., 2017; Trani et al., 2015).

WHAT IS BEING DONE: GLOBAL INITIATIVES

In the past decade, large global initiatives, frameworks, and reports focused on disability inclusion have increased awareness and the willingness of donors, SRH program implementers, universities and activists to include disability in sexual and reproductive health services. Collaborations among major donors, nongovernmental organizations, community-based organizations, disabled people's organizations and universities have made great strides to improve disability inclusion in

sexual and reproductive health. Provided here is a high-level summary of these global initiatives.

Global initiatives on disability inclusion

- The 2006 [Convention on the Rights of Persons with Disabilities](#) (CRPD) is the international treaty recognizing the rights of individuals with disabilities. Key articles relevant to individuals' rights to safe abortion and contraceptive services are Article 9—Accessibility, Article 12—Equal recognition before the law and Article 25—Health.
- The [Committee on the Rights of Persons with Disabilities](#) is the body of independent experts which monitors compliance with the Convention by countries that signed it.
- The [Sustainable Development Goals](#) (SDGs) are a 2015 global framework that establishes the standards for global development goals. The SDGs address disability by focusing on equitable access to education, economic opportunities, and social and political inclusion, as well as gathering and disaggregating data by disability (United Nations, 2015). (United Nations, 2015). [Goal 4](#) and [Goal 16](#) are particularly relevant for disability inclusion and sexual and reproductive health services.
- The [2011 World Report on Disability](#) by the WHO and World Bank is the seminal guiding document on disability inclusion and rights (WHO & The World Bank, 2011).
- [UNFPA We Decide](#) is the global campaign from the UNFPA that advocates for gender equity and social inclusion for young people with disabilities while promoting an end to sexual violence (UNFPA, 2016).
- The [Washington Group on Disability Statistics](#) developed standardized question sets on disability, including a Short Set consisting of six questions, which are commonly referred to as “the Washington Group Questions.” These questions are recommended for use in censuses and have also been used in client exit interviews by sexual and reproductive health program implementers for disaggregating data by disability status (Washington Group on Disability Statistics, 2017).

Contributions from major donors

- **Department for International Development (DFID):** As a global leader for disability inclusion in the international donor community, DFID's policy papers, [Disability Framework—One Year on Leaving No One Behind](#) and [Disability Framework—Leaving No One Behind](#), have served as global directives to inform and influence policy and practice. DFID is working toward realizing the intentions and recommendations in these reports while making inclusion a key aspect of its new sexual and reproductive health and rights program, Women's Integrated Sexual Health. UK AID Connect, an upcoming DFID-funded grant, also prioritizes disability inclusion.
- **Department of Foreign Affairs and Trade (DFAT)/Australian Aid (formerly AusAID):** Another major actor in international development, Australian Aid promotes disability inclusion with its [Development for All 2015-2020: Strategy for strengthening disability inclusive development in Australia's aid program](#) and [Accessibility Design Guide: Universal design principles for Australia's aid program](#).

- **Dutch Coalition on Disability and Development (DCDD):** DCDD collaborated with Share-Net International to publish [Everybody Matters: Good practices for inclusion of people with disabilities in sexual and reproductive health and rights programmes](#), authored/edited by Caroline van Slobbe. This publication includes practical suggestions on how to make sexual and reproductive health programming more inclusive, and stories from different disability-focused organizations in the field while reflecting on challenges and lessons learned.
- **German Development Cooperation (GDC/GIZ):** GIZ's recent commission of a rigorous research study on sexual and reproductive health and rights and disability in Cambodia comprehensively examines barriers to sexual and reproductive health while providing recommendations for actionable steps to promote disability inclusion in social life (German Society for International Development [GIZ] Cambodia, 2016).
- **Swedish International Development Cooperation Agency (Sida):** Sida has created country-specific briefs with guidance on applying a human rights-based approach to working with people with disabilities. Their [Sexual Rights for All](#) brochure also demonstrates their commitment to amplifying the significance of sexual rights for all people (Runeborg et al., 2010).
- **United States Agency for International Development (USAID):** Through Mobility International USA, USAID supports the [Women's Institute on Leadership and Disability](#) (WILD), an empowerment and leadership program for women with disabilities in low-resource settings (USAID, 2015).

Implementers in the field

- **CREA**, a feminist human rights organization based in India, advocates for positive social change at national and international levels. CREA also provides training and learning opportunities to global activists and leaders through its Institute on Disability, Sexuality and Rights; its website on sexuality and disability; and its report series *Unseen, Unheard, Unsung: Violence Against Marginalized Women in South Asia*.
- **ARROW**, an Asia-Pacific women's non-profit organization based in Malaysia, has collaborated with disabled people's organizations, CREA, Association of Southeast Asian Nations Disability Forum and others on various sexual and reproductive health and rights and disability workshops, trainings and advocacy.
- **Leonard Cheshire Disability and Inclusive Development Centre at University College London/Cheshire Global Alliance** is an academic research center that applies qualitative and quantitative research on disability to advance the global evidence base.
- **International Planned Parenthood Federation (IPPF)** affiliates and association members from Israel, Tunisia, Trinidad and Tobago, Uganda, Macedonia and elsewhere have designed and implemented various sexual and reproductive health and rights programs and services with and for people with disabilities.
- **Women with Disability Taking Action on Reproductive and Sexual Health (W-DARE)**, is a three-year research project in the Philippines dedicated to increasing access to and quality of sexual and

reproductive health services for women and girls with disabilities. [W-DARE](#) works through partnerships with [Nossal Institute](#) at the University of Melbourne, disabled people's organizations, and a national non-profit women's health service provider.

Disabled people's organizations

Achieving disability inclusion in the sexual and reproductive health and rights sector depends on active and meaningful participation from disabled people's organizations. These are associations and organizations composed of and led by local people with disabilities. As direct representatives of people with disabilities, these organizations play a pivotal role in promoting self-efficacy, advocating for equal rights, raising community awareness, creating social support, and building a disability rights movement. The disability rights movement is a collaboration among disabled people's organizations, federations, international organizations and networks and disability advocates. Disabled people's organizations are fundamental in ensuring that the sexual and reproductive health and rights of people with disabilities are respected and fulfilled.

WHAT IS BEING DONE: LESSONS FROM THE FIELD

Ipas and MSI have conducted several disability inclusion interventions in Africa and Asia. An overview of these projects is provided here—including examples of disability inclusion in practice—with the intention of generating discussion on how other sexual and reproductive health practitioners can improve disability inclusion in their own programming.

Nigeria

Funded by the Australian High Commission – Nigeria, the Deaf Women's Association of Nigeria (DWAN) partnered with Ipas Nigeria on a twin-track disability inclusion program with the goal of increasing opportunities for deaf women to access appropriate postabortion care and sexual and reproductive health services. This project aimed to increase access to reproductive health care for deaf women by strengthening the capacity of sign language interpreters to provide accurate, rights-based information and communication on sexual and reproductive health to deaf women. The project also worked to increase access to sign language interpretation within health centers and the government health system. Sensitization workshops on sexual and reproductive health and rights and disability were conducted with health-care providers, deaf women and sign language interpreters, and focused on the financial, communication and information barriers experienced by deaf women. Advocacy meetings were also held with key government stakeholders and health facility management to promote buy-in and uptake of sign language interpretation services at sites.

Key lessons learned from this program include:

- Access to sign language interpreters at sexual and reproductive health service sites is imperative to promote access to quality services for deaf women and ultimately reduce maternal morbidity and mortality amongst this population.
- Provision of free sign language interpretation services to support deaf women in accessing health care must be accompanied by advocacy with health facility leadership to secure buy-in and facilitate policies—

including waiving certain costs—that optimize service use by people with disabilities.

- Engaging the leadership of various community members and institutions is crucial to ensure ownership of the project.

“Before our work with Ipas we didn’t know how important it is to have linkages with these groups. They help women access [sexual and reproductive health] services, and doctors become friendlier and more willing to help deaf women.”

Hellen Anurika Udoye, a deaf disability activist with Deaf Women’s Association of Nigeria

Bangladesh

Ipas Bangladesh partnered with the National Council of Disabled Women (NCDW) in Bangladesh on several disability inclusion initiatives to sensitize, raise awareness, and strengthen collaboration between Ipas Bangladesh staff, partners and people with disabilities. The initiatives also aimed to promote positive attitudes toward people with disabilities, as well as more favorable policies and practices for them. In conjunction with NCDW, Ipas Bangladesh co-facilitated workshops and stigma-reduction activities and piloted a short set of disability questions in client exit interviews at service-delivery sites.

Key lessons learned from the various initiatives include:

- Build organizational and staff capacity for disability inclusion from the beginning (for example through participatory methods, co-facilitated workshops, values clarifications activities and mutual learning with disabled people’s organizations).
- Despite free menstrual regulation services at government health facilities in Bangladesh, people with disabilities are often charged fees or turned away. Policymakers and health facility administrators need to become aware of and address this unequal practice.
- Disability inclusion can be low-cost and easy to incorporate into existing tools, meetings and trainings by applying approaches that aim to mainstream disability content into existing practice (for example through integrating disability content into annual meetings, workshops and adapted values clarification activities).

“Some of the main challenges of people with disabilities is that families do not understand the need of getting services since [people with disabilities] are not counted like general people ... [and] always face disrespect and negligence in receiving health care from providers due to poverty and disability,” explains Nasima Akhter, a disability activist and President of the National Council of Disabled Women in Bangladesh. Akhter participated in Ipas Bangladesh’s disability inclusion programs.

Akhter tells the story of a pregnant disabled woman who went to the hospital to deliver her baby, but at reception the provider asked who her guardian was and who would cover the costs of the delivery. “Without money to pay for services or respect for bodily autonomy, women with disabilities will not be served,” she says.

Timor-Leste

Marie Stopes Timor-Leste (MSTL) provides a unique and comprehensive approach to sexual and reproductive health education and services through outreach teams, a clinic, a national youth hotline and capacity-building projects with the Ministry of Health. In 2014, MSTL started partnering with local and international disability organizations to increase disability-inclusive services and demand for these services among people living with disabilities. MSTL has made progress in the field by developing and implementing a disability policy within their organization, establishing a session on disability in MSTL new staff orientation, restructuring the organization to include a formal disability coordinator position and having Ra'és Hadomi Timor-Oan, Timor-Leste's national disabled people's organization, conduct a disability-inclusive site audit of the MSTL clinic and support office.

Though creating a new job position and remodeling the clinic's bathroom were more resource-intensive changes, most of MSTL's achievements have been low-cost, such as partnerships and relationship building, simple adjustments like new door handles, creating more accessible educational materials (using Braille, for example) and changing educational methods to meet the needs of people with disabilities. To evaluate the impact of these changes, MSTL used a short set of disability questions from the Washington Group Questions in 2016. MSTL asserts that working with disabled people's organizations and individuals with disabilities has been fundamental to understanding and improving the disability inclusiveness of its services. Next MSTL plans to pursue more inclusive services by teaching sign language to youth educators, training health providers in disability inclusive practices and continuing to invest in partnerships with disabled people's organizations at the local level.

Kenya

Since 1985, Marie Stopes Kenya (MSK) has been the biggest sexual and reproductive health organization in Kenya, serving people through 23 health centers, 14 mobile outreach teams and a social franchise network. From 2011-2016, the Australia Africa Community Engagement Scheme (AACES) prioritized serving people with disabilities, establishing 30 social franchise health centers, partnering with disabled people's organizations, and adjusting services to meet the needs of clients with disabilities. Though disability is often regarded as an individual's problem, 65% of Kenyans with disabilities regard their *environment* as the biggest impediment to comfortable daily living.

Zakiya, a 22-year-old new mother from Kaloleni District, has multiple disabilities—physical, speech, and hearing. Like other people with disabilities who are at an increased risk of experiencing sexual violence, when Zakiya's family left her at home alone, she was raped and subsequently became pregnant. With her aunt serving as her interpreter, the two women went to the local government health dispensary where they learned of the AACES project, and of a MSK social franchise providing quality contraceptive services and counseling. AACES helped Zakiya learn about different contraceptive methods and decide what choice was best for her to prevent another unplanned pregnancy.

CONCLUSION: THE TIME TO ACT IS NOW

We have the power and ability to create disability inclusive services, programming and policies to ensure that no one is left behind.

We can create “a world where people with disabilities have a voice, choice and control over the decisions that affect them. Where they participate in and benefit equitably from everyday life, everywhere” (Department for International Development [DFID], 2015).

Despite being a considerable percentage of the world’s population, people with disabilities are underserved in contraceptive and abortion services due to pervasive negative attitudes and stigma surrounding their sexuality. Constrained economic opportunities, high rates of poverty and an increased likelihood of experiencing sexual and gender-based violence result in a high number of unwanted pregnancies. Because of this, people with disabilities may experience a greater need for safe abortion care but be less likely to access it since they are often dependent on others for financial support, transportation and communication. It is essential that we prioritize providing safe abortion and contraceptive care to people with disabilities by committing resources, training health-care providers, training policymakers and advocates, addressing physical and information/communication barriers and eliminating stigma toward people with disabilities.

Disabled people’s organizations, community-based organizations, nongovernmental organizations and other actors have made progress promoting access to general health services for people with disabilities. However, serving people with disabilities still needs to be intentionally and systematically mainstreamed across the sexual and reproductive health sector, specifically regarding abortion and contraceptive care. Co-creating appropriate and accessible safe abortion and contraceptive services through a twin-track approach will help prevent unsafe abortion, which can otherwise result in maternal mortality, disability and mental health problems.

We must act now to understand and address all barriers to safe abortion care—physical, communication, systemic and stigma-related—that people with disabilities face at the policy, service delivery, community and family levels. We must use the momentum generated by global donors, sexual and reproductive health program implementers, disabled people’s organizations and activists to not only improve safe abortion and contraceptive services for people with disabilities, but to also support them, their families and communities, health-care providers and policymakers to ensure people with disabilities are fully able to realize and act on their rights.

Please see the accompanying *Access for Everybody: A guide for disability inclusion in abortion and contraceptive care* for steps that outline immediate actions we can all take in our programs to promote disability inclusion in abortion and contraceptive services at the policy, service delivery and community levels.

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Ipas works globally so that women and girls have improved sexual and reproductive health and rights through enhanced access to and use of safe abortion and contraceptive care. We believe in a world where every woman and girl has the right and ability to determine her own sexuality and reproductive health.

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